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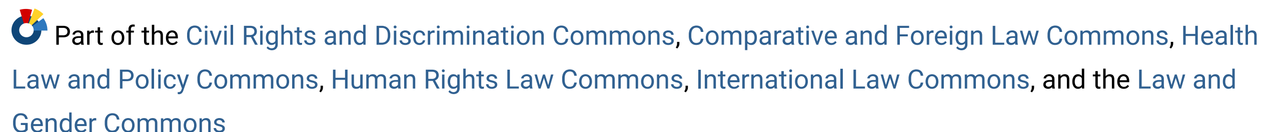
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Exploring the African Regional Human Rights Standards as the Basis for an Enabling Environment for Self-Managed Abortion

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Abstract

Self-managed abortion holds great promise to save lives and promote reproductive autonomy, particularly in Africa. Indeed, the African region records very high numbers of unsafe abortions, and the burden of abortion-related mortality is the highest globally. Abortion remains generally criminalized in violation of numerous internationally and regionally recognized human rights standards. The advent of abortion medicines and the increased grassroots energy geared towards curbing the harms of unsafe abortion evince medical abortion holds great promise for revolutionizing people's access to high-quality reproductive care. This study discusses regional human rights frameworks, policy, case law, and a few representative domestic legislative frameworks in light of recent evidence and human rights developments surrounding self-managed abortion.

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Standards such as access to the most comprehensive range of medicines, the highest attainable standard of health and scientific innovations, and repeal of discriminatory laws, including unnecessary regulatory barriers, emerge from the African human rights system. We conclude that while much work is needed to further elaborate on the standards set at the regional level, our research shows that a robust normative foundation for self-managed abortion emerges from the African human rights system.

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I. Introduction

The advent of abortion medicines coupled with different models of access—both within institutional health systems and autonomous health movements—has come to change the landscape of abortion.[1] Self-managed abortion (SMA), defined as ending a pregnancy outside of the clinical setting, is increasingly recognized as a model of access used globally in liberal and more restrictive settings.[2] Indeed, the increased use of abortion medicines, misoprostol and mifepristone, is already associated with a global reduction of abortion-related morbidity and mortality.[3]

The growing recognition of SMA is reflected in the World Health Organization's ("WHO") recently adopted Abortion Care Guidelines that demand that States recognize self-management as a potentially empowering and active extension of the health system and task-sharing approaches.[4] Moreover, there is a notable surge in grassroots energy and dedicated efforts to broaden the

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1. *See* Joanna Erdman et al., *Understandings of Self-Managed Abortion as Health Inequity, Harm Reduction and Social Change*, 26 REPROD. HEALTH MATTERS 13, 13 (2018) (exploring transformed understandings of safe abortion due to medicine and new models of access).

2. *See id.* ("Self-sourcing of abortion medicines (mifepristone and misoprostol, or misoprostol alone) followed by the self-use of the medicines including self-management of the abortion process outside of a clinical context."). We use in this paper the definition proposed by Erdman, Jelinska, and Yanow that understands SMA as the practice of "self-sourcing of abortion medicines (mifepristone and misoprostol, or misoprostol alone) followed by self-use of the medicines including self-management of the abortion process outside of a clinical context." *Id.*

3. *See* Bela Ganatra et al., *Global, Regional, and Subregional Classification of Abortions by Safety, 2010-2014; Estimates from a Bayesian Hierarchical Model*, 390 LANCET 2372, 2378–80 (2017) (discussing the development and impact of safer abortion medicines).

4. *See* Human Reproduction Programme, *Abortion Care Guideline*, WORLD HEALTH ORGANIZATION [WHO], 67 (2022) ("Such self-assessment and self-management approaches can be empowering for women and help to triage care, leading to a more woman-centered and more optimal use of health resources.").

availability of safe abortion across the continent.[5] As a result, self-managed abortion is emerging as a potential model with the capacity to revolutionize the landscape of reproductive healthcare in Africa.

The international human rights framework[6] urges all States to remove legal and policy barriers to abortion that hinder pregnant people's access to abortion care.[7] Restrictive abortion laws disproportionately harm underserved communities that already face barriers to accessing care and have grave consequences for people's health and lives.[8] In addition, evidence shows that criminalization contributes to opportunity costs, including traveling for abortion, delayed abortion and post-abortion care, emotional distress, financial costs, and other harmful consequences.[9] This may, in turn, force pregnant people to turn to unsafe abortions.[10]

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5. *See* Heid Moseson et al., *Contextualizing Medication Abortion in Seven African Nations: A Literature Review*, 40 HEALTH CARE FOR WOMEN INT'L 950, 950 (2019) (assessing the landscape of abortion-related scientific knowledge and proposing creative interventions that could improve people's access to safe medication abortion).

6. *See generally* G.A. Res. 217(III) A, Universal Declaration of Human Rights (Dec. 10, 1948) (declaring a common standard of fundamental human rights to be universally protected).

7. *See* Lucia Berro Pizzarossa, Abortion, Health and Gender Stereotypes: A Critical Analysis of the Uruguayan and South African Abortion Laws Through the Lens of Human Rights 116 (2019) (Ph.D. dissertation, University of Groningen) (on file with the University of Groningen) (discussing the importance of lawmakers and advocates tracking the development of restrictive initiatives that may fail to comply with the international human rights framework).

8. *See id.* at 255 ("The requirements set by law not only violate the obligations to eradicate barriers . . . they also result in inequities in access and create disproportionate risks for poor women, young women, ethnic minorities, and other women in vulnerable positions.").

9. *See* World Health Org. [WHO], *Supplementary Material 1: Evidence-to-Decision Frameworks for the Law and Policy Recommendations* 4–30 (Human Reprod. Programme, Abortion Care Guideline, 2022) (recommending the full decriminalization of abortion and illustrating the impact of abortion criminalization outcomes through 22 studies).

10. *See, e.g.*, Ibrahim Obadina, *Addressing Maternal Mortality Through Decriminalizing Abortion in Nigeria: Asking the 'Woman Question,' in* ADVANCING SEXUAL & REPROD. HEALTH & RTS. IN AFR., 35,

While there has been increasing evidence on the benefits of self-managed abortion and the human rights standards which underpin this novel model, there is still work to be done to guarantee the enjoyment of abortion rights and embrace the potential of self-managed abortion. WHO has recently highlighted multiple legal, health system, and community actions to be taken "so that everyone who needs it has access to comprehensive abortion care."[11] Indeed, this "enabling environment"—as described by WHO—is underpinned by a series of human rights enshrined in national, regional, and international human rights instruments, and is the cornerstone of comprehensive quality abortion care.[12]

This paper examines the African regional human rights framework in light of the recent evidence and legal developments around self-managed abortion, focusing on the human rights standards underpinning the obligation to create an enabling environment for self-managed abortion and abortion more broadly. This paper is a part of a larger project which includes the previously published piece *Self-Managed Abortion in Africa: The Decriminalization Imperative in Regional Human Rights Standards*.[13] The paper argues that strong regional human rights standards

35–50 (Ebenezer Durojaye et al. eds., 2021) (showing that restrictive abortion laws in Nigeria have caused an "alarming increase" in unsafe abortions and maternal mortality).

11. *See* Human Reprod. Progamme, *supra* note 4, at xx, ("The three cornerstones of an enabling environment for abortion are . . . : 1) respect for human rights including a supportive framework of law and policy, 2) availability and accessibility of information, and 3) a supportive, universally accessible, affordable and well functioning health system.") [perma.cc/R6VX-A58Q].

12. *See id.* at 5–6 (detailing the "core components of an enabling environment for abortion care," including legal schema, governmental policies, and financial enablement).

