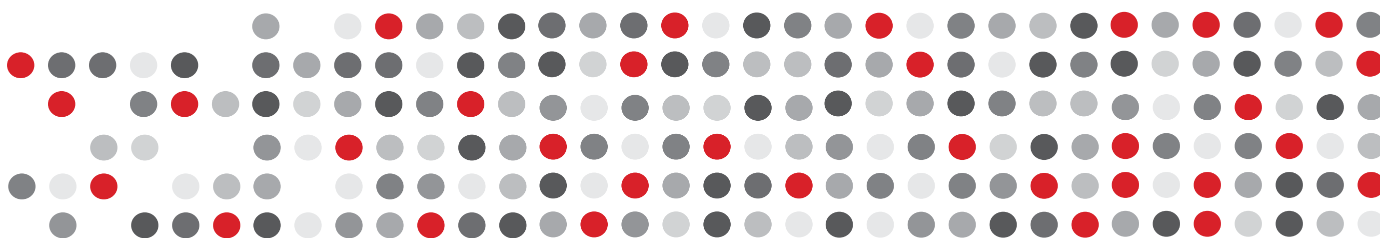
4th Regional Capacity Strengthening Convening for African Human Rights Institutions

16 -18 September 2019
Johannesburg, South Africa



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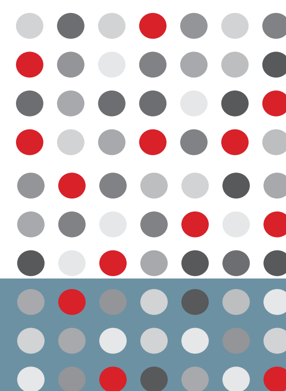
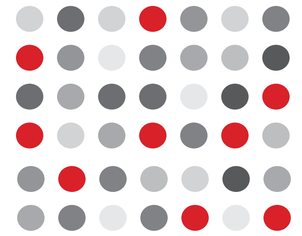
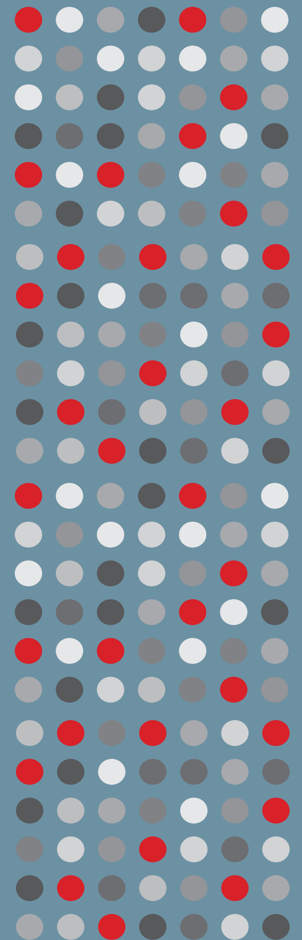


ACRONYMS

ACHPR	African Commission on Human and People's Rights
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ARASA	AIDS and Rights Alliance for Southern Africa
AU	African Union
CAL	Coalition of African Lesbians
CRR	Center of Reproductive Rights
CSO	Civil Society Organisation
DRC	Democratic Republic of Congo
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
ICPD	International Conference on Population and Development
IGM	Intersex Genital Mutilation
KELIN	Kenya Legal & Ethical Issues Network on HIV/AIDS
KNHRC	Kenya National Commission on Human Rights
KP	Key Populations
MDG	Millennium Development Goals
MDR-TB	Multi Drug Resistant Tuberculosis
MHRC	Malawi Human Rights Commission
NANHRI	Network of National Human Rights Institutions
NHRI	National Human Rights Institutions
PLHIV	People Living with HIV
SALC	South African Litigation Center
SAHRC	South African Human Rights Commission
SAMA	Southern Africa Miners Association
SAT	Southern Africa Trust
SDG	Sustainable Development Goals
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
WPATH	World Professional Association for Transgender Health



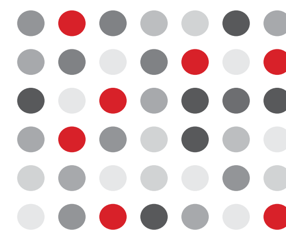
INTRODUCTION



The AIDS and Rights Alliance for Southern Africa (ARASA), in collaboration with the Network of African National Human Rights Institutions (NANHRI) have for the last three years hosted the **Regional Capacity Strengthening Convening for National Human Rights Institutions**, under the Global Fund Africa Regional Grant on HIV: Removing Legal Barriers to engage in evidence based discussions on Human Rights, HIV, and TB in the region. This year, ARASA and NANHRI welcomed a new partner as one of the hosts, the Center for Reproductive Rights (CRR) in order to strengthen the conversation on Sexual and Reproductive Health and Rights (SRHR).

The Regional Capacity Strengthening Convening brought together 15 senior NHRI representatives and 10 key experts in HIV and Sexual and Reproduction Health and Rights (SRHR) from 15 African countries.[1] The Convening focused on multiple SRHR issues such as access to safe abortion, maternal healthcare, adolescent SRHR, HIV as an SRHR issue as well as sexual orientation and gender identity as SRHR issues. The meeting provided a space for reflection on the work and advocacy priorities that were undertaken by NHRIs since 2016 while providing a platform for prioritisation and action planning between NHRIs, ARASA, CRR and NANHRI for the next three years.

[1] Botswana, Cameroon, Cote d'Ivore, Democratic Republic of Congo, Kenya, Malawi, Mauritius, Mozambique, Sierra Leone, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.



BACKGROUND

ARASA and NANHRI have, for the last three years, hosted the Regional Capacity Strengthening Convening for NHRIs under the Africa Regional Grant on HIV: Removing Legal Barriers. The fora provided a platform for NHRI representatives from different African countries to engage in evidence-based discussions on human rights, HIV, TB and SRHR. The meetings not only assist in increasing the knowledge of NHRIs on health and human rights issues, but they also build a bridge between NHRIs and civil society in order to foster effective in-country partnerships and cooperation.

