HHR Health and Human Rights Journal

Self-Managed Abortion in Africa: The Decriminalization Imperative in Regional Human Rights Standards

LUCÍA BERRO PIZZAROSSA, MICHELLE MAZIWISA, AND EBENEZER DUROJAYE

Abstract

Self-managed abortion holds particular promise for revolutionizing people's access to quality reproductive care in Africa, where the burden of abortion-related mortality is the highest globally and where abortion remains criminalized, in violation of various internationally and regionally recognized human rights. Increasingly safe and effective, self-managed medication abortion is still subject to many restrictions, including criminal laws, across the continent. Drawing on recent evidence and human rights developments around self-managed abortion, this paper explores whether and to what extent Africa's regional legal framework builds a normative basis for the decriminalization of self-managed abortion. We conclude that the region's articulation of the rights to dignity, to freedom from cruel, inhuman, and degrading treatment, and to nondiscrimination, among others, provides strong grounds for decriminalization, both concerning individuals who need abortions and concerning the constellation of actors who enable self-management.

Lucía Berro Pizzarossa, LLB, LLM, PhD, is a postdoctoral fellow at the O'Neill Institute for National and Global Health Law, Georgetown University Law Center, Washington, DC, United States.

Michelle Maziwisa, LLB, LLM, LLD, is senior postdoctoral fellow and program manager for human rights and democratization in Africa at the Centre for Human Rights, University of Pretoria, South Africa.

Ebenezer Durojaye, PhD, is head of the Socio-Economic Rights Project at the Dullah Omar Institute, University of the Western Cape, Cape Town, South Africa.

Please address correspondence to Lucía Berro Pizzarossa. Email: Lberropizzarossa@gmail.com.

Competing interests: None declared.

Copyright © 2023 Berro Pizzarossa, Maziwisa, and Durojaye. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

Introduction

Self-managed abortion is a model of abortion care used globally in liberal and restrictive settings alike.[1] The increased use of abortion medicines (misoprostol and mifepristone) is already associated with a global reduction in abortion-related morbidity and mortality.[2] This increase, coupled with growing grassroots energy and efforts to expand access to safe abortion generally, has the potential to transform the landscape across Africa.[3]

The World Health Organization (WHO) demands that states recognize self-management as a potentially empowering and active extension of the health system and task-sharing approaches, recommending self-managed abortion as an option until the 12th week of pregnancy.[4] Moreover, recent research indicates that self-managed abortion, with accompaniment-group support and linkages to the health care system, may be an effective and safe option for abortion beyond the first trimester.[5] United Nations treaty monitoring bodies and WHO have urged states to remove legal and policy barriers to abortion, which have long hindered pregnant people's access to abortion care.[6] Restrictive abortion laws disproportionately harm underserved communities that already face barriers to accessing care and have various grave consequences for people's health and lives. In addition, evidence shows that criminalization contributes to opportunity costs, including travel costs, delayed abortion and post-abortion care, emotional distress, financial costs, and sexual and financial exploitation.[7] Such conditions mean that more pregnant people may turn to unsafe abortions.[8]

However, despite the increasing evidence and human rights standards in this regard, there is still work to be done to guarantee the enjoyment of abortion rights and embrace the potential of self-managed abortion. The African region is home to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (Maputo Protocol), an instrument that aims to strengthen African women's rights in general and sexual and reproductive rights in particular, including through improved access to safe abortion services.[9] Progress has been made in some jurisdictions, yet in most countries on the African continent—for example, Zimbabwe and Kenya—abortion remains an option only under exceptional circumstances.[10]

This paper examines the African regional human rights framework in light of the recent evidence and legal developments around self-managed abortion, with a particular focus on the human rights imperative of decriminalization. We argue that regional human rights standards support the decriminalization of self-managed abortion and that specific provisions support the call to embrace its potential in the continent. We review the regional legal framework, draw lessons from jurisprudence, and debate critical issues. This study does not endeavor to study each African country in detail but rather provides illustrative examples from the region.

Self-managed abortion in Africa

Throughout history, people worldwide have self-managed their abortions using different methods. However, the increased use of misoprostol and mifepristone has transformed self-management to no longer be associated with invasive or dangerous methods. Research has shown that these drugs, used individually or in combination, are over 85% successful and that the risk of complications is negligible.[11] WHO has added these drugs 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.[12] 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."[13] Studies from the United States show that medication abortion is safer than many common drugs, including acetaminophen (Tylenol) and sildenafil (Viagra), which are sold over the counter in many countries.[14] In fact, the 2020 WHO *Abortion Care Guideline* states that self-managed abortion with medicines is not just a measure of last resort but an alternative care model

that many people find works better for them for myriad reasons.[15]

Different brands of these drugs and combi packs (containing misoprostol and mifepristone) are already available in Africa.[16] 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.[17] These drugs cannot be accessed without a prescription in many countries, but research shows that they are generally available in informal markets.[18] While still subjected to unnecessary regulatory restrictions and not fully embraced in national essential medicines lists, these drugs—especially misoprostol—have made their way into the continent.