13. *See* Lucía Berro Pizzarossa et al., *Self-Managed Abortion in Africa: The Decriminalization Imperative in Regional Human Rights Standards*, 25 HEALTH & HUM. RTS. J. 171, 172, 180 (June 2023) (including a thorough discussion on the right to non-discrimination in the context of abortion, and showcasing the connection of sexual and reproductive health and the right to equality and right to non-discrimination).

support the decriminalization of self-managed abortion and that specific provisions support the call to embrace its potential in the continent. It overviews the legal framework, draws lessons from jurisprudence, and debates critical issues. The paper reviews international, regional, and domestic legal frameworks, policies, and case law. This study is limited to the African region and does not attempt to study each African country in detail but provides illustrative examples from the region.

II. Self-Managed Abortion in Africa

People worldwide have self-managed their abortions using different methods throughout history.[14] While there has been a historical association of self-managed abortions with dangerous and invasive methods there has been a more recent radical transformation with the increased use of misoprostol and mifepristone and the growing movement of grassroots activists contributing to simpler, de-medicalized models of access.[15]

Abortion medicines used for self-managed abortions have increasingly proven to be safe and effective.[16] Indeed,

14. *See* Heidi Moseson et al., *Self-Managed Abortion: A Systematic Scoping Review*, 63 BEST PRAC. & RSCH. CLINICAL OBSTETRICS & GYNECOLOGY 87, 90–96 (2020) (demonstrating that self-managed abortions occur in eight main categories of methods based on a total of 94 studies from 38 countries).

15. *See* Pizzarossa, *supra* note 13 (showing that tedious requirements for access to self-managed abortions are unnecessary and that less medicalized models are both desirable and possible); *see generally* Drew Halfmann, *Recognizing medicalization and demedicalization: discourses, practices, and identities*, Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine 16:2 (2011) (contrasting medicalization of social problems with demedicalization, where a social phenomenon is no longer conceptualized as a purely medical issue).

16. *See* Abigail R.A. Aiken et al., *Safety & Effectiveness of Self-Managed Medical Abortion Provided Using Online Telemedicine in the United States: A Population Based Study*, 10 LANCET REG'L HEALTH – AMS. 1, 2 (2022) (discussing a study with a very high success rate for self-managed abortions that occurred through online telemedicine in the U.S.; 96% of women did not require surgical intervention from a clinical provider, a comparable rate to an in-clinic setting).

research has shown that these drugs, used individually or in combination, are over 85% successful, and the risk of complications is negligible.[17] Studies from the United States show that medication abortion is safer than many common drugs, including acetaminophen (Tylenol) or sildenafil (Viagra),[18] which are readily sold over-the-counter in many countries. WHO has added misoprostol and mifepristone to its Model List of 'core' medicines, one step up from the previous listing as 'essential medicines,' and has removed the need for close medical supervision.[19] These drugs "ha[ve] enabled safer self-management and self-use, centering autonomy, privacy, and confidentiality, while also contributing to the reduction of abortion-related morbidity and mortality globally."[20]

Various brands of these drugs and combination packs, which contain misoprostol and/or mifepristone, are already available on the market in Africa.[21] In 2008, officials in

17. *See* Lucía Berro Pizzarossa & Patty Skuster, *Toward Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion: A Review of the Last Decade of Legal Reform*, 23 HEALTH & HUM. RTS. J. 199, 201 (2021) (showing evidence of a consistently proven success rate for the drugs through the twelfth week of pregnancy and highlighting WHO's support of the use of these drugs for first-trimester abortions).

18. *See* BIXBY CTR. FOR GLOB. REPRO. HEALTH, SAFETY AND EFFECTIVENESS OF FIRST-TRIMESTER MEDICAL ABORTION IN THE UNITED STATES 1 (Aug. 2016) (showing that common drugs like Tylenol and Viagra can result in serious medical outcomes such as acute liver failure or even death).

19. *See* Roopan Gill et al., *WHO Essential Medicines for Reproductive Health*, BMJ GLOB. HEALTH, Dec. 2019, at 1, 1–2 (demonstrating that mifepristone and misoprostol moved to the core list of medicines in June 2019, thus providing more opportunity for organizations to advocate for these medicines to be included on national essential medicine lists).

20. Lucía Berro Pizzarossa & Rishita Nandagiri, *Self-Managed Abortion: A Constellation of Actors, a Cacophony of Laws?*, 29 SEX. & REPROD. HEALTH MATTERS at 1 (2021).

21. *See Medical Abortion Commodities Database*, INT'L PLANNED PARENTHOOD FED'N (Sep. 28, 2018) (highlighting that these drugs are available under various brand names such as Cytotec, Mifepack, and Misofar in most African countries including Angola, Benin, Botswana, Cambodia, Cameroon, Democratic Republic of Congo, Ethiopia, Ghana, Guinea, Liberia, Kenya, Madagascar, Mali, Mozambique, Nigeria,

Uganda issued a marketing authorization for misoprostol use to prevent postpartum hemorrhage and included it on their Essential Medicines List in 2012.[22] Uganda was not alone in its assessment of misoprostol as Nigeria also included the drug on its Essential Medicines List in 2010 for reproductive health indications,[23] Benin did so in November 2013, and Burkina Faso followed in December 2014.[24]

While these drugs can only be accessed with a prescription in many countries, research shows that they are generally available in informal markets.[25] Research from Tanzania, for example, shows that "miso is common," pointing to the fact that the medicine is known, accessible, in demand, and sold in pharmacies at prices that range from $0.50 (USD) to $30 (USD).[26] While still subjected to

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Senegal, South Africa, Togo, Tunisia, Uganda, Zambia, and Zimbabwe) [perma.cc/ZX65-3BCE].

22. *See* Esther Cathyln Atukunda et al., *Civil Society Organizations and Medicines Policy Change: A Case Study of Registration, Procurement, Distribution and Use of Misoprostol in Uganda*, 130 SOC. SCI. & MED. 242, 244 (2015) (showcasing the timeline of the introduction of misoprostol in Uganda and the role of civil society organizations).

23. *See* Carine Baxerres et al., *Abortion in Two Francophone African Countries: A Study of Whether Women have Begun to Use Misoprostol in Benin and Burkina Faso*, 97 CONTRACEPTION 130, 134 (2018) ("Nigeria also included misoprostol on its Essential Medicines List in 2010 for reproductive health indications.").

24. Isabelle Boko et al., *Interroger au Bénin les usages populaires d'un médicament abortif, le misoprostol* [*Questions Regarding the Popular Use of the Abortion Drug Misoprostol in Benin*], 9 REVUE DE MEDECINE PERINATALE 20, 23 (2017) ("Since the end of 2013, this drug was included in the list essential medicines from Benin."); *see also* Seydou Drabo, *The Domestication of Misoprostol for Abortion in Burk. Faso: Interactions Between Caregivers, Drug Vendors & Women*, ANTHROPOLOGIES OF GLOB. MATERNAL & REPROD. HEALTH 57, 62 (2022) ("Despite regulations that aim to restrict the use of misoprostol to induce abortion, social and institutional factors enable its availability in the health system and individuals' access to it. First, misoprostol has been on the list of essential medicines for clinical use since 2014.").

25. *See* Boko, *supra* note 24, at 23 (demonstrating that misoprostol is sold in the large Dantokpá market in Cotonou); Drabo, *supra* note 22, at 63 (showing that misoprostol in Burkina Faso can be obtained through marketplace street drug vendors).

26. *See* Ingvild Hernes Solheim et al., *Beyond the Law: Misoprostol and Medical Abortion in Dar es Salaam, Tanzania*, SOC. SCI. & MED., Jan. 2020, at 4–5 (discussing the availability of Misoprostol in

unnecessary regulatory restrictions and not fully embraced in many national essential medicines lists, these drugs—especially misoprostol—have made their way into the continent.[27]

Based on the experience of various regions, in particular Latin America but also Asia and Africa, misoprostol is a real opportunity for people to self-manage abortions in restrictive contexts.[28] The availability of misoprostol has contributed to a decrease in maternal mortality and morbidity, as the possible complications are less severe than with unsafe 'traditional' methods.[29] Furthermore, empirical evidence from Latin America has recently shown that SMA, with accompaniment group support and linkages to the healthcare system, can be an effective and safe option for abortion beyond the first trimester.[30]

One of the most significant advantages of medical abortion for Africa is that it is far safer than the invasive surgical technique of dilation and curettage, which despite no longer being recommended, is still used in many countries.[31] Furthermore, it offers comparative advantages

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Tanzania); *see also The Unsafe Practice of Intended Abortion Fueled by Drug-Stores*, CITIZEN (updated Mar. 2021) (discussing the usage of pills to have abortions in Tanzania and the health effects) [perma.cc/GA6L-MGK3].

