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A RIGHTS-BASED APPROACH TO SELF-MANAGED ABORTION IN NIGERIA.

By

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PLAGIARISM DECLARATION

I, NGOZICHUKWU KELECHI CHUKWUMA, declare that the work presented in this dissertation is original. It has not been given to any other university or institution. Where other people's work has been used, it has been duly acknowledged.

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This work is dedicated to everyone who has fought for reproductive rights and justice and those who continue to advocate for safe, accessible abortion services in Nigeria and beyond.

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Summary

In Nigeria, the intersection of restrictive abortion laws, socio-cultural barriers, and inadequate healthcare services has significantly hindered women's access to safe and legal abortion, leading many to resort to self-managed abortion (SMA). This research critically examines self-managed abortion through a rights-based approach, highlighting the urgent need to align Nigeria's legal and policy frameworks with international and regional human rights standards.

The study explores how existing legal provisions in Nigeria, such as the Criminal Code and Penal Code, criminalise abortion except under limited circumstances, violating women's rights to autonomy, privacy, and the highest attainable standard of health. It further analyses the socio-cultural factors, including stigma, gender inequality, and religious beliefs, that perpetuate harmful practices and restrict women's access to safe abortion services.

Through a comprehensive review of international human rights instruments, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the African Charter on Human and Peoples' Rights, the research emphasises the principles of self-determination, dignity, non-discrimination, freedom from torture, cruel, inhumane or degrading treatment and health as fundamental to women's reproductive rights. The study also draws on lessons from other African jurisdictions, particularly Kenya, to propose a progressive legal and policy framework that supports self-managed abortion in Nigeria.

The research concludes with recommendations for legislative reform, increased public awareness, and the integration of SMA into Nigeria's healthcare system. It advocates for a shift from punitive approaches to supportive measures that respect women's autonomy and promote safe reproductive health practices, thereby advancing reproductive rights and health equity in Nigeria.

This work is essential for legal, ethical, and policy discourses on reproductive rights in Nigeria, contributing to the broader struggle for gender equality and women's empowerment.

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Acronyms/Abbreviations

WHO	World Health Organization
PPMVs	Patent and Proprietary Medicine Vendors
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
ICESCR	International Covenant on Economic, Social and Cultural Rights
SMA	Self-Managed Abortion
CESCR	Committee on Economic, Social and Cultural Rights
UN	United Nation
SRHR	Sexual and Reproductive Health and Rights
ACHPR	African Charter on Human and People's Rights
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
SRH	Sexual and Reproductive Health
NAFDAC	National Agency for Food and Drug Administration and Control
NGO	Non-Governmental Organization
SRRA	Sexual and Reproductive Rights in Africa
MAPUTO PROTOCOL	Protocol to the African Charter on Human and People's Rights on Women's Rights in Africa.

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A RIGHTS-BASED APPROACH TO SELF-MANAGED ABORTION IN NIGERIA.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND AND CONTEXT:

Recently, there has been an increasing global movement towards recognising individuals' rights to decide about their bodies, including reproductive choices.[1] Nigeria, as a country with a high population and limited access to comprehensive reproductive health services, has not been immune to these debates and discussions.[2] A rights-based approach to self-managed abortion in Nigeria encompasses the intersection of various elements that seek to empower individuals to make informed decisions about their reproductive health.[3] This approach is grounded in the principle that individuals have the right to self-determination, health, and access to safe and legal reproductive healthcare services.[4]

However, the country's restrictive abortion laws and societal norms have led to limited access to safe procedures, contributing to a myriad of issues surrounding abortion practices.[5] The criminalisation of abortion, except in cases where the mother's life is in danger, has created a climate of fear and secrecy, jeopardising the health of those seeking abortions and perpetuating a cycle of misinformation and clandestine practices.[6] This has profound implications, contributing to maternal morbidity and mortality and exacerbating existing health inequalities, particularly affecting