Based on the experience of various regions, particularly Latin America but also Asia and Africa, we know that abortion medicines present a real opportunity for people to self-manage abortions in restrictive contexts and have contributed to a decrease in maternal mortality and morbidity, as the possible complications are less severe than with unsafe "traditional" methods.[19] One of the most significant advantages of medication 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.[20] Furthermore, a 2017 study in South Africa found that women sought abortions outside the formal health system because they wanted privacy and perceived that an abortion in the formal health system would be costly.[21] Increasingly, the availability of medication abortion, which can be managed outside of institutional health systems or with minimal interaction, can help pregnant people achieve a safe, private, low-cost abortion.[22] Furthermore, given that self-managed abortion has similar effects as a miscarriage, it can facilitate access to post-abortion care from health care providers.[23] Besides reducing risks, using misoprostol properly means autonomy and respect for privacy for women.[24]

Like other regions, the African continent is home to many organizations working on expanding access to self-managed abortion information and support, such as the MAMA Network.[25] A 2019 review of medication abortion in seven sub-Saharan African countries found that laypeople can provide accurate information about medication for abortion when given the resources to do so. In addition, it showed that the "innovative programmatic interventions from the region hold immense potential for medication abortion," particularly in the contexts of reducing morbidity and mortality and improving the quality of abortion care.[26]

However, legal barriers remain. Law and policy makers in Africa—and worldwide—have imposed various legal restrictions that limit access to abortion, including self-managed abortion. 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 people's human rights.[27] Examples are the Malawian and Ugandan Criminal Codes and Togo's Public Health Law, all of which criminalize anyone who self-manages an abortion and anyone who advises, supports, provides, or procures an abortion.[28] While safe and effective from a public health perspective, self-managed medication abortion is still subject to many restrictions, and more work is needed to embrace its potential.

African human rights instruments and standards

Within the region, various human rights instruments enshrine sexual and reproductive rights. The African regional human rights system is universal in character and distinctively African in its scope and principles. Under the auspices of the African Union, Africa has a "corpus" of human rights mechanisms, laws, and norms, at the center of which lies the African Charter on Human and Peoples' Rights.[29] This paper aims to review this robust African human rights framework and analyze whether and to what extent it supports the decriminalization of self-managed abortion.

It is important to note that many African countries are parties to international human rights instruments that have increasingly recognized

the imperative of abortion decriminalization, the elimination of barriers to abortion, and the right to access essential medicines and information for self-managed abortion.[30] This paper focuses not on these standards—which have been analyzed elsewhere—but on regional human rights standards.

Decriminalization of abortion and removal of barriers to access

Under current national laws, people who self-manage abortion—as well as those who provide information, support, or accompaniment for another person's self-managed abortion—risk arrest, police harassment, prosecution, and imprisonment. Even when the threat of criminalization does not yield a conviction, it can result in further stigma around abortion, the restriction of information, the restriction of access to essential medicines, and a chilling effect on health care providers and these innovations for abortion care.

The harms of criminalization and barriers to accessing abortion are well documented.[31] The denial of access to abortion services and the criminalization of abortion jeopardize a person's physical and mental health and impair their autonomy and agency. Furthermore, they unjustly deny them the freedom to live with dignity and on equal terms with other human beings, while exposing them to various forms of violence and oppression.[32] Criminalization may force providers to wait until a life-threatening situation occurs before performing an abortion under the legal exceptions to a country's criminal ban. In addition, the fear of criminal prosecution can affect health care workers, causing them to refuse to provide abortions even in legal cases. Furthermore, evidence suggests that criminalization does not influence a person's abortion decisions or prevent them from having an abortion.[33]

The decriminalization of abortion has been part of the African human rights agenda for decades. In 2007, the African Commission on Human and Peoples' Rights noted the lack of harmonization of national laws with the Maputo Protocol, as well as countries' prohibition of abortion.[34] In 2015, in a joint statement by United Nations human rights experts, the Rapporteur on the rights of women of the Inter-American Commission on Human Rights, and the Special Rapporteurs on the rights of women and human rights defenders of the African Commission on Human and Peoples' Rights reiterated that the criminalization of abortion constitutes discrimination based on sex and noted that states have an obligation to remove punitive measures for women who undergo abortion and, at the very minimum, legalize abortion in cases of sexual assault, rape, incest, and where a continued pregnancy endangers the life or the mental or physical health of the pregnant woman.[35]

In 2016, the African Commission on Human and Peoples' Rights launched a continental campaign for the decriminalization of abortion in Africa.[36] As part of this campaign, on September 28, 2016, the African Commission, through the Special Rapporteur on the Rights of Women in Africa, called for African states to honor their commitments under the African Charter on Human and Peoples' Rights and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa; the Maputo Plan of Action; and the Campaign for the Accelerated Reduction of Maternal Mortality in Africa by decriminalizing abortion in their respective countries.[37] This call is in line with existing international and regional commitments made by states in the region, including the 2007 Resolution on the Health and Reproductive Rights of Women in Africa.[38] In 2021, the African Commission reiterated the need for states to decriminalize abortion.[39]

While the Maputo Protocol demands the decriminalization of abortion based on specific grounds—an approach that has been widely criticized—some legal scholars have argued that African human rights standards as a whole actually provide robust language to advocate for the full decriminalization of abortion.[40] For example, the African Commission unequivocally notes in its General Comment 2 that "women must not be

subjected to criminal proceedings and should not incur any legal sanctions for having benefited from health services reserved to them, such as abortion and post-abortion care."[41] Moreover, a thematic report by the African Commission on the denial of abortion and post-abortion care as constituting torture and other cruel, inhuman, or degrading punishment calls on states to "amend their penal and criminal laws to remove criminal sanctions related to abortion, and immediately place a moratorium on the prosecution and detention of women who have illegal abortions."[42]