The 2019 convening provided a space for reflection and evaluation to measure the impact of such regional peer-to-peer sharing platforms, and to inform and shape future meetings of a similar nature.

GLOBAL FUND AFRICA REGIONAL HIV: REMOVING LEGAL BARRIERS (RLB)

In 2015, the AIDS and Rights Alliance of Southern and East Africa (ARASA), Enda Santé, the Southern African Litigation Centre (SALC), Kenya Legal & Ethical Issues Network (KELIN) and the United National Development Programme (UNDP) secured funding from the Global Fund to fight AIDS, TB and Malaria (GFATM) to undertake regional level interventions in ten countries in West, East and Southern Africa. The overall goal of the Removing Legal Barriers (RLB) programme was to *work with parliamentarians, policy makers, law enforcement officials, cultural leaders, lawyers and the judiciary to strengthen access to services for key populations in 10 countries – Botswana, Cote d'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda, and Zambia.*

The objectives of the RLB programme were:

1. Strengthening evidence-based law reform to support improved delivery of and access to HIV and TB services for key populations;
2. Improving the legal environment that provides rights-based protections through access to justice and enforcement of supportive laws for key populations; and
3. Protecting key populations in the event of human rights crises, which impede access to HIV and TB services.

JUSTIFICATION

Historically, governments have employed coercive criminal sanctions to isolate and incapacitate individuals who are considered carriers of infectious diseases. Often, criminal laws are used to either to regulate and/ or punish people based on their HIV-status. The criminalisation of HIV exposure, non-disclosure and transmission is a growing global phenomenon and increasingly, African countries are adopting punitive HIV-related legislation, which can result in the violation of the rights of people living with HIV. Similarly, current responses to TB often fail to respect human rights and apply overly broad punitive approaches to persons with TB (who are often also living with HIV); for example, enforcing involuntary treatment, hospitalisation, isolation and detention in prisons; home arrests; and travel restrictions. Criminal sanctions can also be applied as a measure to control the spread of TB and force people to adhere to treatment.

The promotion of enabling legal and policy environments for the general and key populations remains central to advancing rights-affirming comprehensive sexual and reproductive health, HIV and TB health care interventions.

Addressing the structural barriers in the African context, is of specific importance if we are to achieve the Sustainable Development Goals (SDGs)[2] and ensure equitable and equal Universal Health Coverage (UHC)[3].

NHRIs play a significant role in monitoring and addressing the inappropriate use of criminal law at national level. NHRIs are in a unique position to hold governments accountable to their commitment to respect, protect and fulfil reproductive rights as defined in the International Conference on Population and Development (ICPD)[4] Programme of Action and further articulated in international human rights documents, and national laws. Therefore, NHRIs can advance gender equality and equity, to ensure sustained access to the SRHR health services for young people, adolescent young girls and women. The 2012 Amman Declaration and Programme of Action provided instructive broad principles and priority areas of work for NHRIs to advance sexual and reproductive rights.

OBJECTIVES OF THE 4TH REGIONAL CAPACITY STRENGTHENING CONVENING FOR NATIONAL HUMAN RIGHTS INSTITUTIONS INCLUDED;

a) To provide a platform for NHRI representatives to engage in evidence informed discussions and identify their roles in advancing human rights-based responses to HIV and SRHR;

b) To share lessons learned and identify functional models on how NHRIs can promote and protect the rights of People living with HIV and key populations, through monitoring the impact of criminal law on TB and HIV;

c) To increase the capacity of NHRIs around key structural barriers to HIV and SRH services, to strengthen their reporting and guidance to governments priority areas of focus; and

d) To evaluate the impact and outcomes of the convenings since 2016.

[2] SDGs - are the blueprint to achieve a better and more **sustainable** future for all. They address the global challenges we face, including those related to poverty, inequality, climate, environmental degradation, prosperity, and peace and justice.

[3] UHC - **Universal health coverage** means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative **health** services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

[4] ICPD - **International Conference on Population and Development**. The United Nations coordinated an **International Conference on Population and Development (ICPD)** in Cairo, Egypt, on 5–13 September 1994 that resulted in the **Programme of Action** that is the steering document for the United Nations **Population** Fund (UNFPA)

METHODOLOGY OF THE CAPACITY STRENGTHENING CONVENING

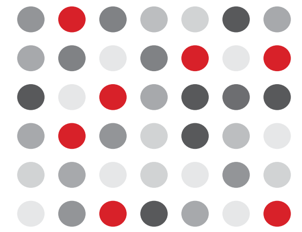
The regional capacity strengthening was a four-day interactive workshop, which included facilitated discussions, presentations by expert resource persons and group work sessions.

The use of case studies related to criminalisation of key populations, public health and human rights were utilised for the purpose of deepening knowledge and considering avenues that the participants could use to promote reforms in their countries.

TOPICAL ISSUES FOR THE CONVENING

- Adolescents Sexual and Reproductive Health and Rights
- Comprehensive maternal health
- Access to safe abortion and post abortion care
- HIV Prevention and structural barriers
- Universal Health Coverage (UHC)
- Sexual and Reproductive Health and Rights (SRHR) with a focus on Sexual
- Orientation, Gender Identity and Expression (SOGIE)
- The role of NHRIs in civic space advocacy. The role of NHRIs in relation to the Africa Commission on Human and People's Rights (ACHPR)

DAY ONE
16 SEPTEMBER, 2019



MORNING SESSION

WELCOME AND INTRODUCTION

The meeting was opened by **Felicita Hikuam**, the Deputy Director of ARASA who welcomed all into the space while providing a short brief on ARASA's work. She spoke about the growth of the organisation from 5 to over a 100 partner organisations as well as highlighting the recent strategic reworking and broadening of ARASA's scope of work to focus on the rights to bodily autonomy and integrity. Felicita then spoke about strategic partnership between ARASA, NANHRI and the Center for Reproductive Rights (CRR) in order to advance SRHR in the region.

Marie Ramtu, Programme Officer at the Network of African National Human Rights Institutions

Marie Ramtu from NANHRI then spoke about how the convening allowed NHRIs to reflect on SDG[5], despite the fact the NHRIs had been criticised for just dealing with political rights, stating that the convening allowed for the discussion to also encompass economic and social rights. She ended her welcome by thanking ARASA for the work done over the last 3 years and welcomed the CRR.