27. *See* Solheim, *supra* note 26, at 2–3 (describing the drug's entry into use in Africa and the regulatory and political obstacles this entry has faced).

28. *See* Heidi Moseson et al., *Effectiveness of Self-Managed Medication Abortion with Accompaniment Support in Argentina and Nigeria (SAFE): a Prospective, Observational Cohort Study and Non-Inferiority Analysis with Historical Controls*, 10 LANCET GLOB. HEALTH e105, e106 (2022) (comparing the effectiveness of abortions under medical care with abortions performs without clinical).

29. *See* Iqbal H. Shah & Elisabeth Åhman, *Unsafe Abortion Differentials in 2008 by Age and Developing Country Region: High Burden Among Young Women*, 20 REPROD. HEALTH MATTERS 169, 169–73 (2012) (breaking down the rates of unsafe abortions based on age).

30. *See* Moseson, *supra* note 5, at 980 (analyzing the landscape of abortion-related scientific knowledge in seven African countries).

31. *See* Akinrinola Bankole et al., *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress*, GUTTMACHER INST. at 5, 22 (Dec.2020) (compiling information about abortion in Sub-Saharan Africa and its four subregions focusing on legality, safety, and quality of

to the formal healthcare system. A 2017 study in South Africa found that women sought abortions outside the formal health system because they wanted privacy and believed that an abortion in the formal health system would be costly.[32] Increasingly, the availability of abortion medicines, which can be used to safely self-manage outside of the institutional health systems or with minimal interaction, can help pregnant people achieve a safe, private, low-cost abortion without resorting to unsafe practices.[33] A study from Nigeria and Argentina has recently shown that self-managed medication abortion with accompaniment group support is highly effective and, for those with pregnancies of less than 9 weeks gestation, non-inferior to the effectiveness of clinician-managed medication abortion administered in a clinical setting.[34] Furthermore, given that self-managed abortion has similar effects as a miscarriage, it can facilitate access to post-abortion care from healthcare providers.[35] Besides reducing risks, SMA means autonomy of action and respect for privacy for women,[36] representing a deliberate move towards new ways of making meaning and reimagining abortions.[37]

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care and recommending that the use of dilation and curettage be "discontinued without delay . . . [and] replaced by either medication abortion or vacuum aspiration.") [perma.cc/4VV2-BEZK].

32. *See* Caitlin Gerdts et al., *Women's Experiences Seeking Informal Sector Abortion Services in Cape Town, South Africa: A Descriptive Study*, 17 BMC WOMEN'S HEALTH 1, 7 (2017) (discussing the informal forms of abortion and the availability of such options in South Africa).

33. *See* Marta Bornstein et al., *Documenting Activism and Advocacy Around Medication Abortion in Central, East, and West Africa*, 27 AFR. J. REPROD. HEALTH 84, 88 (2023) (detailing perception and realities surrounding short and long-term costs of abortion in Africa without these more inexpensive options).

34. *See* Moseson, *supra* note 28, at e105 (discussing the effectiveness and safety of medication abortion in clinical settings and barriers that have been enacted to access those in light of the COVID-19 pandemic).

35. *See* Baxerres, *supra* note 23, at 135 ("[Misoprostol] is cheaper, easier for women to use, and also easier to obtain post-abortion care from healthcare providers because the effects are similar to miscarriage.").

36. *See* Berro Pizzarossa, *supra* note 20, at 1 ("The steady increase in the use of medical abortion (MA) drugs – misoprostol and

Efforts to embrace the potential of self-managed abortion should also happen in connection with strengthened efforts to make facility-based abortion care accessible. While SMA provides an alternative model for abortion access, it is also crucial that pregnant people decide where, how, and with what support their abortion takes place, giving them the array of access options to care and methods they need and deserve.[38]

Like other regions, the African continent hosts many organizations working on expanding access to self-managed abortion information and support, such as the MAMA Network (Mobilizing Activists around Medical Abortion).[39] A 2019 review of medication abortion in seven sub-Saharan African countries led by the MAMA Network found that laypeople can provide accurate information about medication for abortion when given the resources to do so.[40] In addition, it showed that the "innovative programmatic interventions from the region hold immense potential for

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mifepristone – has enabled safer self-management and self-use, centring [sic] autonomy, privacy and confidentiality, while also contributing to the reduction of abor-tion-related morbidity and mortality globally.").

37. *See* Rishita Nandagiri& Lucia Berro Pizzarossa, *Transgressing Biomedical and Legal Boundaries: The "Enticing and Hazardous" Challenges and Promises of a Self-Managed Abortion Multiverse*,100 WOMEN'S STUD. INT'L F., Sept.–Oct. 2023, at 4 (referencing activism for SMA that "transgresses multiple social, legal, and bio-medical lines").

38. *See* Ruvani Jayaweera et al., *The Potential of Self-Managed Abortion to Expand Abortion Access in Humanitarian Contexts*, 2 FRONTIERS GLOB. WOMEN'S HEALTH 1, 4 (2021) ("While SMA interventions can reach multitudes of people with lifesaving information long before humanitarian agencies have the political will and technical abilities to provide this care, humanitarian agencies and advocates should renew and strengthen their efforts to make facility-based abortion care accessible . . . .").

39. *See About*, MOBILIZING ACTIVISTS AROUND MED. ABORTION (MAMA) NETWORK ("The MAMA Network represents a regional movement of activists working to share evidence-based and stigma-free information about self-managed medical abortion and sexual and reproductive health and rights directly with women on community level.") [perma.cc/SKN6-Q7NM].

40. *See* Moseson, supra note 5, at 951 (**"**With accurate information and access to reliable medicines, medication abortion with misoprostol, and mifepristone where available, is a safe and effective way to terminate pregnancy.").

medication abortion," in particular to be used in these contexts to reduce morbidity and mortality and improve the quality of abortion care.[41]

However, legal barriers remain. Lawmakers and policymakers in Africa—and around the world—have imposed various legal restrictions that limit access to abortion, including self-managed abortion.[42] In most countries, criminal laws directly ban self-induced abortion and create vulnerability and risk for those engaged in the practice by censoring access to information and overregulating access to essential medicines violating peoples' human rights.[43] While safe and effective from a public health perspective, self-managed medical abortion is still subject to many restrictions,[44] and more work is needed to embrace its potential.

III. African Human Rights Instruments and Standards

The African regional human rights system is "universal in character and distinctively African in its scope and principles," and various instruments enshrine sexual and reproductive rights.[45] "[U]nder the auspices of the African Union [. . .], Africa has a 'corpus' of human rights

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41. *Id.* at 973.

42. *See id.* at 971 ("Due to legal restrictions that severely limit access to safe abortion . . . [a] substantial proportion of maternal deaths in each country was due to complications of abortion – complications that in nearly all cases could be preventable if access to accurate information and safe methods were more widely available.").

43. *See* U.N. High Commissioner for Human Rights, Technical Guidance on the Application of the Human Rights-Based Approach to Implementation of Policies and Programs to Reduce Preventable Maternal Morbidity and Mortality, ¶ 16, U.N. Doc. A/HRC/21/22, (July 2, 2012) (explaining how maternal health can be prioritized to reduce maternal mortality rates) [perma.cc/83AF-8USD].