Besides calling for decriminalization, the African human rights framework calls for removing barriers. For example, General Comment 2 explains that the duty to respect rights requires state parties to refrain from hindering, directly or indirectly, women's rights and to "remove the obstacles such as those arising from marital status, age, disability as well as economic and geographic barriers faced by women who want access to family planning/contraception and safe abortion services."[43] More specifically, the general comment supports task-sharing approaches to reproductive health and calls on states to "avoid all unnecessary or irrelevant restrictions on the profile of the service providers authorized to practice safe abortion and the requirements of multiple signatures or approval of committees."[44] 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. 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.[45] According to WHO, women themselves have an essential role in managing their health through self-assessment and self-management.[46] Indeed, WHO recognizes that "self-management of medication abortion is an intervention that can take place without direct supervision of a healthcare provider; in this situation, the woman herself can be considered a healthcare provider."[47]

The right to liberty

Integral to the imperative of decriminalization is the right to liberty and security of the person as enshrined in article 6 of the African Charter. While the African Commission has yet to hand down a decision on the link between the right to liberty and sexual and reproductive health, the commission noted in *Amnesty International v. Sudan* that a state may not rely on its national law to limit the enjoyment of the right to liberty if doing so will be inconsistent with the provisions of the charter.[48] Thus, one could argue that laws and policies in African states that criminalize access to safe abortion services are inconsistent with the letter and spirit of the African Charter and the Maputo Protocol.

Available data from the region evince the harms and abuses that current laws lend themselves to. For example, in Uganda, police officers prioritize the enforcement of abortion laws above the provision of medical treatment to women and girls who have suffered complications or are in need of care following an abortion, and in Kenya, health care personnel are being prosecuted for murder with "malice aforethought" for providing post-abortion emergency care.[49]

Further, and according to the African Commission's General Comment 2, states must take measures to prevent third parties from interfering with the enjoyment of women's sexual and reproductive rights, which can be understood as respecting women's decisions and their privacy. The obligation entails the formulation of standards and guidelines containing the precision that the consent and involvement of third parties, including but not limited to parents, guardians, spouses, and partners, is not required when adult women and adolescent girls want to access contraception or safe abortion services.[50] This arguably accommodates the right of pregnant people to self-managed abortion and provides normative grounds for the eradication of all barriers to access, including unnecessarily medicalizing models and burdensome requirements.

The right to dignity

Many scholars argue that abortion criminalization

constitutes a profound violation of respect for human dignity, which is fundamental to realizing all human rights.[51] Article 4 of the Maputo Protocol states that "every woman shall be entitled to respect for her life and the integrity and security of her person. All forms of exploitation, cruel, inhuman, or degrading punishment and treatment shall be prohibited."[52] Furthermore, article 3 states that "every woman shall have the right to dignity inherent in a human being and the recognition and protection of her human and legal rights" and that "States shall adopt and implement appropriate measures to prohibit any exploitation or degradation of women."[53] The African Commission recognizes that the right to dignity includes the freedom to make personal decisions without interference from state or non-state actors. Moreover, General Comment 2 makes this connection explicit, asserting that the right to dignity is directly connected to women's right to make personal decisions about their sexual and reproductive lives.[54] While elaboration is needed to further explore the connection between abortion and dignity, we argue that these standards recognize African women's and pregnant people's right to self-manage their abortions.

Further, the right to dignity necessitates a legal and policy environment centered on the needs and rights of people who need abortion services, including self-managed abortion. The general approach to decriminalization has been that of partial decriminalization, with burdensome requirements for accessing abortion services. This approach, while a step forward, ignores the too-common mistreatment and abuse of abortion seekers within formal health care systems, where providers may believe they have a moral, if not legal, right to accuse, judge, and condemn. While many clinicians work hard to provide quality, comprehensive reproductive health care, there are also multiple accounts of stigma, harassment, and violence within institutional systems of medical practice, which can be rigid, conservative, and slow to change.[55] Differently, a model of care that centers the needs of service users can be a source of reprieve from the indignities of formal settings and experiences of shame and powerlessness.[56]

The right to nondiscrimination

Abortion services are needed by women and other pregnant people to exercise their right to autonomy and to live a dignified life. However, the criminalization of abortion tends to perpetuate the historical marginalization of a group of people and undermine their right to equality and nondiscrimination. The suffering and deaths resulting from restrictive abortion laws demonstrate the discrimination that women face. Such harms are not only preventable but also disproportionately inflicted on vulnerable groups of women.[57]

Concerning nondiscrimination, articles 2 and 3 of the African Charter speak to the entitlement of every individual to the equal enjoyment of the rights and freedoms recognized and guaranteed in the charter without discrimination based on sex, among other things, and that everyone is equal before the law and is entitled to equal protection of the law. Furthermore, General Comment 2 explicitly recognizes that laws, policies, procedures, practices, and sociocultural attitudes and standards that impede access to sexual and reproductive rights violate the right to nondiscrimination.[58] In a joint statement with international experts, the Special Rapporteurs on the rights of women and human rights defenders of the African Commission on Human and Peoples' Rights argue that "the criminalization of or other failures to provide services that only women require, such as abortion and emergency contraception, constitute discrimination based on sex, and is impermissible."[59] Legal scholar Charles Ngwena has argued that the Maputo Protocol's provision on abortion offers an opportunity to achieve substantive equality for women in that it empowers women to exercise their right to sexual and reproductive autonomy.[60]