Lucy Minayo from CRR, a global organisation with a footprint in the Global South, stated that CRR has established a regional network for SRHR that has since brought together 35 organisations in 30 countries, some of which included NHRIs. She reiterated that the meeting aligned with their strategy. She closed off the by pointing to the fact that this convening called for all to question and reflect continuously while safeguarding and responding to the ways in which SRHR advocacy continues to face pushbacks.

THIRD REGIONAL CAPACITY STRENGTHENING CONVENING RECAP

Nthabiseng Mokoena, ARASA's Regional advocacy officer began their presentation by providing a recap of the Convenings since 2016. They brought attention to the fact that the 2019 meeting was smaller, emphasizing that the number of participants was significantly smaller than the previous meetings in order to have more in-depth conversations in smaller groups to enable all in the room to plan for the next 3 to 5 years. Nthabiseng provided a recap of the programme's journey since 2016 noting that:

- The first convening in 2016 was aimed at relationship building between Key Populations (KPs) and NHRIs, noting that the relationship that existed before was one where there was a lack of trust from both parties. The meeting therefore provided a space for both parties to address the systemic issues that existed in the past while allowing for the creation of a space for investigation and interrogation of roles and way forward for both.
- The second convening of 2017 addressed human rights-based approached to HIV/AIDS and TB

[5] SDG 3 - Ensure healthy lives and promote wellbeing for all at all ages

- The third convening in 2018 primarily focused on HIV and SRHR however at the end of the meeting participants felt that SRHR should be covered and discussed more, hence the 2019 convening specifically aimed at further unpacking SRHR in line with ARASA's new strategic plan.

Nthabiseng further spoke of the health and rights themes that had been discussed in the convenings since 2016 and the role of the NRHIs in the discussions. They highlighted that the underlying principle in all those health and rights themes was the recognition of bodily autonomy and bodily integrity. Noting that issues of safety, consent, power and freedom from torture, which were key discussions since 2016 all also clearly connected to issues of bodily autonomy and integrity. Nthabiseng went on to provide an overview of the topics of the 2019 convening as:

- Adolescent SRHR;
- Maternal health;
- Access to safe abortion and post abortion care;
- Universal Health Coverage (UHC);
- SRHR and Sexual Orientation Gender Identity and Gender Expression issues.

Nthabiseng Mokoena, ARASA Regional Advocacy Officer

Felicita Hikaum, ARASA Deputy Director

Felicita from ARASA went on to set the context of the next 3 days of the convening. She utilised the power walk activity [6] and a video screening to introduce the next session. Felicita provided an overview of SRHR and what the regional commitments were around SRHR, while providing a specific definition of sexual rights and reproductive rights. She went on to highlight the global trends affecting SRHR, while providing a brief on how HIV is a SRHR issue.

Felicita spoke around the focus for ARASA for the next 3 years being on: SOGIE rights, HIV prevention, Universal Health Coverage and access to safe abortion. The session concluded by offering participants the opportunity to reflect on the programme with some statements reflected below:

[6] The power walk activity – This is an exercise whose purpose is to enable participants learn to recognize how power and privilege can affect our lives even when we are not aware it is happening.

Participant 1 from Kenya:

These meetings have been very useful, these convenings bring us together to share and learn even though the topics are hot and controversial. Being here allows us to understand these in the context of human rights, from a South-South perspective. KP's exist in our countries and this conversation has been helpful with doing the work and I look forward to this conversation. Making this a South-South conversations allows us to take away the belief that these human rights are not ours and we are importing something that comes from the west.

Participant 2 from Côte d'Ivoire:

I echo what was said, these ideas are taboo in our countries but with these conversations we have managed to mainstream Human rights work and have organised interventions even though we have been questioned, but this has allowed us to do a lot of work.

Participant 3 from Cameroon:

We found ways to partner with CSO in order to do justice to KP's. We found people in government to champion these rights and we did surveys on social media which allowed us to use our numbers to speak to politicians by threatening to not vote for them if they do not mainstream KP's health care and this has allowed us to tackle these issues.

Participant 4 from Ghana:

I share the sentiments of my colleagues. We got into this believing our duty bearers are doing human rights work, but we have learnt that they were not. So, we have learnt to capacitate duty barriers, showing them that all human rights are important, and we do a lot of work within. We highlight the African Charter, it's such an inclusive document and allows us to be fair to all humans. Non-discrimination being the center of this conversation. Sometimes it's not that the duty barriers don't want to but sometimes they just don't know.

Participant 5 from Eswatini:

I also share my colleagues' sentiments. Eswatini has had some complaints on LGBTI and I have assisted with it, we are currently undertaking a training with all duty bearers. People in my country see LGBTIQ [7] people as second-class citizens, this is a belief we are more than ready to challenge .

[7] LGBTIQ - Lesbian Gay Bisexual Transgender Intersex Queer

CONTEXT SETTING

Lucy from CRR opened the session by taking participants through some statements to measure their understanding of human rights-based approach to SRHR and to question individual beliefs. The distinction is that CSOs can often choose which human rights they advocate for, however, NHRIs have to deal with all rights, without seeing one right as inferior to the other. NHRIs have a mandate that requires them to encourage the state to comply with rights that they might not agree with. Lucy used examples from Morocco and Kenya to demonstrate how NHRIs can be at the forefront of SRHR issues such as access to safe abortion.

Some thoughts from the exercise were:

Participant A:

I do not agree in terms of abortion when you abort you are killing a human being. I am a Christian and for us the fetus is human but if a girl is raped, she should be able to abort.

Participant B:

When it comes to rape there is always an assumption that the victims always wants to abort the fetus, but I have heard the testimony of individuals who have kept their children and are happy and proud of keeping their children. There is also a lot of individuals that have aborted and live with guilt for years or individuals who have given their child up for adoption have gone back to look for their child.