44. *See id.* ¶ 30 ("Laws and policies that impede access to sexual and reproductive health services must be changed, including laws criminalizing certain services only needed by women . . . .").

45. *See* Moussa Samb, *Fundamental Issues and Practical Challenges of Human Rights in the Context of the African Union*, 15 ANN. SURV. INT'L & COMPAR. L. 61, 62 (2009) (highlighting the continent's history of human rights resolutions and declarations).

mechanisms, laws and norms, at the cent[er] of which lies the African Charter on Human and Peoples' Rights (African Charter)."[46] This article aims to review this robust African human rights framework and analyze whether and to what extent it offers a robust normative framework for the creation of an enabling legal environment for self-managed abortion and abortion more generally.

Importantly, Africa is home to the Protocol to the African Charter on Human and Peoples" Rights on the Rights of Women (Maputo Protocol), an instrument aiming to strengthen African women's rights in general and sexual and reproductive rights.[47] In particular, it includes improved access to safe abortion services.[48] Progress has been made in some jurisdictions, and yet for most countries on the African continent, abortion remains an exception, only to be accessed legally in minimal circumstances; for example, in Zimbabwe,[49] and Kenya[50]. Many African countries are parties to international human rights standards which have increasingly recognized the imperative of abortion decriminalization, the elimination of

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46. *Id.*

47. *See* Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, art. 14(1), July 11, 2003, 3269 U.N.T.S. 26363 [hereinafter Maputo Protocol] ("States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.").

48. *See id.* at art. XIV(2)(c) (requiring parties to take steps to "[p]rotect the reproductive rights of women by authori[z]ing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the f[]etus").

49. *See* Zimbabwe: Termination of Pregnancy Act (1977) Chapter 15:10, § 4 (Zimbabwe) (allowing women to receive abortion care when (1) the pregnancy seriously endangers the mother's life or threatens to permanently impair her physical health; (2) there is a significant risk that the child would be born with serious physical or mental defects; or (3) conception resulted from unlawful intercourse);

50. *See* CONSTITUTION art. 26 (2010) (Kenya) (prohibiting abortions in Kenya unless, in the opinion of a trained health professional, there is need for emergency treatment, the life or health of the mother is in danger, or if permitted by any other written law).

barriers to abortion, and the right to access essential medicines and information for self-managed abortion.[51]

IV. Rights Implicated by Self-Managed Abortion

A. Self-Managed Abortion and the Right to Health

Undoubtedly, the right to health is at the heart of an enabling environment for self-managed abortion.[52] The African Charter on Human and Peoples' Rights ("ACHPR") guarantees the right to enjoy "the best attainable state of physical and mental health"[53] and establishes the African Commission to promote and protect human and peoples' rights.[54] General Comment No. 2 (GC 2) of the African Commission has interpreted this article as incorporating both physical and mental health and that sexual and reproductive health and rights ("SRHR"), like other health services, should be made available, accessible, acceptable, and of good quality.[55] It also notes that SRHR must be understood regarding the right to equality and non-

51. *See* Berro Pizzarossa, *supra* note 13 at 202–03 (providing an overview of international human rights standards for abortion care). This Article will not focus on these standards in this work—which also apply entirely and have been analyzed elsewhere—but on regional human rights standards.

52. *See id.* (noting that the Committee on Economic, Social and Cultural Rights "affirms that the right to sexual and reproductive health care is an integral part of the right to health and recognizes abortion services as a component part of the right to health").

53. African Charter on Human and Peoples' Rights, art. 16, June 27 1981, 3269 U.N.T.S. 2363.

54. *See id.* at art. 30 ("An African Commission on Human and Peoples' Rights . . . shall be established within the Organization of African Unity to promote human and peoples' rights and and ensure their protection in Africa.").

55. *See* Afr. Comm'n. on Hum. & Peoples' Rts., *General Comment No. 2, on Article 14.1, (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, Preface, (Nov. 28, 2014) [hereinafter *General Comment No. 2*] (highlighting the importance of protecting the women's sexual and reproductive rights).

discrimination, building on the indivisible nature of these rights.[56]

In addition, the African Commission adopted the Maputo Protocol, which gives much guidance as the first instrument to expressly protect women's SRHR, especially the right to abortion.[57] Most African states have ratified or acceded to this legal instrument.[58] Article 14(2)(c) of the Protocol guarantees the right to abortion in instances "where the pregnancy would risk the physical or mental health of the woman, or the life of the woman or the fetus, as well as where the pregnancy resulted from sexual assault, rape or incest."[59] This right has two elements: first, the individual right of the woman to obtain an abortion; and second, the duty of the State to provide the necessary infrastructure and budgetary allocations, information, and health workers to ensure the enjoyment of this right.[60]

Experts like Ngwena and Durojaye understand that under the Maputo Protocol, the right to abortion is posited

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56. *See id.* ("The rights to exercise control over one's fertility, to decide one's maternity, the number of children and the spacing of births, and to choose a contraception method are inextricably linked, interdependent and indivisible.").

57. *See* Maputo Protocol, *supra* note 47 (directing member states to take measures to "protect the reproductive rights of women by authori[z]ing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the f[]etus"); *see also* C. G. Ngwena, *Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa*, 32 HUM. RTS. Q. 783, 852–56 (2010) (explaining both the significance and limitations of abortion provisions in the Maputo Protocol).

58. *See* CRISTOF KEYNS & MAGNUS KILLANDER, COMPENDIUM OF KEY HUMAN RIGHTS DOCUMENTS OF THE AFRICAN UNION 431–32 (6th ed. 2016) (listing Algeria, Botswana, Burundi, Central African Republic, Chad, Egypt, Eritrea, Ethiopia, Madagascar, Mauritius, Niger, Sahrawi Arab Democratic Republic, Sao Tome and Principe, Somalia, Sudan, South Sudan, Tunisia as states that had not ratified).

59. *Id.*

60. *See* Lucía Berro Pizzarossa & Ebenexer Durojaye, *International Human Rights Norms and the South African Choice on Termination of Pregnancy Act: An Argument for Vigilance and Modernization,* 35 S. AFR. J. ON HUM. RTS. 50, 55 (2019) ("[A]bortion entails a positive obligation of the state to take steps to fulfil the reali[z]ation of the right [to abortion].").

as a reproductive health right correlative to the duty of the State to ensure the right to health of women.[61]

Many States still have reservations about Article 14(2)(c),[62] and the trend is that once states ratify the Maputo Protocol, they tend not to change their domestic legal framework, except for one country, Rwanda.[63] Kenya, among others, has been urged to lift its reservation in light of Article 26(4) of the Kenyan Constitution.[64] Nevertheless, these standards are considered authoritative across the continent and invoked in regional and national court cases and policy documents. For example, on March 29, 2022, the High Court of Botswana awarded damages in the case of *G.M.J. v. Attorney General*[65] against the State for negligence in providing reproductive health services.[66] This

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61. *See* Charles Ngwena, *June Medical Services and Access to Abortion: Comparative Lessons for the African Region*, HARV. L. PETRIE-FLOM CTR. (July 23, 2020) (arguing the right to abortion "is also a socioeconomic right which imposes a positive obligation on the state to facilitate its fulfillment") [perma.cc/TB8A-FQT3]; EUNICE BROOKMAN-AMISSAH ET AL., STRENGTHENING THE PROTECTION OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE AFRICAN REGION THROUGH HUMAN RIGHTS 20 (Charles Ngwena, Ebenezer Durojaye eds., 2015) ("[T]he now well-established triad of human rights obligations – to 'respect,' 'protect' and 'fulfill' – applies equally to corresponding state obligations arising from a human right to sexual health.").

62. *See* Charles Ngwena, *Access to Safe Abortion as a Human Right in the African Region: Lessons from Emerging Jurisprudence of UN Treaty Monitoring Bodies*, 29 S. AFR. J. ON HUM. RTS., 399, 401–02 (2013) ("Seemingly, the preponderance of states that have ratified the Protocol are not in a hurry to comply with art 14.1.").