Furthermore, the African Commission, through a statement issued by the Special Rapporteurs on the rights of women in Africa and on freedom of expression and access to information in Africa, strongly supports the decision of the High Court in Kenya that found the withdrawal by the director of medical services of the 2012 Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya to

be unconstitutional.[61] The statement applauds this decision, which holds that withdrawing these two instruments (which promoted women's sexual and reproductive health and rights) was prejudicial to women and violated their rights to health, to non-discrimination, to information, and to benefit from scientific progress, as well as their consumer rights. Furthermore, the African Commission notes that this decision aligns with article 14(2)(c) of the Maputo Protocol and the Guidelines on Combating Sexual Violence and Its Consequences in Africa.[62] Moreover, the thematic report on the denial of abortion and post-abortion care as constituting torture unequivocally states that "the suffering and deaths resulting from restrictive abortion laws are a clear manifestation of the discrimination which women face. They are not only preventable but they are disproportionately inflicted on vulnerable groups of women."[63]

Paragraph 32 of General Comment 2 explains that "the right to be free from discrimination also means that women must not be subjected to criminal proceedings and should not incur any legal sanctions for having benefitted from health services that are reserved to them such as abortion and post-abortion care."[64] This paragraph builds on the call for decriminalization discussed above and follows the international standards set by the United Nations Committee on the Elimination of Discrimination against Women that regard the provision of reproductive health services as essential to women's equality and which note that "it is discriminatory for a State Party to refuse to provide legally for the performance of certain reproductive health services for women."[65] Additionally, General Comment 2 explains that "the right to health care without discrimination requires State parties to remove impediments to the health services reserved for women, including ideology or belief-based barriers."[66]

Regarding the right to nondiscrimination in the context of abortion, the African Commission has noted that "the obligation to promote obliges State parties to create the legal, economic and social conditions that enable women to exercise their sexual and reproductive rights with regard to family planning/contraception and safe abortion," thereby showcasing the inextricable connection between sexual and reproductive rights and the right to equality and nondiscrimination.[67]

The right to freedom from torture and other cruel, inhuman, or degrading treatment

An African Commission report notes further that despite states' commitments to human rights, women continue to be subjected to torture due to restrictive abortion laws, stigma, and violations of medical confidentiality in health care settings.[68] These violations cause tremendous pain and suffering, can have long-lasting consequences for individuals' health and lives, and may constitute torture and other ill-treatment.[69]

Article 5 of the African Charter guarantees the right to human dignity and freedom from torture and other cruel, inhuman, or degrading treatment, which is a non-derogable right. The Committee for the Prevention of Torture in Africa, which has the mandate to develop this right, has considered the link between abortion and torture in its 2017 inter-session activity report. This report acknowledges that the denial of women's sexual and reproductive health rights, including to abortion and post-abortion care, can amount to torture and a violation of article 5 of the African Charter.[70] Additionally, the African Commission, in its General Comment 4 on the right to redress for victims of torture and other cruel, inhuman, or degrading punishment or treatment, acknowledges that gender-based violence or the state's failure to respond to such violence may amount to torture or ill-treatment and that the denial of reproductive rights, including forced or coerced pregnancy and abortion, can constitute torture and other ill-treatment.[71] In addition, General Comment 2 requires states to ensure that women are not treated in an inhuman, cruel, or degrading manner when they are seeking safe abortion and notes that "being forced to carry the pregnancy to term in cases where a foetus has a fatal anomaly would constitute cruel and inhuman treatment."[72]

While the African Commission has not clarified the scope or content of this provision of article

5, it has noted that states must ensure that women are not treated inhumanly, cruelly, or degradingly while seeking sexual and reproductive health services, addressing the detention of pregnant women in health facilities.[73]

Moreover, the Johannesburg Declaration and Plan of Action on the Prevention and Criminalization of Torture in Africa requires state parties to ensure that national legal frameworks and practices align with international obligations, including by enacting comprehensive legislation to prohibit and prevent torture.[74] The African Commission's Robben Island Guidelines for the prohibition and prevention of torture require states to "pay particular attention to the prohibition and prevention of gender-related forms of torture and ill-treatment."[75] Training, education, and empowerment on human rights are also critical features of these guidelines.[76] Perhaps the most crucial part with regard to abortion is the protection of victims of torture. The guidelines encourage states to protect victims and their families from violence, intimidation, and reprisal that may arise under a report or investigation. Moreover, they place a duty on the state to offer reparation to victims of torture, regardless of whether the perpetrator is convicted.[77]

The African Commission also recognizes that "being forced to carry the pregnancy to term in cases where a fetus has a fatal anomaly would constitute cruel and inhuman treatment."[78]

In *Huri-Laws v. Nigeria*, the commission reasoned that "the prohibition of torture, cruel, inhuman or degrading treatment or punishment is to be interpreted as widely as possible to encompass the widest possible array of physical and mental abuses."[79] This sentiment was reiterated in *Media Rights Agenda v. Nigeria*, which held that article 5 of the African Charter must be "interpreted so as to extend to the widest possible protection against abuses, whether physical or mental."[80] According to the decision in *Institute for Human Rights and Development in Africa v. Angola*, this includes a "lack of access to medicine or medical care."[81] It can be argued that the lack of access to medicines and medical care, which extends to the broadest possible protection against abuses, would necessarily include the lack of access to abortion medicine and post-abortion care.