Participant C:

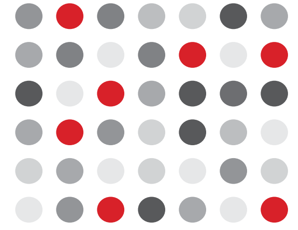
It's a rare circumstance that people have abortions and regret it but if you are raped, you should choose how you deal with it from a human rights point of view. Someone has done something to your body without consent but from that point, you have a right to do what you want with the pregnancy that resulted from that. We are certainly not speaking about coerced abortion.

The session concluded with reflections noting that dealing with human rights issues often requires one to question their beliefs, religion and own prejudices. Regardless of personal beliefs, working for an NHRI means protecting and promoting the rights of all people, in most cases these are vulnerable and marginalised populations that the majority often do not agree with.

Lucy went on to focus on legal, programmatic and institutional frameworks that exist for NHRIs to integrate SRHR issues. Lucy unpacked the Amman Declaration and Program of Action (2012) [8] , stating that the declaration had 17 principles and broad areas of work, with 4 themes to be prioritised over a 10-year period which were:

- Women's political participation
- Women's Economic and Social Rights
- Violence against Women and Girls
- Women's Health and Reproductive Rights

[8] Amman Declaration and Program of Action for Promoting Gender Equality was passed at the 11th International conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights that took place in Amman, Jordan from 5-7 November 2012. The declaration sets out the steps that NHRIs around the globe have agreed to undertake in order to promote and protect the rights of women and girls



She highlighted that the key commitments from the Declaration were to:

- Promote and protect rights without discrimination
- Encourage collection of evidence
- Review laws and administrative regulations
- Promote access to SRHR information and services

In terms of the NHRIs' specific call to action, Lucy mentioned these to be:

- Integrate and mainstream women's rights and gender equality
- Investigate and respond to violations of women's rights including reproductive rights
- Facilitate access to justice for women and girls per the NHRIs' mandates

FRAMEWORKS THAT ENABLE AND REQUIRE ROBUST NHRI INVOLVEMENT IN SRHR

The afternoon session continued with the focus on SRHR and more specifically highlighting that:

- Women and girls were dying from unsafe abortions;
- Adolescents were not getting adequate sexuality education;
- Adolescents were in jail for having sex with their own peers; and
- Women were not getting adequate contraceptive information.

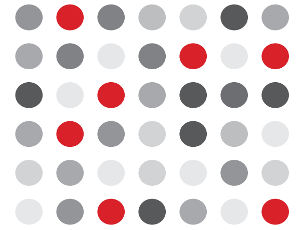
It was however noted that there were enough laws and policies that could assist in tackling these issues, with the Amman Declaration being referred to due to its groundbreaking nature and how it explicitly challenges NHRIs to do work with women and girls.

Referring specifically to the Amman Declaration, the commitments made by NHRIs were:

- To find evidence that they could use to lobby government to enforce the commitments under the Amman Declaration
- Integrate women and girls SRHR issues into their various National Action Plans
- Promote greater involvement and collaboration between a vast array of stakeholder including but not limited to judges and law enforcement
- Integrate issues of sex trafficking and compensation of victims
- Develop stringent measures that focus on internal and external sexual harassment
- Review of laws that promote and protect women's rights in-country

The role of the Global Alliance of National Human Rights Institutions (GANHRI) and NANHRI was addressed with participants stating that they should review countries based on the Amman Declaration, while also ensuring that these reviews are included in the UN CSW. Some reflections included the following;

- In some instances, NHRIs were failing people by taking the stance that human rights were political opinions, with the participants asking NANHRI put together a compilation of soft laws that would be sent to the heads of the respective NHRIs to remind them of their role



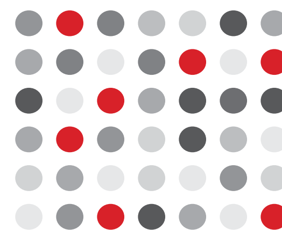
- In finding a way forward for the next 3-5 years, there is need to acknowledge that there is no implementation framework that exists as there is no acknowledgement of the actual declarations made. There is need for GANHRI and NANHRI to pick up the declarations as well as the Marrakesh Declaration [9] and SDG 1 [10] and see how these fit together and can be used to hold NHRIs accountable.
- There is need to further examine the Amman Declaration and to follow up with a framework that speaks to gender equality as a whole
- The accessibility of NHRIs by CSOs was also questioned, NHRIs were encouraged to actively seek out and consult with CSOs

The session ended with a challenge posed to the group to integrate and mainstream women and adolescent rights.

Lucy, CRR

[9] Marrakesh Declaration - Marrakesh Declaration on the Rights of Religious Minorities in Predominantly Muslim Majority Communities – declaration made around defending the rights of religious minorities in predominantly Muslim countries

[10] SDG 1 – No poverty i.e. end poverty in all its forms everywhere



AFTERNOON SESSION

PANEL DISCUSSION: HOW HAVE NHRI'S RESPONDED TO SRHR ISSUES? (CAMEROON, GHANA AND KENYA)

Marie Ramtu from the NANHRI facilitated a discussion governed by the Chatham House Rules [11] between NHRIs from Kenya, Ghana and Cameroon around their experiences of working on SRHR issues. The sessions allowed the panelists the opportunity to share their challenges and successes while also allowing other NHRIs to share their experiences.