[1] Guttmacher Institute, 'Women's experiences with self-managed misoprostol abortions in Lagos state, Nigeria,' August 24, 2022, https://www.guttmacher.org/fact-sheet/womens-experiences-with-misoprostol-abortions-nigeria, accessed 17 February 2024.
[2] Guttmacher Institute (n 1)
[3] Safe Abortion Action Fund, 'Why We Advocate for the Right to Access Safe Medical Abortion in Nigeria' January 30, 2023, https://saafund.org/why-we-advocate-for-the-right-to-access-safe-medical-abortion-in-nigeria/, accessed 24 February 2024.
[4] Safe abortion action fund (n 3)
[5] P Okorie and A Abayomi 'Abortion laws in Nigeria: a case for reform' (2019) *23*(1) *Annual survey of international & comparative Law*, 165.
[6] Okorie and Abayomi (n 5)

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marginalised communities.[7] Research indicates that unsafe abortions contribute to approximately 13% of maternal mortality in the country.[8] In addition, the average maternal mortality rate in Nigeria is estimated to be around 704 deaths per 100,000 live births, with variations observed across different regions of the country.[9] In line with the evolving global reproductive health guidelines, there is an urgent need to promote access to self-managed abortion in Nigeria, recognising the agency of individuals in making informed choices about their reproductive health.[10]

The World Health Organisation (WHO) has been a critical advocate for the recognition of self-management as a safe and effective option for abortion. The WHO recommends self-managed abortion as an option until the 12th week of pregnancy based on extensive research and evidence of its safety and efficacy.[11] Self-managed abortion, also known as self-induced abortion or self-abortion, refers to the practice of individuals ending a pregnancy on their own without the supervision of a healthcare provider.[12] This can involve the use of medications, such as misoprostol or other methods, and it is on the rise globally due to the increasing availability of simple, safe, and highly effective medicines that meet people's need for safe abortion on their terms.[13] In Nigeria, medication abortion drugs, particularly misoprostol, have become widely available in recent years through the country's large market of formal and informal drug sellers.[14] A prospective, observational cohort study in Nigeria has also been conducted to measure the effectiveness of self-managed medication abortion.[15]

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[7] B Willis *et al*. 'The preventable burden of mortality from unsafe abortion among female sex workers: a community knowledge approach survey among peer networks in eight countries' (2023) 31(1) *sexual and reproductive health matters* 2250618.
[8] A Olumodeji *et al.,* 'Socio-demographic and clinical characteristics of women with unsafe abortion in South-Western Nigeria' *GSC Advanced research and reviews* 14, no. 2 (February 28, 2023): 022–030.
[9] O Omoniyi-Esan *et al,* 'Autopsy-certified maternal mortality at Ile-Ife, Nigeria' *International Journal of Women's Health*, December 2013, 41.
[10] L B Pizzarossa *et al,* 'Self-managed abortion in Africa: the decriminalisation imperative in regional human rights standards' (2023) 25(1)) *Health and Human Rights* 171.
[11] Pizzarossa *et al* (n10)
[12] Pizzarossa et *al* (n 10)
[13] Ipas, 'Supporting the right to self-managed abortion' October 10, 2023, https://www.ipas.org/our-work/self-managed-abortion/, accessed 13 January 2024.
[14] Guttmacher Institute (n 1)
[15] H 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,' *The Lancet Global Health* 10, no. 1 (January 2022).

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To address this issue, a rights-based approach to self-managed abortion in Nigeria seeks to shift the focus from criminalising women who seek abortion to ensuring their access to safe and comprehensive reproductive healthcare.[16] Such an approach recognises individuals' agency in making decisions about their bodies. It addresses the social, cultural, and systemic barriers that hinder access to safe and legal reproductive healthcare services in Nigeria.[17] A rights-based approach to self-managed abortion in Nigeria recognises that the freedom of women to control their fertility is not only a fundamental human right but also the basis for other essential liberties.[18][19] It acknowledges that the ability to make informed decisions about reproductive healthcare directly impacts women's overall health, economic empowerment, and autonomy.[20]