63. *See id.* at 401 (claiming that abortion reform's "regional malaise" can be explained by the lack of "interpretive guidance or application" by the African Charter's "main protective and adjudicatory organs," the African Commission on Human and Peoples' Rights and the African Court on Human and Peoples Rights). Rwanda ratified the Maputo Protocol, with a reservation to art 14(2)(c), however, in August 2012, Rwanda lifted the reservation and amended the Penal Code to comply with Article 14. *Id.* at 401 n.17.

64. *See* CONSTITUTION art. 26(4) (2010) (Kenya) ("Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.").

65. Medupe-Jonas v. Att'y Gen. Bots. (2018) (Bots.).

66. *See Botswana: Challenging Prescription in Medical Negligence Claim*, S. AFR. LITIG. CTR. (June 15, 2018) (explaining why the High

judgment notes the importance of women's reproductive rights and mental health in African countries, even in the case of a state like Botswana, that still has not ratified the Maputo Protocol.[67] In the same vein, the African Commission has urged various States Parties to the ACHPR to review their laws to ensure access to safe abortion.[68] "The Commission has called on Mauritius, the Federal Republic of Nigeria, Uganda, Malawi, and Kenya, to review their abortion legislation to align with international and regional standards and obligations."[69]

Furthermore, at its 41st Ordinary Session in 2007, the African Commission firmly requested "States to reduce the maternal mortality rate and to take adequate measures to provide effective access for women to reproductive health services, including access to lawful medical abortion per the Protocol."[70] In various instances, the African Commission

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Court of Botswana reinstated appellant's negligence claim after she "had undergone a total abdominal hysterectomy. . . [and] was later diagnosed as having fistula") [perma.cc/7R36-3C8G].

67. *See Botswana: High Court Awards Damages Against the State for Negligence*, S. AFR. LITIG. CTR. (Apr. 1, 2022) ("The court found that the state had failed to show that the Plaintiff had received treatment with the required skill and care, resulting in her sustaining the injuries she did.") [perma.cc/G759-BHQT]; Janet Ramatoulie Sallah-Njie (Special Rapporteur on Rights of Women in Africa), *Report of the Special Rapporteur on Rights of Women in Africa*, Afr. Comm'n on Hum. & Peoples' Rts. Seventy-First Ordinary Session, (Apr. 22, 2022) (calling *GMJ* a "progressive decision advancing women's rights in Botswana," but noting that Botswana has not yet ratified the Maputo Protocol) [perma.cc/BUK2-7W6W].

68. *See* Lucy Asuagbor (Special Rapporteur on the Rights of Women in Africa), Statement by the Special Rapporteur on the Rights of Women in Africa on the Occasion of the Global Day of Action for Access to Safe and Legal Abortion (Sept. 28, 2022) (calling on all AU member states to decriminalize abortion) [perma.cc/4QCP-VQ78].

69. Lawrence Mute (Chairperson, Cmm. for the Prevention of Torture in Afr.), *Inter-Session Activity Rep. (May 2017 to Nov. 2017) and Thematic Rep. on Denial of Abortion and Post-Abortion Care as Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment*, ¶ 17, Sixty-First Ordinary Session, Afr. Comm'n on Hum. & Peoples' Rts., (Nov. 1, 2017) [perma.cc/7UHY-YY6K].

70. Afr. Comm'n on Hum. & Peoples' Rts. Res. 110(XXXI)07, Resolution on the Health and Reproductive Rights of Women in Africa (May 30, 2007).

has connected state obligations to prevent deaths and illness to unsafe abortion.[71]

This implicitly requires states to take positive measures, including the recognition of SMA, to prevent avoidable deaths resulting from unsafe abortion.[72] Indeed, as SMA has already been associated with reducing abortion-related morbidity and mortality globally, embracing self-managed abortion is critical to fulfilling African States' obligations to reduce maternal mortality and unsafe abortion rates, guaranteeing the right to the highest attainable standards of health.

The recognition of self-managed abortion (SMA) by states is a crucial step in preventing avoidable deaths resulting from unsafe abortion practices. By acknowledging SMA as a legitimate and safe option for individuals seeking to terminate their pregnancies, states can fulfill their obligations to reduce maternal mortality and unsafe abortion rates, ultimately guaranteeing the right to the highest attainable standards of health for their populations.

Furthermore, these standards need to be understood with due consideration to the promise of the task-sharing and task-shifting approaches to health that involves the redistribution of health tasks within workforces and communities, especially in the context of shortage of Africa's

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71. *See Concluding Observations, Fourth Periodic Report of Nigeria*, Afr. Comm'n on Hum. & Peoples' Rts., Fiftieth Ordinary Session of Nigeria, (May 7, 2015). (recommending that Nigeria take steps to prevent unsafe abortion-related mortality, although it did not refer to Article 14(2)(c) at all); *Concluding Observations and Recommendations – Malawi: Initial and Combined Periodic Reports, 1995-2013*, ¶ 106, Afr. Comm'n on Hum. & Peoples' Rts., Fifty-Seventh Ordinary Session, (Nov. 18, 2015) [hereinafter *Malawi Reports*] (requesting Malawi to "[u]ndertake concrete measures to reduce the [incidents] of unsafe abortion, which is one of the main causes of maternal mortality in Malawi") [perma.cc/6EH6-H4XV]; *see also* Ngwena *supra* note 62, at 401 (referencing the Fourth Periodic Report of Nigeria as an example of when "the African Commission has alluded to state obligations to prevent deaths and illness from unsafe abortion').

72. *See Malawi Reports*, *supra* note 71, ¶ 109 (directing for Malawi to "[c]onclude the on-going process of reviewing its laws and policies on abortion to bring them in line with the Maputo Protocol").

long-standing health worker shortage.[73] Indeed, in General Comment 2, the African Commission notes that there are not enough trained physicians available in many African countries and that mid-level providers such as midwives and other health workers should be trained to provide safe abortion care.[74] This obligation can be read—in line with recent developments in human rights standards—to include feminist networks, hotlines, and other lay health care workers.[75]

By embracing this novel, de-medicalized, and simpler model of abortion care, African States can proactively address the significant public health issue of unsafe abortion and its consequences. Recognizing SMA as a safe and viable option aligns with States' obligations to protect and promote the health and well-being of their citizens. It signifies a commitment to ensuring that individuals have the means to terminate their pregnancies safely and without resorting to unsafe methods that jeopardize their health and lives.

B. The Right to Make Decisions About One's Sexual and Reproductive Life

The right to decide one's sexual and reproductive rights is fundamental and has been increasingly recognized in the

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73. *See* Aaron Orkin et al., *Conceptual Framework for Task Shifting and Task Sharing: An International Delphi Study*, 19 HUM. RES. FOR HEALTH 1 (2021) ("Task shifting and task sharing is a promising way to address global health workforce shortages and insufficient access to care for critical health problems.").

74. *See General Comment No. 2*, *supra* note 53, ¶ 58 (requesting health worker training programs to "include non-discrimination, confidentiality, respect for the autonomy and free and informed consent of women and girls").

75. See Claire Glenton, et al., *Implementation Considerations When Expanding Health Worker Roles to Include Safe Abortion Care: A Five-Country Case Study Synthesis*, 17 BMC PUB. HEALTH 730, 737 (2017) (documenting and contrasting existing efforts to train lay people in abortion care).

international and regional human rights arenas.[76] GC 2 of the African Commission provides a robust recognition of the rights to exercise control over one's fertility, decide one's maternity, the number of children, and the spacing of births, and choose a contraception method are inextricably linked, interdependent, and indivisible.[77] In turn, the GC recognizes that "administrative laws, policies, procedures, and practices, as well as socio-cultural attitudes and standards that impede access to contraception/family planning, violate the woman's right to life, non-discrimination and health, in that they deprive her of her decision-making power and force her to undergo early pregnancy, unsafe or unwanted pregnancy, with a consequence, the temptation to seek unsafe at the risk of her health and her life."[78]

Besides Article 14(2)(c) of the Maputo Protocol,[79] the States Parties of the African Charter should comply with the Guidelines on Combating Sexual Violence and its Consequences in Africa, adopted by the African Commission on Human and Peoples' Rights during its 60th Ordinary Session.[80] These guidelines require States to ensure that the victims of sexual violence have access to medical abortions, as set out in the Protocol and the International

76. *See* Lucía Berro Pizzarossa, *Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Human Rights Law*, 7(3):29 LAWS 1, 1 (2018) ("While sexual and reproductive health and rights are increasingly recognized in the international arena, this evolution has not come without controversy.").