CAMEROON
Successes:

- Advocacy around patient health and access to healthcare services - The patients attending the day hospital at present can now access services without fear of stigma and discrimination, as they were previously discriminated against due to their HIV status and/or sexual orientation
- Successfully advocated for LGBTI persons to start their own organisations in order to have a voice. The NHRI developed stronger collaboration and partnership with this LGBTI organisations to ensure sustainability and awareness on SOGIE issues

Challenges:

- Continually working with LGBTI groups while maintaining anonymity and guaranteeing their protection in a country that criminalises same-sex sex

GHANA
Successes:

- Despite homosexuality and other KPs being criminalised, with the assistance of UNAIDS, HBP and the GFATM there have been successful discrimination reporting programmes put in place
- A unit that is part of the police has been set up after engagement with civil society due to the fact that the vulnerable groups were unable to report violations due to stigma and discrimination. The platform is web-based ensuring anonymity of the person reporting the case
- Developed a policy on privacy and discretion with a training taking place with law enforcement
- The NHRI is part of a steering committee to develop a human rights plan for 2021-2025 addressing human rights violations in relation to HIV

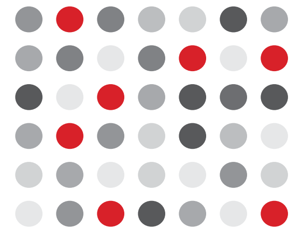
Challenges:

- The inability to maintain the health rights desk due to staff turnover, leading to continuous training to orientate new appointments to the role
- Lack of awareness around HIV by healthcare workers especially around KPs adds to stigma and discrimination.
- Law enforcement targets marginalised groups
- Lack of coordination among stakeholders
- There is no gender commission as such issues of marginalised groups are not taken into account and are not seen a human rights issue

Way forward:

- Mainstream coordination with the Ghana AIDS Commission as well as UNAIDS
- Deepen HRs knowledge with health care workers, judiciary and law enforcement among others
- Sharing country experiences

[11] Chatham House Rules - a rule or principle according to which information disclosed during a meeting may be reported by those present, but the source of that information may not be explicitly or implicitly identified.



KENYA

Successes:

- There has been collaboration with CSOs on the development of UPR reports with direct reference to SRHR, where there was a significant stride made around abortion guidelines for women and girls under the medical guidelines
- Using evidence to build cases around inclusion e.g. cases of children born as a result of rape and the effects thereafter following the 2007 post-election violence
- Part of the process of developing a non-discriminatory law on SOGIE, with the assistance of a 5 country programme currently in place to help with the realization of Resolution 275 led by the NANHRI Secretariat
- NHRI was an *amicus curie* [12] on the petition to decriminalize same sex relationships case and are currently in the process of lodging an appeal
- Through work with Intersex Activists, Intersex persons were included as part of the National Census that happened in August of this year

Challenge:

- Currently there is the KNCHR, the Ombudsman and the Gender Commission, and despite there being collaboration between these institutions there is no focus on KP issues. The proposal to merge all 3 and come up with one commission has been denied

Way Forward:

- There is need for NHRIs to mainstream and prioritise women and girls in their work, by creating policies in line with the commitments in the Amman Declaration
- There needs to be coordination and cooperation at a national, regional and international levels similar to the work being done with ARASA and NANHRI

QUESTION AND ANSWER SESSION: PANEL DISCUSSION

Participant from Cote d'Ivoire:

I want to ask the Kenyan commission, I'm not sure if I heard him well. During census you included the 3rd sex. What is your objective with this? Will you include this in the law or is it just to understand numbers? I have also come to learn that in many countries there is a duplication of services, our constitution only allows NHRI to deal with human rights issues. Therefore, can the NHRI look at the country without the government and thereafter make many evidence-based approaches to change government's implementation process?

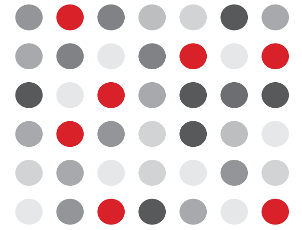
Participant from CAL:

There is an issue with the use of the term KP and the language therein as it is not inclusive of LGBTI identifying individuals. How then are NHRIs using the framework of Resolutions 275 to address this?

Participant from Zambia:

How did Kenya do litigation on sodomy? Does your constitution specifically mention sodomy?

[12] Amicus curiae - (literally, "friend of the court"; plural, **amici curiae**) is someone who is not a party to a case and may or may not have been solicited by a party and who assists a court by offering information, expertise, or insight that has a bearing on the issues in the case;



Answers:

Responses from the panelists to the questions asked are reflected below:

Kenya's response

- What we were challenging was the Penal Code, specifically sections: 161 and 162, by highlighting that the rights in the Constitution are higher than the Penal Code, saying all Kenyans should enjoy these rights regardless of Gender Identity and Sexual Orientation. We further challenged this notion around the elections, where we had a gay prominent figure stand for elections. In one of the gatherings we realised that the issue was around getting buy in from the top and it has made it easier to deal with it.
- We need to use terms and terminology that are affirming, it's important not to use language that leads to othering of persons.
- Yes, indeed we have a third sex code, male, female and intersex and the task force went to all 47 counties in the country and we discovered there was 800 000 to 1 million people that identify as intersex. The complainants had told us all their issues, and now after gathering the data it will become a case on discrimination due to a lack of access to adequate health care, education and employment due to their sex descriptor.

DAY TWO:
17 SEPTEMBER, 2019

MORNING SESSION

RECAP

The day began with an overview of the previous day's engagements and activities. Delegates were invited to reflect on their experiences of the day and raise any questions or concerns that they may have had.

One question that emerged was around victims of rape and the rights perpetrator in terms of the of the child should the incident result in one; and whether the room was ready to create a space where the perpetrator sought to spend time with or be in the life of the child, and if this should even be allowed.

The second was around age and what NHRIs should do when a person is detained in a juvenile center even after they have passed 18 years, as this is often the case in most countries.

The questions were reflective of the depth of discussions from the previous day and also a called for all to engage further and look at how as NHRIs they can intervene even in difficult situations.

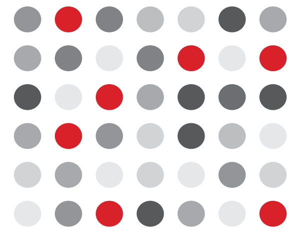
ADOLESCENT SRHR

Felicita Hikuam from ARASA opened the session on Adolescents SRHR by introducing Dr Natasha Kaoma from Copper Rose in Zambia. Copper Rose is a youth led organisation that works on youth SRHR from a human rights perspective. Natasha began the session by going through the definitions of the words she would use, such as adolescence (age 10 to 19) and youth (age 15-35) and that the catch all is young people. She then invited everyone to participate in a memory activity about their childhood memories, with participants writing memories of their childhood on sticky notes then reading them out. Natasha went on to open the floor for reflections about these memories and it was highlighted that most of these memories were attached to SRHR and it was necessary for everyone to realise that these were universal lived realities.