Abortion activists as human rights defenders

Self-managed abortion, rather than a solely individual act, entails a constellation of actors who shape and influence abortion trajectories at different points along a person's journey. These actors, functioning locally, nationally, and transnationally, enable self-managed abortion access and provide different types of support.[82] A recent study documenting abortion activism in Central, East, and West Africa concludes that increased engagement of activists in the dissemination of medication abortion information "has enormous potential to improve access to safe abortion, and to change attitudes toward sexual and reproductive health."[83] Indeed, activists face a health crisis created by stigma and criminalization and respond with community-level direct action that brings professionally controlled knowledge and technology into lay use.[84] The critical role of these activists has already been recognized in the continent, and research shows that legislative reform for women is significantly less likely to occur without action by domestic women's coalitions and activists. In addition, evidence indicates that attacks on women human rights defenders, shrinking civic space, and scrutiny of women's organizations further hinder efforts.[85] As the opposition to abortion rights rises, people who have abortions, abortion providers, and activists become targets for arrest, prosecution, and incarceration.

In her 2011 report to the United Nations Human Rights Council, the Special Rapporteur on the situation of human rights defenders calls attention to the work of sexual and reproductive rights defenders. This group includes several individuals who might not initially be recognized as falling under the umbrella of "human rights defenders," such as LGBT activists; reproductive health care workers who provide access to contraception and abortion; and those providing access to HIV information, prevention services, and treatment.[86]

The Special Rapporteur's recent explicit acknowledgment of sexual and reproductive rights

defenders reflects the understanding that women's rights, sexual rights, and reproductive rights are central human rights issues and that individuals working to realize these rights face unique threats as human rights defenders. Recognition of sexual and reproductive health providers as human rights defenders also reflects their crucial role in ensuring the right to health and allowing people to realize their reproductive and sexual autonomy.[87]

A 2015 statement issued by the Special Rapporteurs on the rights of women and human rights defenders of the African Commission on Human and Peoples' Rights recognizes the role of human rights defenders in issues related to abortion. It notes that "women human rights defenders should receive protection against gender-specific threats and violence they may face due to their work on sexual and reproductive health and rights and their challenging of deep-seated patriarchal structures and societal gender norms."[88]

Furthermore, during its 41st Ordinary Session in 2007, the African Commission expressed concern regarding the situation faced by human rights defenders within the state parties, urging them

> *to take all the necessary measures to ensure the protection of all human rights defenders and ensure that they have an environment which allows them to carry out their activities safely, without suffering any acts of violence, threats, reprisals, discrimination, pressure and any arbitrary acts by State or non-State actors as a result of their human rights activities.*[89]

The commission also urged state parties to take specific measures to ensure the physical and moral integrity of human rights defenders, to enable the latter to fully play their role in the promotion and protection of human rights.

In recent years, the African Commission has continued to appeal for the protection of human rights defenders, especially women human rights defenders, recalling state parties' responsibility to ensure their safety and protection. In 2014, it called on states "to ensure that human rights defenders work in an enabling environment that is free of stigma, reprisals or criminal prosecution as a result of their human rights protection activities, including the rights of sexual minorities."[90] In 2016, it urged states "to release arbitrarily detained human rights defenders and put an end to all forms of harassment and other acts of intimidation against human rights defenders including individuals or groups of individuals who cooperate with or bring matters before African human rights mechanisms."[91] In 2017, with regard to human rights defenders promoting access to sexual and reproductive health and rights, the African Commission urged all state parties to

> *adopt specific legislative measures to recognize the status of human rights defenders, and protect their rights and the rights of their colleagues and family members, including women human rights defenders and those working on issues such as extractive industries, health and HIV/AIDS, reproductive health, sexual orientation and gender identity, promotion of peace and democracy, fight against terrorism, and respect for human rights.*[92]

The recognition of abortion activists as human rights defenders is based on the crucial role that they play in promoting access to abortion, supporting law reform efforts, and promoting and defending human rights in general, coupled with the vital role that these activists play in supporting safe self-managed abortion trajectories.[93] Without these activists, abortion in general (and self-managed abortion in particular) would likely involve significantly higher levels of risk, be harder to access, and force people to resort to unsafe methods.

Conclusion

When it was signed in 2003, the Maputo Protocol made the African continent a pioneer in enshrining abortion rights. Since then, a series of robust human rights standards have been developed that can ground practical, policy, and legal developments to embrace the potential of self-managed abortion.

Increasing evidence from the region confirms that self-managed abortion is a process that people can and should be able to use legally, safely, with community support, and without medical supervision.[94] Recent developments from different jurisdictions worldwide and on the African con-

tinent show that burdensome requirements for access are unnecessary and that simpler and less medicalized models are desirable and possible.[95]

Furthermore, as our research indicates, there is ample evidence and support from African regional human rights standards to ground progress toward a favorable legal environment for self-managed abortion. First, strongly grounded in the rights to dignity, to freedom from cruel, inhuman, and degrading treatment, and to nondiscrimination, the decriminalization imperative emerges clearly from our findings. The use of the most onerous, intrusive, and punitive state powers to regulate matters of abortion runs contrary to the standards that exist at the regional level. Abortion should not be criminalized, and neither the person self-managing the abortion nor those who support them should be subjected to criminal law. The leading expert institution on international global health, WHO, also advises the full decriminalization of abortion, including "self-management."[96] The decriminalization imperative involves, at the very least, three prongs: (1) the decriminalization of (self-managed) abortion; (2) the recognition of abortion activists as human rights defenders and, consequently, the decriminalization of the constellation of actors who enable safer abortion trajectories; and (3) the repeal of all criminal provisions related to the dissemination of scientific information about abortion and those connected to regulatory restrictions to access to abortion medicines.

Second, arguments for the decriminalization of abortion show us the human rights that should be at the center of any advances in this regard. The obligations of states not only require full decriminalization but also entail creating the conditions in which people can safely self-manage their abortions. This includes ensuring access to accurate information and resources, such as medicines and medical equipment. It also involves providing community support and removing any unnecessary barriers to accessing abortion care.