77. *See id.* at 11 ("According to GC 2, the duty to respect requires states to refrain from interfering with individuals' right to exercise their sexual or reproductive health.").

78. *See General Comment No. 2*, *supra* note 53, at ¶ 27 (stating that legal impediments to family planning and contraception can violate a woman's right to life by forcing her to undergo an unwanted or unsafe pregnancy); *see also* Maputo Protocol *supra* note 47, at art. 14.2(a), (c) (stating that parties must respect and promote the right to health of women, including the sexual and reproductive).

79. Maputo Protocol, *supra* note 47, at art. 14(2)(c).

80. Guidelines on Combating Sexual Violence and its Consequences in Africa, Afr. Comm'n on Hum. & Peoples' Rts. (2017).

Covenant on Economic, Social, and Cultural Rights.[81] States must adopt the appropriate laws, regulations, and programs to ensure the de jure and de facto exercise of the right to obtain a medical abortion in cases of sexual violence and ensure that women who have had abortions are not criminally prosecuted.[82]Moreover, women who wish to obtain a medical abortion or emergency medical care after having undergone a clandestine abortion must not be questioned or prosecuted.[83] This bar on prosecution emphasizes the importance of the protection and respect of bodily autonomy of women who decide to undergo an abortion, and it also indicates that women's decisions must be respected without the need for permission from any third party.[84]

Harnessing the potential of SMA can be crucial to enjoying this right. Indeed, evidence indicates that besides being safe and effective, SMA centers on pregnant people's needs, desires, and trajectories, promoting an alternative access model that enables autonomy in reproductive decisions.[85] Embracing SMA as an integral part of reproductive healthcare acknowledges the autonomy and

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81. *See id.*, at 25–26 (describing the actions States should take to comply with the Maputo Protocol and the International Covenant on Economic, Social and Cultural Rights regarding medical abortions).

82. *See id.* at 27 ("States must adopt the appropriate laws, regulations and programs to ensure the de jure and de facto exercise of the right to obtain a medical abortion in cases of sexual violence. States must ensure that women who have had abortions are not criminally prosecuted.").

83. *See id.* ("Women who wish to obtain a medical abortion or emergency medical care after having undergone a clandestine abortion must not be questioned or prosecuted.").

84. *See id.* ("States must adopt the necessary measures to enable adult women victims of sexual violence to make a decision to have an abortion without the need for permission from any third party, especially their spouse or partner.").

85. *See* Sara Larrea et al., "*No One Should be Alone in This Process": Trajectories, Experiences and User's Perceptions about Quality of Abortion Care in a Telehealth Service in Chile*, 29 SEXUAL & REPROD. HEALTH MATTERS, 213, 213–14 (2022) (explaining that self-managed abortion enables pregnant people to have health bodily autonomy even when their rights to those are not guaranteed).

agency of individuals in making decisions about their own bodies and reproductive lives. It recognizes that individuals are best positioned to make choices that align with their personal circumstances and values. By supporting SMA, states uphold the principles of bodily autonomy and reproductive rights, allowing individuals to exercise control over their reproductive health without fear of legal repercussions or stigma.

C. The Right to Life

"Decriminalize Abortion because African women and girls have a right to life and health" were the closing remarks made by the Special Rapporteur on the Rights of Women in Africa in 2018.[86] Indeed, evidence shows that restrictive abortion laws force people to carry their pregnancy to term against their will, resulting in them seeking unsafe abortions.[87] Furthermore, the African Commission has shown concern for the deaths arising from unsafe abortion and explicitly acknowledged that "these deaths occur partly because of laws that criminalize abortion."[88]

Article 4 of the African Charter notes that "human beings are inviolable" and are entitled to respect for their life and the integrity of the person, and further that no one

86. *See* Lucy Asuagbor, *supra* note 68 ("I urge all Member States and civil society organizations to continue supporting the ACHPR campaign on decriminalization of abortion in Africa because anti-abortion laws and policies kill women.").

87. *See* Lale Say et al., *Global Causes of Maternal Death: A WHO Systemic Analysis*, 2 LANCET GLOB. HEALTH e323, e331 (2014) (We estimated that 7.9% . . . of all maternal deaths were due to abortion. This finding is lower than the previous assessments, which estimated mortality due to unsafe abortion at 13%.").

88. *See* Lucy Asuagbor (Special Rapporteur on the Rights of Women in Africa), Press Release *Launch of the Campaign for the Decriminalization of Abortion in Africa: Women and Girls in Africa Are Counting on Us to Save Their Lives!*, Afr. Comm'n on Hum. & Peoples' Rts. (Jan. 18, 2016) (agreeing with WHO findings that criminalizing abortion will push women to seek unsafe abortions) [perma.cc/ZC4C-HTSX].

may be deprived of this right.[89] Since the adoption of the Maputo Protocol, it is clear that there is a recognition of a right to abortion (under certain circumstances) in Article 14(2)(c).[90]

Traditionally, the right to life is viewed as a negative right, which requires states not to interfere with the enjoyment of the right.[91] However, recent developments would require States to take positive measures to prevent the loss of life, including in the context of abortion, by ensuring access to safe abortion services.[92] This was emphasized in General Comment 3, where the African Commission noted that states have a positive obligation to prevent loss of life by ensuring that women do not die during pregnancy and childbirth.[93] This position coincides with the position of the Human Rights Committee in its General Comment 36 on the Right to Life.[94]

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89. *See African Charter on Human and Peoples' Rights*, *supra* note 53 at art. 4 ("Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.").

90. *See* Maputo Protocol, *supra* note 47, at art. 14(2)(c) (requiring parties to protect reproductive rights by authorizing medical abortions under certain circumstances).

91. G.A. Res. 2200A (XXI), International Covenant on Civil and Political Rights, at art. 6, ¶ 1 ("Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.").

92. *See* Human Reproduction Programme, *supra* note 4, at 7 ("The right to SRH requires States to ensure that health-care facilities, goods and services are available, accessible, acceptable and of good quality. This should inform all parts of the regulation of abortion.").

93. *See* Afr. Comm'n. on Hum. & Peoples' Rts., *General Comment No. 3 on the African Charter on Human and Peoples' Rights: The Right to Life (Article 4)*, ¶ 7–8 (Nov. 18, 2015) [hereinafter *General Comment No. 3*] (interpreting the right to life to include addressing preventable maternal mortality).

94. *See* Hum. Rts. Comm., *General Comment No. 36 on Article 6: Right to Life*, ¶ 26, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2019) (claiming that measures taken by states to regulate abortions may not violate the rights of pregnant people, including the right to life).

The African Commission has emphasized the link between the enjoyment of the rights to health and life.[95] For instance, in the *Pen International* case, the Commission held that denying access to medical services to prisoners would violate the right to life.[96] It clarified that the right to life also extends to preventing loss of life and is interrelated to individuals' right to health.[97] In this context, it becomes clear that recognizing self-managed abortion can be viewed as a measure that advances the right to life for individuals facing an unsupported pregnancy. Denying individuals the option to safely and autonomously manage their own abortions not only jeopardizes their health and well-being but also places their lives at risk.[98]

D. The Right to Access Information on SRHR

Access to information on abortion is critical to enable safe(r) abortion trajectories and guarantee African states' obligations. However, the lack of general information on abortion laws, coupled with the lack of access to information on essential medicines and modern methods of abortion, impacts people's access to safe abortions significantly.[99]

95. *See General Comment No. 3, supra* note 93, ¶ 42 (expanding on the understanding of the right to life to include other rights, including the right to health).