Dr Natasha Kaoma went on to speak on the state of ASRHR in Zambia, with some of the main issues being identified as:

1. Access to contraceptive information and services
2. Access to safe abortion and post abortion care services
3. Maternal health care
4. Prevention and treatment of HIV
5. Comprehensive sexuality education
6. Violence against women and girls
7. Rights of marginalised populations

Dr Natasha Kaoma



Her presentation further highlighted some of the contributors to barriers on ASRHR including: poor policy implementation, provider discomfort, age of consent, religious-cultural barriers and lack of government investment. Natasha mentioned some of the lessons learned to be:

- Integration of SRHR into other sectors;
- Addressing the gaps in service provision;
- Need for new approaches to SRHR; and
- Capacity building for youth-led organisations.

Her presentation concluded with some recommendations to NHRIs around SRHR including:

- Utilising a rights-based approach;
- Avoiding being emotive;
- Push for laws that positively contribute to ASRHR;
- Create strategic coalitions to address SRHR; and
- Collect data and evidence that can be used to push for policy reforms.

Felicita went on to introduce Tshinondiwa Ramaite (IPAS South Africa) who spoke on the right to safe abortion and the impact the lack of access to this right has on SRHR for adolescent girls and women. She gave a brief description of IPAS and its work speaking to the fact that the organisation mainly worked on abortion, adolescents SRHR and access to contraceptives, noting that there were approximately a million unsafe abortions performed on adolescents. Tshinondiwa went on to provide the following recommendations:

1. Involve young people as a key decision maker in program design, implementation and evaluation;
2. Provide comprehensive accurate information to young people in a manner appropriate to their age and sex;
3. Address barriers to accessing health and information services;
4. Empower adolescents to make life choices and that are best for themselves; and
5. Promote inter-generational dialogue regarding sexual and reproductive health.

The ASRHR discussion was then opened up to the audience for discussion and comments around the presentations as well as views on what NHRIs they thought were the gaps and ways in which these could be addressed. Some of the comments were:

Participant 1:

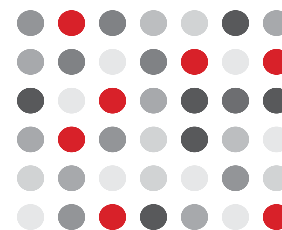
As NHRIs we need capacity to address how we solve issues of sexuality at an earlier age. What are the tools we can use to teach sexuality? When we go back to our countries who are the services providers we can contact? Furthermore, when we talk about reproductive health, what does that really mean?

Participant 2:

In Zambia, for an abortion, the Termination of Pregnancy Act requires the primary medical practitioner to make the decision, but then you need 2 more medical practitioners to sign off on this procedure. Even then there's still a very narrow negotiation space such as mental health risk or any health risk to mother etc.

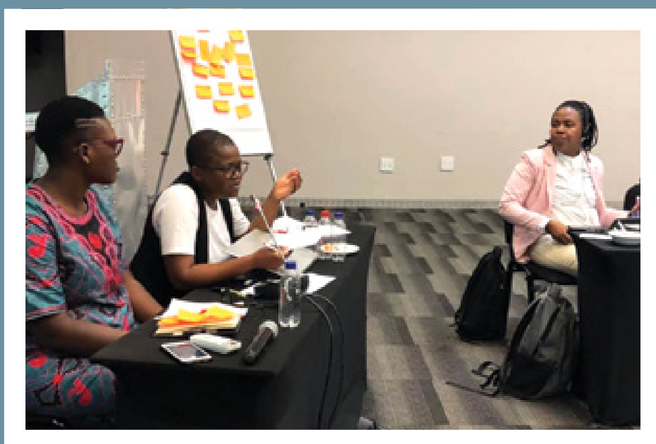
Participant 3:

I was disturbed by the low use of modern contraceptives; I would attribute the low use to religious and cultural practices but is this everywhere or just in my country?



The session closed with remarks from both presenters with Tshinondiwa Ramaite, who reflected on the fact that as society there is need to come to terms with the fact that youth are sexually active while also being in contact with sexual content. There's need to educate them and keep them safe from STIs and unwanted pregnancies. It was noted that there is need to educate them from home at a very early age because they need to be equipped with the necessary knowledge. The presenters also explored what sexual health looked like and how it can be ensured that children have their rights realised, stating that this starts at home, where there should be discussion around what safe sex looks like as well as what sexual violation looks like.

Dr Natasha Kaoma highlighted the need to accept that young people were indeed sexually active despite there being denial around this within society. She spoke to the fact that abstinence only programmes do not work, with the biggest problem in Africa being denial. The session concluded with Dr Kaoma stressing the need to work with CSOs while encouraging NHRIs to access various toolkits online on SRHR.



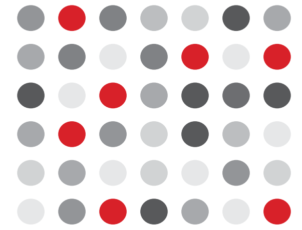
Natasha, Tshino and Nthabiseng

MATERNAL HEALTH

The session was opened by Marie Ramtu who introduced Louise Camrody from Amnesty International and Nyasha Chingore-Munazvo from ARASA.

Louise Carmondy from Amnesty International began by stating that maternal health and access to care was indeed a human right. She noted that maternal death was a result of human rights violation based on gender inequality. Louise emphasized that maternal death was the result of the rights to access to health and the right to life being violated. She noted that the unintended consequences of these violations were experienced by individuals that lived in poverty with layers of oppression that ultimately increase inequality and morbidity. Louise stated that the UN has since declared high maternal deaths a global crisis. She gave an example of the South African government that has recommended there be 8 free pre-natal consultations and access to Nevirapine for pregnant women living with HIV. However, even though it had been recommended, it was still not written into policy resulting in a failure to implement. Louise stated that for there to be preventable maternal and morbidity there was need to employ a human rights-based approach. She went on to identify some of the barriers to maternal health as;

- insufficient ward space, beds and theaters;
- storage of drugs and medical equipment;
- bypass fees/out of pocket costs;
- shortage of ambulances and fuel;
- negligence and lack of accountability;
- lack of water and proper sanitation; and
- Insufficient allocation to health from national budgets



She emphasized that African countries must meet their commitment under the Abuja declaration of 15% of the national budget going towards health.