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 self-managed abortion 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, thereby enjoying the array of options to care and methods they need and deserve.[97]

Notably, the African Commission has highlighted that it is "more than willing to accept legal arguments with the support of appropriate and relevant international and regional human rights standards based on the principle of universality as per the Vienna Declaration and Programme of Action of 1993."[98] In this way, international law on women's right to equality and nondiscrimination—such as the Convention on the Elimination of All Forms of Discrimination against Women and the International Covenant on Economic, Social and Cultural Rights—can be used to argue for sexual and reproductive rights, including, for example, the right to access essential medicines for abortion, in line with WHO guidelines. This opens the door for further developments at the regional level that draw on the evolution of scientific evidence, guidelines, and human rights standards.

While much work is needed to elaborate on the standards set by the instruments discussed above, for now it is clear that they set a robust normative foundation for self-managed abortion, access to a comprehensive range of medicines and scientific innovations, and repeal of discriminatory laws, including unnecessary regulatory barriers. Abortion in Africa 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.

References

1. In this paper, we use the definition proposed by Joanna Erdman, Kinga Jelinska, and Susan Yanow that understands self-managed abortion 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." J. Erdman, K. Jelinska, and S. Yanow, "Understandings of Self-Managed Abortion as Health Inequity, Harm Reduction and Social Change," *Reproductive Health Matters* 26/54 (2018). We use "women and girls" when citing international instruments or studies that refer

exclusively to cisgender women and girls. However, the considerations in this paper extend to all those who may need an abortion, including transmen and nonbinary persons, along with women and girls.

2. B. Ganatra, C. Gerdts, C. Rossier, et al., "Global, Regional, and Subregional Classification of Abortions by Safety, 2010–14: Estimates from a Bayesian Hierarchical Model," *Lancet* 390/10110 (2017).

3. H. Moseson, J. Shaw, S. Chandrasekaran, et al., "Contextualizing Medication Abortion in Seven African Nations: A Literature Review," *Health Care for Women International* 40/7–9 (2019).

4. World Health Organization, *Abortion Care Guideline* (Geneva: World Health Organization, 2022), recommendation 50.

5. H. Moseson, K. A. Bullard, C. Cisternas, et al., "Effectiveness of Self-Managed Medication Abortion between 13 and 24 Weeks Gestation: A Retrospective Review of Case Records from Accompaniment Groups in Argentina, Chile, and Ecuador," *Contraception* 102/2 (2020).

6. L. Berro Pizzarossa, *Abortion, Health and Gender Stereotypes: A Critical Analysis of the Uruguayan and South African Abortion Laws through the Lens of Human Rights, PhD thesis* (University of Groningen, 2019).

7. World Health Organization, *Abortion Care Guideline: Supplementary Material 1* (2022), https://cdn.who.int/media/docs/default-source/reproductive-health/abortion/supplementary-material-1.pdf.

8. See, for example, I. Obadina, "Addressing Maternal Mortality through Decriminalizing Abortion in Nigeria: Asking the 'Woman Question,'" in E. Durojaye, G. Mirugi-Mukundi, and C. Ngwena (eds), *Advancing Sexual and Reproductive Health and Rights in Africa: Constraints and Opportunities* (London: Routledge, 2021).

9. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), OAU Doc. CAB/LEG/66.6 (2003), art. 14(2)(c).

10. Zimbabwe, Termination of Pregnancy Act, sec. 4; Constitution of Kenya (2010), art. 26(4).

11. L. Berro Pizzarossa and P. Skuster, "Toward Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion: A Review of the Last Decade of Legal Reform," *Health and Human Rights Journal* 23/1 (2021).

12. Ibid.

13. L. Berro Pizzarossa and R. Nandagiri, "Self-Managed Abortion: A Constellation of Actors, a Cacophony of Laws?," *Sexual and Reproductive Health Matters* 29/1 (2021).

14. Advancing New Standards in Reproductive Health, Issue Brief: Safety and Effectiveness of First-Trimester Medication Abortion in the United States (2016), https://www.ansirh.org/sites/default/files/publications/files/medication-abortion-safety.pdf.

15. H. Moseson, S. Herold, S. Filippa, et al., "Self-Managed Abortion: A Systematic Scoping Review," *Best Practice and Research: Clinical Obstetrics and Gynaecology* 63 (2020).

16. IPPF, "Medical Abortion Commodities Database," https://www.ippf.org/blogs/introducing-ippfs-new-medical-abortion-commodities-database.

17. I. H. Solheim, K. M. Moland, C. Kahabuka, et al., "Beyond the Law: Misoprostol and Medical Abortion in Dar es Salaam, Tanzania," *Social Science amd Medicine* 245 (2020). See also "The Unsafe Practice of Intended Abortion Fuelled by Drug-Stores," *Citizen* (February 27, 2017), https://www.thecitizen.co.tz/magazine/The-unsafe-practice-of-intended-abortion-fuelled-by-drug-stores/1840564-3829544-format-xhtml-nfwkat/index.html.

18. Solheim et al. (see note 17).

19. H. Moseson, R. Jayaweera, I. Egwuatu, 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," *Lancet Global Health* 10/1 (2022); M. Stillman, O. Owolabi, A. Fatusi, et al., "Women's Self-Reported Experiences Using Misoprostol Obtained from Drug Sellers: A Prospective Cohort Study in Lagos State, Nigeria," *BMJ Open* 10/5 (2020); I. H. Shah and E. Ahman, "Unsafe Abortion Differentials in 2008 by Age and Developing Country Region: High Burden among Young Women," *Reproductive Health Matters* 20/39 (2012).