96. *See Int'l Pen & Others ex rel.* Saro-Wiwa *v. Nigeria,* Nos. 37/94, 139/94, 154/96, 161/97, Decision, African Commission on Human and Peoples' Rights [ACHPR], ¶ 104 (Oct. 31, 1998) ("Here at least one of the victims' lives was seriously endangered by the denial of medication during detention. Thus, there are multiple violations of Article 4.") [perma.cc/2TMD-EMLN].

97. *See id.* ("The protection of the right to life in Article 4 also includes a duty for the state not to purposefully let a person die while in its custody.").

98. *See* Say *supra* note 87, at e328 (noting that regions with greater restrictions on abortion have higher maternal mortality rates than those where abortion is more freely accessible).

99. *See* Monica Frederico et al., *Factors Influencing Abortion Decision-Making Processes among Young Women,* INT'L J. ENV'T RSCH. & PUB. HEALTH, Feb. 13, 2018, at 8 (determining "recurring factors that negatively impacted on the decision-making process" including women's "lack of general knowledge" regarding the abortion process).

Additionally, while the drugs may be available, current product package inserts for misoprostol and mifepristone in 20 countries contain inadequate storage instructions and outdated gestational age limits and regimens, making it difficult for people to most effectively self-manage their abortions.[100]

One of the primary challenges in implementing new laws is the failure to adequately inform the public about their provisions and implications. Highlighting the critical importance of effective public information campaigns, it becomes evident that the experience of Zambia exemplifies the consequences when new legal services remain hidden, as decades may elapse before this essential information reaches all stakeholders.[101] Guttmacher reports that "a generalized lack of knowledge" about the abortion law "contributed substantially to the high proportion" of unsafe abortions and serious human rights violations in abortion care trajectories.[102]

Lack of access to information is not only an obstacle to ensuring the realization of sexual and reproductive health and rights, but also it goes against the regional standards. Moreover, article 26 of the Maputo protocol explicitly tethers state obligations to individual rights, enjoining States to adopt all necessary measures, including budgetary measures, to fulfil the rights guaranteed by the Protocol.[103]

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100. *See* Laura J. Frye et al., *A Cross-Sectional Analysis of Mifepristone, Misoprostol, and Combination Mifepristone-Misoprostol Package Inserts Obtained in 20 Countries*, 101 CONTRACEPTION 315, 319 (2020) ("This study suggests that there is variation in the information provided on package inserts for medical abortion commodities in low- and middle-income countries and that there is a need to ensure that accurate, complete, and up-to-date information is distributed.").

101. Bankole, *supra* note 31, at 15.

102. *See id.* ("Research from 2005 indicates that a generalized lack of knowledge about the South African abortion law contributed substantially to the high proportion of abortions obtained outside of formal facilities there, despite nearly a decade since decriminalization.").

103. *See* Maputo Protocol, *supra* note 47, at art. 26 (mandating States to undertake necessary measures at a national level to fulfil the rights guaranteed by the Protocol).

"Thus, state obligations arising from article 14(2)(c)" of the Protocol "require implementation at the [S]tate level, not just in terms of recognizing the grounds for abortion, but also [in] providing the requisite infrastructure, including health information and health care services for the fulfillment of abortion rights guaranteed by the [P]rotocol."[104]

Furthermore, Article 1 of the Declaration of Principles on Freedom of Expression and Access to Information in Africa states:

> freedom of expression and access to information are fundamental rights protected under the African Charter and other international human rights laws and standards. The respect, protection and fulfilment of these rights is crucial and indispensable for the free development of the human person, the creation and nurturing of democratic societies and for enabling the exercise of other rights.[105]

The Declaration contemplates access as well to information online.[106] Accordingly, principle five on the protection of the rights to freedom of expression and access to information online declares that "[t]he exercise of the rights to freedom of expression and access to information shall be protected from interference both online and offline, and States shall interpret and implement the protection of these rights in this Declaration and other relevant international standards accordingly."[107] Therefore, access to

104. Charles G. Ngwena, *Conscientious Objection to Abortion and Accommodating Women's Reproductive Health Rights: Reflections on a Decision of the Constitutional Court of Colombia from an African Regional Human Rights Perspective*, 58 J. AFR. L. 183, 190 (2014).

105. Afr. Comm'n. on Hum. and Peoples' Rts., *Declaration of Principles on Freedom of Expression and Access to Information in Africa*, at 10, 65th Ordinary Session (Nov. 10, 2019).

106. *See id.* at 23–24 ("States shall facilitate the rights to freedom of expression and access to information online and the means necessary to exercise these rights.").

107. *Id.* at 11.

information on medical abortion and telemedicine should be free, accessible, and not restricted.

Regarding education and access to information on sexual and reproductive health, the Guidelines on Combating Sexual Violence published by the African Commission underline the responsibility of States to create "educational program[s] and materials that promote gender equality, combat discrimination and violence against women, and challenge sexist and gender stereotypes."[108] "These program[s] and materials must include specific modules on sex education, all forms of sexual violence, its causes and consequences, and sexual and reproductive health."[109]

Self-managed abortion activists bridge the gap and play a crucial role in supporting the dissemination of accurate, up-to-date scientific information to enable safe abortion self-management.[110] Activists all across the continent have devised innovative strategies for the dissemination of information including songs, mobile apps, and translation of WHO protocols into different languages.[111] Ensuring access to comprehensive and accurate information on abortion is vital for African states to uphold reproductive rights, reduce unsafe abortions, and promote the well-being of their populations.[112] Efforts should be made to disseminate information widely, leveraging technology, and empowering self-managed abortion activists to bridge the gap in

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108. *Guidelines on Combating Sexual Violence and its Consequences in Africa, supra* note 80, at 21.

109. *Id.*

110. *See Resources*, MOBILIZING ACTIVISTS AROUND MED. ABORTION (MAMA) NETWORK, (providing annual reports and resources in PDF form that include user-friendly protocols for medication abortion in Swahili, Luganda, Chichewa, Igbo, French, and English) [perma.cc/WT8P-2T7A].

111. *See* Berro Pizzarossa *supra* note 15, at 178–79 (describing abortion activists working at the international, national, and community-level as "human rights defenders").

112. *See id.* at 180 (including "access to accurate information and resources, such as medicines and medical equipment" as essential to self-managed abortion).

knowledge and support safe reproductive choices for all individuals.

E. The Right to Access Essential Medicines

Article 16 of the African Charter on Human and Peoples' Rights guarantees "the right to enjoy the best attainable state of physical and mental health,"[113] and that States must ensure that everyone has access to "medical attention,"[114] this last understood as access to treatment, medicines, and medical care. [115]

The African Commission recognizes that access to needed medicines is a fundamental component of the right to health. Parties to the African Charter are obligated to either supply essential medications or enable access to them when it is relevant. This includes considerations for physical accessibility, affordability, and the provision of information regarding the availability and effectiveness of these medicines.[116] Further, the Commission urged parties "to fulfill access to medicines by adopting all necessary and appropriate measures to promote, provide, and facilitate access to needed medicines" and "meet the minimum core obligations of ensuring the availability and affordability of all essential medicines."[117] Additionally, in *Free Legal Assistance Group and Others v. Zaire*, the African Commission held that a shortage of medicine violated Article 16 of the African Charter.[118]

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113. *Afr. Charter on Hum. & Peoples' Rts*, *supra* note 53, at art. 16, ¶ 1.

114. *Id.*

115. *See* Afr. Comm'n. on Hum. & Peoples' Rts. [ACHPR] Res. 141 (XXXXIIII)08, *Access to Health and Needed Medicines in Africa*, at 1 (Nov. 24, 2008) (affirming the Commission's commitment to access to "medicines for treatment, prevention, and palliative care").