1.2 PROBLEM STATEMENT:

The limited availability of safe and legal abortion services in Nigeria suggests a potential reliance on self-managed abortion practices.[21] While specific statistics on the prevalence of self-managed abortions may be insufficient, anecdotal evidence and qualitative studies indicate that individuals may resort to these methods due to barriers to accessing formal healthcare services.[22][23]

The prevailing issue stems from a combination of stringent legal measures and deeply entrenched societal norms, creating a challenging environment where individuals are

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[16] Pizzarossa *et al* (n 10)
[17] Pizarossa *et al* (n 10)
[18] Pizzarossa *et al* (n 10)
[19] PLOS global public health, 'Effectiveness of self-managed abortion during the COVID-19 pandemic: results from a pooled analysis of two prospective, observational cohort studies in Nigeria,' October 20, 2022, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10022159/, accessed February 24, 2024.
[20] PLOS (n 19)
[21] Y A Adojutelegan *et al*, 'Drug sellers' knowledge and practices, and client perspectives after an intervention to improve the quality of safe abortion care outside of formal clinics in Nigeria," BMJ sexual & reproductive health, January 2022, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8685617/ accessed 24 March 2024.
[22] PLOS (n 19)
[23] H Väisänen *et al*, 'Sexual and reproductive health literacy, misoprostol knowledge and use of medication abortion in Lagos state, Nigeria: a mixed methods study' (2021) 52 (2) *Studies in Family Planning* 217–37.

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forced to navigate stigma and secrecy to secure safe abortion services.[24][25] Data indicates that a substantial number of women in Nigeria experience serious health consequences due to predominantly unsafe abortions, with a significant portion not receiving the necessary treatment for complications.[26] Studies show that in Nigeria, an estimated 212,000 women received treatment for complications of unsafe abortion, with a treatment rate of 5.6 per 1,000 women of reproductive age, and an additional 285,000 women experienced severe health consequences without receiving necessary care.[27] Additionally, it was estimated that 142,000 women in Nigeria sought treatment for abortion-related complications annually, with unsafe abortion contributing to at least 13% and potentially 30-40% of maternal deaths.[28] This situation underscores the critical gaps in access to quality reproductive healthcare services, resulting in adverse health outcomes for women.[29] Additionally, the societal stigma surrounding abortion in Nigeria contributes to underreporting and a lack of transparency regarding abortion practices, hindering efforts to address the challenges faced by women seeking reproductive healthcare services.[30]

In Nigeria, patent and proprietary medicine vendors (PPMVs) are crucial in providing medications for various health conditions, including abortion, despite legal restrictions.[31] These informal healthcare providers are often the first point of contact for individuals seeking healthcare services, including medication and abortion.[32] PPMVs are recognised as a primary source of orthodox drugs for both rural and urban populations in Nigeria.[33]

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[24] A Bankole et al, 'Abortion-seeking behaviour among Nigerian women' (2008) 40 (2) *Journal of Biosocial Science* 247–68.
[25] Gbadamosi Olaide and Titilayo O. Aderibigbe, 'Justification of women's right of access to safe and legal abortion in Nigeria,' Brill, July 30, 2014, https://brill.com/view/journals/ajls/7/2/article-p177_1.xml, accessed 14 January 2024.
[26] Gbadamosi *et al* (n 25)
[27] A Bankole *et al,* 'The incidence of abortion in Nigeria' (2015) 41 (4) *International perspectives on sexual and reproductive health* 170–81.
[28] S K Henshaw *et al,* 'Severity and cost of unsafe abortion complications treated in Nigerian hospitals' (2008) 34 (1) *International Family Planning Perspectives* 040–051.
[29] Henshaw (n 28)
[30] F Okonofua *et al,* 'Self-reporting of induced abortion by women attending prenatal clinics in urban Nigeria' (2010) 111 (2) *International Journal of Gynecology & Obstetrics* 122–25.
[31] N Beyeler *et al,* 'A systematic review of the role of proprietary and patent medicine vendors in healthcare provision in Nigeria' (2015) 10 (1) *PLOS ONE*.
[32] M Stillman et al, 'Women's self-reported experiences using misoprostol obtained from drug Sellers: a prospective cohort study in Lagos state, Nigeria, (2020) 10 (5) *BMJ Open*.
[33] T A Okeke *et al,* 'An in-depth study of patent medicine sellers' perspectives on malaria in a rural Nigerian community' (2006) 5 (1) *Malaria journal*.