20. A. Bankole, L. Remez, O. Owolabi, et al., *From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress* (New York: Guttmacher Institute, 2020).

21. C. Gerdts, S. Raifman, K. Daskilewicz, et al., "Women's Experiences Seeking Informal Sector Abortion Services in Cape Town, South Africa: A Descriptive Study," *BMC Women's Health* 17/1 (2017).

22. M. Bornstein, Y. Young, L. Berro Pizzarossa, et al., "Documenting Activism and Advocacy around Medication Abortion in Central, East, and West Africa," *African Journal of Reproductive Health* 27/1 (2023).

23. C. Baxerres, I. Boko, A. Konkobo, et al., "Abortion in Two Francophone African Countries: A Study of Whether Women Have Begun to Use Misoprostol in Benin and Burkina Faso," *Contraception* 97/2 (2018).

24. Pizzarossa and Nandagiri (see note 13).

25. Mobilising Activists around Medical Abortion, https://mamanetwork.org.

26. Moseson et al. (2019, see note 3).

27. Human Rights Council, Technical Guidance on the Application of the Human Rights-Based Approach to Implementation of Policies and Programs to Reduce Preventable Maternal Morbidity and Mortality: Report of the Office of the United Nations High Commissioner for Human Rights, UN Doc. A/HRC/21/22 (2012), para. 16.

28. Malawi, Penal Code; Uganda, Penal Code; Togo, Public Health Code.

29. M. Samb, "Fundamental Issues and Practical Challenges of Human Rights in the Context of the African

Union," *Annual Survey of International and Comparative Law* 15/1 (2009).

30. Berro Pizzarossa and Skuster (see note 11).

31. Bankole et al. (see note 20).

32. Office of the United Nations High Commissioner for Human Rights, "Abortion Is Essential Healthcare and Women's Health Must Be Prioritized over Politics" (2021), https://www.ohchr.org/en/statements/2021/09/abortion-essential-healthcare-and-womens-health-must-be-prioritized-over.

33. World Health Organization (2022, see note 4).

34. African Commission on Human and Peoples' Rights, Resolution on the Health and Reproductive Rights of Women in Africa, ACHPR/Res.110(XXXXI)07 (2007).

35. Office of the United Nations High Commissioner for Human Rights, "Joint Statement by UN Human Rights Experts, the Rapporteur on the Rights of Women of the Inter-American Commission on Human Rights and the Special Rapporteurs on the Rights of Women and Human Rights Defenders of the African Commission on Human and Peoples' Rights" (September 24, 2015), https://www.ohchr.org/en/statements/2015/09/joint-statement-un-human-rights-experts-rapporteur-rights-women-inter-american.

36. International Justice Resource Center, "African Human Rights Commission Launches Campaign to Decriminalize Abortion," https://ijrcenter.org/2016/02/02/african-human-rights-commission-launches-campaign-to-decriminalize-abortion/; African Commission on Human and Peoples' Rights, "Statement by Commissioner Lucy Asuagbor during the Launch of ACHPR Campaign for the Decriminalization of Abortion in Africa" (January 18, 2016), https://www.achpr.org/news/viewdetail?id=83.

37. International Campaign for Women's Right to Safe Abortion, "Africa: Statement by the Special Rapporteur on the Rights of Women in Africa" (2016), https://www.safeabortionwomensright.org/isad/africa-statement-by-the-special-rapporteur-on-the-rights-of-women-in-africa.

38. African Commission on Human and Peoples' Rights (2007, see note 34).

39. M. T. Manuela, "Statement of the Special Rapporteur on the Rights of Women on the Occasion of the Global Day of Action for Access to Safe and Legal Abortion," https://www.achpr.org/pressrelease/detail?id=602.

40. C. Ngwena, "Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa," *Human Rights Quarterly* 32 (2010).

41. African Commission on Human and Peoples' Rights, 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 (2014), para. 32.

42. Committee for the Prevention of Torture in Africa, Inter-Session Activity Report (May 2017 to November 2017) and Thematic Report on Denial of Abortion and Post-Abortion Care as Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (2017), https://achpr.au.int/index.php/en/intersession-activity-reports/committee-prevention-torture-africa-6.

43. African Commission on Human and Peoples' Rights (2014, see note 41), paras. 57, 61.

44. Ibid., para. 57.

45. Ibid.

46. World Health Organization, *Health Worker Role in Providing Safe Abortion Care and Post Abortion Contraception* (Geneva: World Health Organization, 2004).

47. World Health Organization, *WHO Meeting on Ethical, Legal, Human Rights and Social Accountability Implications of Self-Care Interventions for Sexual and Reproductive Health* (Geneva: World Health Organization, 2018).

48. *Amnesty International v. Sudan* (2000) AHRLR 297 (ACHPR 1999).

49. A. Finden, *The Law, Trials and Imprisonment for Abortion in Kenya* (International Campaign for Women's Right to Safe Abortion, 2017), http://www.safeabortionwomensright.org/wp-content/uploads/2017/04/kenya-report-final-.pdf.

50. African Commission on Human and Peoples' Rights (2007, see note 34).

51. J. N. Erdman and R. J. Cook, "Decriminalization of Abortion: A Human Rights Imperative," *Best Practice and Research: Clinical Obstetrics and Gynaecology* 62 (2020); Ngwena (see note 40); K. I. Teklehaimanot, "Using the Right to Life to Confront Unsafe Abortion in Africa," *Reproductive Health Matters* 10/19 (2002).

52. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), OAU Doc. CAB/LEG/66.6 (2003), art. 4.

53. Ibid., art. 3.

54. African Commission on Human and Peoples' Rights (2014, see note 41), para. 24.

55. *PAK and Salim Mohammed v. the Attorney General et al.*, High Court of Kenya in Malindi (2022).

56. Erdman et al. (see note 1).

57. African Commission on Human and Peoples' Rights (2014, see note 41).

58. Ibid., para. 27.

59. Office of the United Nations High Commissioner for Human Rights (2015, see note 35).

60. Ngwena (see note 40).

61. African Commission on Human and Peoples' Rights, "Press Release on the Decision of the High Court of Kenya regarding the Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya and the National Training Curriculum for the Management of Unintended, Risky, and Unplanned Pregnancies" (June 21, 2019), https://achpr.au.int/en/news/press-releases/2019-06-21/press-release-decision-high-court-kenya.

62. Ibid.

63. Committee for the Prevention of Torture in Africa (see note 42), para. 16.

64. African Commission on Human and Peoples' Rights (2014, see note 41), para. 32.

65. Committee on the Elimination of Discrimination against Women, Report of the Committee on the Elimination of Discrimination against Women (CEDAW) 18th and 19th Session, UN Doc. A/53/38/Rev.1 (1998).

66. African Commission on Human and Peoples' Rights (2007, see note 34).

67. Ibid.

68. Committee for the Prevention of Torture in Africa (see note 42), paras. 9, 18.

69. African Commission on Human and Peoples' Rights, General Comment No. 4: The Right to Redress for Victims of Torture and Other Cruel, Inhuman, or Degrading Punishment or Treatment (Article 5) (2017).

70. Committee for the Prevention of Torture in Africa (see note 42).

71. African Commission on Human and Peoples' Rights (2017, see note 69).

72. African Commission on Human and Peoples' Rights (2007, see note 34), para. 40.

73. Ibid., para. 36.

74. African Commission on Human and Peoples' Rights, Commemorative Seminar on the 10th Anniversary of the Robben Island Guidelines: Enhancing Torture Prevention in Africa (2012).

75. African Commission on Human and Peoples' Rights, Resolution on Guidelines and Measures for the Prohibition and Prevention of Torture, Cruel, Inhuman or Degrading Treatment or Punishment in Africa: The Robben Island Guidelines, 2nd edition (2002), para. C5.

76. Ibid., paras. D45–E48.

77. Ibid., paras. E49–50.

78. African Commission on Human and Peoples' Rights (2007, see note 34), para 40.

79. *Huri-Laws v. Nigeria* (2000) AHRLR 273 (ACHPR 2000).

80. *Media Rights Agenda v. Nigeria* (2000) AHRLR 262 (ACHPR 24).

81. *Institute for Human Rights and Development in Africa v. Angola* (2008) AHRLR 43 (ACHPR 2008), para. 52.

82. Berro Pizzarossa and Nandagari (see note 13).

83. Bornstein et al. (see note 22).

84. N. Braine, "Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action," *Health and Human Rights Journal* 22/2 (2020).

85. Commission on the Status of Women, Statement Submitted by International Women's Health Coalition, a Non-governmental Organization in Consultative Status with the Economic and Social Council, UN Doc. E/CN.6/2021/NGO/115 (2020).

86. Human Rights Council, Report of the Special Rapporteur on the Situation of Human Rights Defenders, Margaret Sekaggya, UN Doc. A/ HRC/16/44 (2010); C. Soohoo and D. Hortsch, "Who Is a Human Rights Defender? An Essay on Sexual and Reproductive Rights Defenders," *University of Miami Law Review* 65 (2010).

87. African Commission on Human and Peoples' Rights, *Report of the Study of Women Human Rights Defenders in Africa*, http://peacewomen.org/sites/default/files/report_of_the_study_on_the_situation_of_women_human_rights_defenders_in_africa.pdf.

88. Office of the United Nations High Commissioner for Human Rights (2015, see note 35).

89. African Commission on Human and Peoples' Rights, Resolution on the Situation of Human Rights Defenders in Africa, ACHPR/Res.104(XXXI)07 (2007).

90. African Commission on Human and Peoples' Rights, Resolution on Protection against Violence and Other Human Rights Violations against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity, ACHPR/Res.275(LV)2014 (2014).

91. African Commission on Human and Peoples' Rights, Resolution on the Situation of Human Rights Defenders in Africa, ACHPR/Res.345(LVIII)2016 (2016).

92. African Commission on Human and Peoples' Rights, Resolution on the Situation of Human Rights Defenders in Africa, ACHPR/Res.376(LX)2017 (2017).

93. Berro Pizzarossa and Nandagiri (see note 13).

94. Moseson (2022, see note 19); N. Braine and M. Velarde, "Self-Managed Abortion: Strategies for Support by a Global Feminist Movement," *Women's Reproductive Health* 9/3 (2022).

95. A. M. Prandini and S. Larrea, "Why Self-Managed Abortion Is So Much More Than a Provisional Solution for Times of Pandemic," *Sexual and Reproductive Health Matters* 28/1 (2020).

96. World Health Organization (2022, see note 4), p. 102.

97. J. Ruvani, B. Powell, C. Gerdts, et al., "The Potential of Self-Managed Abortion to Expand Abortion Access in Humanitarian Contexts," *Frontiers in Global Women's Health* 2 (2021).

98. *Purohit and Another v. The Gambia* (2003) AHRLR 96 (ACHPR 2003), paras. 48–49.