116. *See id.* at 2 (stating that the African Charter urges states to adopt measures to promote access to essential medicines through ensuring their availability and affordability).

117. *Id.*

118. *See* Free Legal Assistance Grp. v. Zaire, Commc'n, Nos. 25/89, 47/90, 56/91, 100/93, African Commission on Human and Peoples'

The African Commission refers explicitly to WHO Action Programme on Essential Drugs—of which WHO Model Lists of Essential Medicines is an integral part—and calls states to immediately meet the minimum core obligations of ensuring availability and affordability of all of the essential medicines.[119] Since 2003, WHO has included medical abortion as a recommended method to terminate a pregnancy, and since 2015, these drugs have been included in WHO Essential Medicines List.[120] The recommended medications for induced abortion are mifepristone and misoprostol in combination or misoprostol alone.[121] This means that they should be "available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price, the individual and the community can afford."[122] This undoubtedly indicates, as the African Commission states, that African countries must guarantee access and refrain from any measures that negatively affect access to these drugs.[123]

Rights [ACHPR], ¶ 47 (1995) ("The failure of the Government to provide basic services such as . . . the shortage of medicine . . . constitutes a violation of Article 16.") [perma.cc/7JB2-K3G5].

119. *See* Afr. Comm'n. on Hum. & Peoples' Rts., *supra* note 53 (referencing the WHO Action Programme on Essential Drugs's urging of states to ensure the availability of medicines).

120. *See Mifepristone – Misopostol*, WORLD HEALTH ORG. (July 26, 2023) (stating that WHO released recommendations for clinical care and addressed policy and health system considerations for safe abortions) [perma.cc/4DSV-MGWG].

121. *See Safe Abortion: Technical and Policy Guidance for Health Systems*, WORLD HEALTH ORGANIZATION [WHO] 35, 39 (2003), ("The availability of safe and effective medical methods of inducing abortion has expanded due to the increased registration and use of mifepristone and misoprostol.") [perma.cc/7YQQ-ET88]; Katrina Perehudoff et al., *Realizing the Right to Sexual and Reproductive Health: Access to Essential Medicines for Medical Abortion as a Core Obligation*, 18 BMC INT'L HUM. RTS. 1, 7 (emphasizing the safety and efficacy of mifepristone and misoprostol for first trimester medical abortions).

122. DIANA E. PANKEVICH ET AL., IMPROVING ACCESS TO ESSENTIAL MEDICINES FOR MENTAL, NEUROLOGICAL, AND SUBSTANCE USE DISORDERS IN SUB-SUBHARAN AFRICA 1 (2014).

123. *See Access to Health and Needed Medicines in Africa*, *supra* note 115 at 1 ("[A]ccess to needed medicines is a fundamental component of

These standards emphasize the importance of access to needed medicines as a fundamental aspect of the right to health, urging States parties to fulfill their obligations by providing and facilitating access to essential medicines.[124] This includes misoprostol and mifepristone which continue to be subjected to unnecessary regulatory requirements.[125]

F. The Right to Benefit from Scientific Progress

Access to essential medicines is tightly connected with the right to benefit from scientific progress. In GC 2 African Commission refers specifically to Article 15.1(b) of the ICESCR, stating that every individual must benefit from scientific progress and its applications.[126] The comment argues, "[w]omen see themselves denied the right to benefit from the fruits of this progress as soon as they are denied the means to interrupt an unwanted pregnancy safely, using effective modern services."[127] Further, "State parties should ensure [the] availability, accessibility, and acceptability of procedures, technologies, and comprehensive and good quality services, using technologies based on clinical findings."[128] It is possible to see that the African Commission directly connects the right to science and the right to access abortion services, in the understanding that states need to guarantee access to the most up-to-date scientific technologies, including

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the right to health and that States parties to the African Charter have an obligation to provide where appropriate needed medicines, or facilitate access to them.").

124. *See id.* (reaffirming the guarantee of the right to "enjoy the best attainable state of physical and mental health" through access to essential medicine).

125. *See Safe Abortion*, *supra* note 121, at 71 (noting that while WHO has categorized misoprostol and mifepristone as essential medicines, they are not readily available in all countries).

126. *See id.* ¶ 33 ("Article 15.1.b) of the ICESCR states that every individual must benefit from
scientific progress and its applications.").

127. *Id.*

128. *Id.* ¶ 55.

"medication for abortion," in line with the international standards in the matter.[129]

The African Commission requires that "safe abortion services include the methods recommended by WHO, updated and based on clinical findings, including procedures such as evacuation, dilation and intrauterine manual or electric suction, as well as the use of other efficient methods or medicines that might become available in the future. The equipment and medicines recommended by WHO should be included in national essential products and medicines."[130]

Building on the indivisibility of human rights, authors have also argued that since the drug benefits women, "the continued poor availability and use of the drug disadvantages African women, and is a form of social injustice."[131]

V. Conclusions

In 2003, the Maputo Protocol placed the African continent as a pioneer in enshrining abortion rights in its regional instruments.[132] A decade later, essential developments from different jurisdictions worldwide and on the African continent show that burdensome requirements for access are unnecessary and that simple, less medicalized models are desirable and possible.[133] In this paper, we

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129. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 25 on Science and Economic, Social and Cultural Rights (Article 15 (1) (b), (2), (3) and (4) of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 33, UN Doc. E/C.12/GC/25 (Apr. 30, 2020).

130. *General Comment No. 2*, *supra* note 53, ¶ 57.

131. Friday Okonofua, Editorial, *Misoprostol and Women's Health in Africa*, 9 AFR. J. OF REPROD. HEALTH, 7, 9 (2005).

132. *See* Maputo Protocol, *supra* note 47, at art. 14(2)(c) (requiring States to take measure to protect the right to abortions under certain circumstances).

133. *See* Mariana Prandini Assis & Sara Larrea, *Why Self-Managed Abortion is So Much More than a Provisional Solution for Times of Pandemic,* 28 SEXUAL & REPROD. HEALTH MATTERS 37, 37 (2020) (highlighting recent developments in the United Kingdom to promote autonomy in medicalized abortions).

identified a series of robust human rights standards that can ground practical, policy, and legal developments to embrace the potential of self-managed abortion and create an enabling legal environment for this novel model.

Increasing empirical evidence from the region—and beyond—confirms that self-managed abortion is a process that people can, and should legally be able to, do safely with community support and without medical supervision.[134] The leading expert institution on international global health, WHO, advises the full decriminalization of abortion, including self-management and demands that states create an enabling legal environment for SMA.[135]

Undoubtedly, abortion should not be a matter of criminal law; people who access abortions and people who support and accompany them should not fear harassment, stigma, or criminalization. But, as our research indicates, there is ample evidence and support from African regional human rights standards to ground progress towards an enabling legal environment for SMA.[136] One that starts with decriminalizing SMA but also creates the conditions in which people can safely self-manage their abortions. This includes access to the most comprehensive range of medicines and scientific innovations, recognizing abortion activists as human rights defenders, and the repeal of discriminatory laws and unnecessary regulatory barriers and people can safely support others to self-manage. Although additional efforts are needed to expand and elaborate on the standards of the instruments discussed above, they establish a strong normative foundation for self-managed abortion.

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134. *See, e.g.*, Moseson, *supra* note 28, at e111 ("Our findings show that self-managed medication abortion with accompaniment group support is highly effective and, for pregnancies of less than 9 weeks' gestation, is non-inferior to the effectiveness of clinician managed medication abortion administered in a clinical setting.").

135. *See* Human Reproduction Programme, *supra* note 4, at 24 (recommending the full decriminalization of abortion as a law and policy step).

136. *See* Berro Pizzarossa *supra* note 13, at 190–192 (presenting an argument that there is a legal obligation to reform views on gender).