Louise closed off her presentation by providing some recommendations to address the maternal health issue, noting that these were in no way exhaustive recommendation. Some of these include:

- Addressing gender and intersectional discrimination stereotypes which results to denial of health services to women and girls;
- Advocating for access to abortion both in law and practice;
- Supporting CSE in and out of school, therefore ensuring that adolescent girls can enjoy SRHR without discrimination or coercion; and
- Investigating the impact of transport barriers to maternal health for women and girls in rural areas.

Nyansha Chingore-Munazvo from ARASA started her presentation with a Video about the consequences of unsafe abortion aimed at giving a human face to the conversation. She went on to speak to the African Union's Campaign on Decriminalization of abortion in Africa which highlighted the staggering statistics around death due to unsafe abortions. Nyasha spoke about some causes of maternal death, what unsafe abortion was and was perpetuated by, with restrictive laws and limited access to adequate services being the key drivers. She spoke to the fact that only 1 in 4 abortions in Africa was safe, with 93% of women of reproductive age in Africa living in countries with restrictive abortion laws. Nyasha went on to state that restrictive laws led women to seek unsafe abortions, coupled with the fact that these very same laws made women and girls wait longer to have unsafe abortions causing complications.

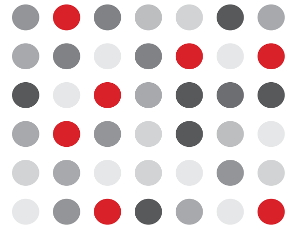
She went on to give an example of South Africa where liberalised laws led to an initial reduction in the rates of unsafe abortions. Nyasha noted that the criminalisation of terminations of pregnancy was both a public health concern and a human rights issue. She highlighted that Article 14 of the Maputo Protocol [13] provides a regional framework on the minimum standard to an inclusive approach to SRH, where General Comment No. 2 provided more guidance on Article 14. She went to note that leaving healthcare workers to decide if this was a serious threat put women at even greater risk. Nyasha also spoke about CEDAW that states that if there are laws that allow individuals to access abortion, the pathways in country must be made clear to guarantee this access.

She also spoke about the Mexico City Policy (also known as the Gag rule), which prevents recipients of certain US funds from working on abortion issues.

Nyasha concluded her session by making recommendations on what NHRIs and CSOs could to facilitate maternal health care, with some recommendation below noting that these are not exhaustive:

- Monitor implementation of existing law through inquiries, complaints and investigations.
- Report on implementation of sub-regional, regional and international treaties.
- Lobby for law reforms and support the efforts of CSOs
- Involve the medical boards in interventions
- Increase public awareness

[13] Maputo Protocol also known as the Protocol to the African Charter on Human and People's Rights on the rights of women in Africa - guarantees comprehensive rights to women including the right to take part in the political process, to social and political equality with men, improved autonomy in their reproductive health decisions, and an end to female genital mutilation.



AFTERNOON SESSION

SRHR AND SOGIE ISSUES

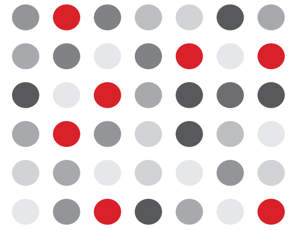
Felicita opened the afternoon session by introducing Anthea from the Coalition of African Lesbians (CAL). Anthea began her session with an introduction of CAL and the work they do around sexual rights specifically for Lesbian, Bisexual and Queer (LBQ) women. She went on to speak around the interdependency of all rights and how sexual rights and access to these were a combination of various factors. Anthea stressed the need to look at LBQ women specifically on how sexual practice is criminalised. She went on to highlight that there is an interdependency between all rights focusing on how sexual rights are a combination of the right to health and protection against violence. However, although these are usually seen as entry points in beginning conversations around SRHR, they can at times have the opposite effect for LBQ and the wider LGBTIQ community as they are then seen as a single-issue group.

Anthea went on to speak about CAL's involvement with the Africa Commission (AC). She began with an overview of the interaction with the AC noting the following:

- 2008: CAL's first application to the AC that was then deferred for 3 years;
- 2011: CAL receives a request from the AC asking them to specify which group they represented
- 2015: CAL reapplies and are voted in. However, 2 months later their observer status is withdrawn
- 2015: CAL takes the case to the African Court leading the Court to then state that NGOs can no longer have legal standing and as such cannot bring cases to the African court
- 2019: The AU released a statement that the African Commission should not cooperate with the Coalition of African Lesbians.

The example from CAL speaks to the level of oppression and silencing that human rights organisations working on sexual orientation and gender identity issues face and continue to face despite there being human rights. Anthea concluded her presentation by reflecting on the independence of the Africa Commission and how this should be promoted and protected at all costs.

Anthea, CAL



UNIVERSAL HEALTH COVERAGE

Felicita began the session by asking those in the room about who had ever heard of Universal Health Coverage (UHC) while asking the room to engage with why they thought it was important to speak to UHC during the session. Some of the responses to the question posed by Felicita were:

Participant 1:

Statistics that we got today give an indication that access to health, education and services is a challenge and UHC is premised on the grounds that it's about access to health care and it's important to leave no one behind.

Participant 2:

Will UHC not still discriminate against marginalised groups?

Participant 3:

There are both human rights implications as far as UHC is concerned

Felicita went on to pose the question around what participants thought the meaning of UHC was, with some responses reflected below:

Participant A:

It has to do with service and financial accessibility.

Participant B:

No one is left behind in health, an example of this is Rwanda where they are actively trying to ensure that this is the case for everyone

Participant C:

Is there a difference between universal health care and universal health coverage.

The responses were followed by the screening of videos looking at UHC in Kenya and Zambia as practical examples demonstrating the concept in action. The screening allowed for the group to see what UHC was and how countries have taken the concept and personalised it to suit their specific country contexts. It was however, noted that in most instances civil society and other stakeholders are being excluded from the roll out and implementation process on UHC despite the vital role played by those sectosr. It was noted that by excluding civil society in particular, government runs the risk of further marginalisation of groups, as those that are criminalised are already excluded from the programming under UHC. There was a note around UHC not falling into the same implementation and roll out trap as the HIV movement and HIV response with a call to learn from this in terms of roll out of UHC in the countries.

The session concluded with ARASA stating they were new to the UHC conversation and what they were trying to achieve was to share learnings and best practices.

DAY THREE:
18 SEPTEMBER, 2019

MORNING SESSION

RECAP

The day began by offering the participants the opportunity to reflect on the previous day's presentations and share their thoughts or some of the highlights from the previous days' discussions. Some of the reflections shared were:

Participant 1:

Maternal mortality, root causes and contributing factors are still very vital for me. There is need to hold government to account on financing of health services. Furthermore, there's need to ensure access to modern contraceptives, information about health services and to provide access to these services. There is need to support interventions like comprehensive SRHR for adolescents coupled with good nutrition.

Participant 2:

What's happening with UHC is only being seen now because the roll out is happening now. The concerns we have now, is how people living with HIV are not being consulted. The work taking place currently is around services that are destigmatized, however there is no consideration of human rights. CSOs and NHRIs should alert those in the conversation around the human rights issues and that these need to be included as part of the UHC conversation.

Participant 3:

These conversations have been important in Uganda and we are monitoring yearly if needs are met, measuring progress and trying to see what the gaps have been. Health is at the top of the list for Uganda.

Participant 4:

I was reflecting around how the Constitution of Swaziland refrains abortion unless if it is rape, incest or in a case where the mother suffers from mental health issues and stuff on intersex.

Participant 5:

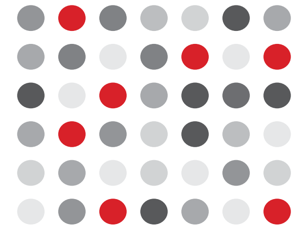
We received a complaint from a trans person who was born male and was transitioning to female, but, was arrested for 14years and was put in a male cell. This individual was violated over and over and my question is around how we should have dealt with this.

Participant 6:

One thing that came out for me yesterday was that NHRIs need to monitor existing laws and we have the mandate for legal reform. We need to give a human rights guide for implementation of the law. We need to be proactive in our law. We are usually not at the conversation but we need to collaborate with the CSOs so we can monitor the laws.

Participant 7:

We are seeing how NHRIs are having conversations with ministers of foreign affairs, there is need at the domestic level to have NHRIs involved in parliamentary proceedings, so our laws are based on a human-rights prospective.



Participant 8:

We grappled with the attorney general on who takes the led when reporting to treaty bodies. We now have a mechanism called the treaty ratification mechanism that includes foreign affairs, NHRIs and the office of the attorney general so we can give wholistic reports to the UN.

The reflection ended with there being a note around the AU and its shifting state given the fact that it was waking up to the recommendations and reporting at Geneva level speaking to Africa and implementation.

WORK PLANNING:

The participants were split into groups and asked to look at not only the 3 days but into the future for the next 3 to 5 years and some of the priorities they would like to take up. The session was for consensus building and for collective prioritisation. The NHRIs came up with priority areas to advance existing work or initiate work around SRHR with some commitments being:

- Eswatini – Prioritisation of work on safe medical abortion as well as looking for an entry points into UHC
- Zimbabwe – Staff training on SOGIE rights
- Zambia – Implement action plan following UNAIDS workshop 2018 – 2021
- Kenya – Evaluate recommendations from the public inquiry on SRHR as well as continue work related to Resolution 275 as well as UHC engagement.
- NHRIs from Mauritius, Ghana, Cameroon and Sierra Leone are going to strengthen their work on SRHR and UHC
- NHRIs from Tanzania, Cote d'Ivoire, DRC, Botswana, Uganda and Mozambique are going to focus on or find entry points to SRHR, implementation of the Amman Declaration as well as strengthen their work on SOGIE issues.

The following were recommendations from the NHRIs;

- Create a working group that utilises the Sustainable Development Goals (SDGs) to advance SRHR while integrating the protection of Human Rights Defenders (HRDs) as per the Marrakech Declaration
- Develop an online portal for NHRIs to increase learning on a human rights-based approach to SRHR
- Establish a core working group on SRHR for NHRIs for the Convening
- Ensure that experts are availed for NRHIs when needed to support national efforts to advance a human rights-based approach to SRHR

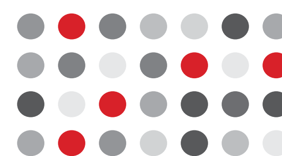
The meeting was closed by Marie Ramtu who thanked the partners for their consistent engagement. She highlighted the need to keep the conversation going and protect spaces that allow for NHRIs to introspect on the work that they are doing. Marie closed by calling for NHRIs to consider addressing violations towards LGBTIQ minors in schools as they were currently left out in interventions for addressing rights violations.

CONCLUSION

The three-day meeting provided a platform for NHRI representatives from different African countries to engage in evidence informed discussions on human rights, SRHR and other pressing health and human rights issues in the region. The convening provided participants with the opportunity to engage with one another, to network and exchange experiences.

Maternal healthcare, access to safe abortion, adolescent SRHR, UHC and SOGIE issues were all identified as high priority areas by the NHRIs, not only at country level where the NHRIs are able to advise governments and provide policy options but also at regional level where NHRIs as well as CSOs can work together to advance a human rights approach and to ensure the development of model laws, resolutions and declarations that progressively speak to SRHR. As a result, the Convening provided a space for NHRIs to prioritise areas of focus for the next three years, which will be used to guide collaborative projects and future Convenings.

In conclusion, the NHRIs emphasised the importance of the Convening, not only for capacity strengthening but for collaboration and networking as well. They thanked ARASA, NANHRI and CRR for their support and technical assistance over the years and advocated for more Convenings in the future.



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