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However, there are concerns about the quality of information and care provided by drug sellers offering medical abortion services in the country.[34] Studies have shown that in Nigeria, individuals seek medication abortion drugs, such as misoprostol, directly from pharmacies or drug sellers due to legal restrictions on abortion.[35] This highlights the significant role that drug sellers play in facilitating access to abortion care in a context where formal healthcare services may be limited or restricted. By investigating the challenges and opportunities for implementing a rights-based approach to self-managed abortion, this research aims to shed light on the pressing need for policy reforms and comprehensive reproductive healthcare strategies to safeguard women's health and rights in the country.

1.3 RESEARCH AIM:

The research aims to investigate the intersection of human rights principles with access to self-managed abortion in Nigeria, with the overarching goal of advancing reproductive rights and health equity. Through a comprehensive analysis of legal and policy frameworks, socio-cultural factors, and accountability mechanisms, the research seeks to assess the current landscape of reproductive rights in Nigeria and identify barriers and challenges to access to self-managed abortion and self-care. The study examines what changing access to these services would mean for health outcomes and maternal health. The goal is to explore the obstacles and prospects associated with the adoption of a rights-based framework for self-managed abortion in Nigeria. Despite the existing legal constraints on abortion, individuals often turn to self-managed abortion as a last resort. This research seeks to investigate the complexities surrounding the implementation of a rights-based approach to self-managed abortion in Nigeria, considering the prevalent legal restrictions and the significant reliance on self-care practices within the context of reproductive healthcare.

[34] Väisänen *et al* (n 23)
[35] Adojutelegan *et al* (n 21)

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1.4 RESEARCH OBJECTIVES:

- To critically analyse the impact of the current legal and policy landscape concerning access to abortion and evaluate its alignment with international human rights standards and principles.
- To examine the multifaceted barriers and challenges to access to self-managed abortion, particularly among marginalised communities in Nigeria.
- To explore the factors influencing women's decisions to self-manage abortions in Nigeria and assess the associated health outcomes.
- To examine how human rights principles and reproductive rights inform strategies for overcoming barriers and promoting access to self-managed abortion in Nigeria.
- To assess the legal and policy framework on access to medicines concerning self-managed abortion in Nigeria.

1.5 MAIN RESEARCH QUESTION:

How can a human rights-based approach contribute to promoting access to self-managed abortion in Nigeria?

Sub-questions:

1. What is Nigeria's current legal and policy landscape on abortion access, and how does it align with international human rights standards?
2. How do sociocultural norms and attitudes in Nigeria shape individuals' access to safe and self-managed abortion for marginalised groups?
3. In what ways do human rights principles inform strategies for overcoming barriers to accessing self-managed abortion in Nigeria?

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4. What is Nigeria's legal and policy framework regarding access to medicines for self-managed abortion, and how effective are the accountability mechanisms in upholding individuals' reproductive rights?
5. What insights can other jurisdictions provide on implementing a rights-based approach to self-managed abortion, and how can these inform advocacy for policy and legal reforms in Nigeria?

1.6 RESEARCH METHODOLOGY: The methodology employed in this study involves a comprehensive desktop review, encompassing primary sources such as international and regional human rights frameworks, national legislation relevant to access to self-managed abortion in Nigeria, and guidelines. Additionally, secondary sources, including journal articles, reports, and books analysing the legal, policy, and socio-cultural dimensions of self-managed abortion access, will be consulted.

1.7 SIGNIFICANCE OF THE RESEARCH:

From a human rights perspective, regional instruments like the Maputo Protocol emphasise the rights of women, including sexual and reproductive rights, laying the groundwork for destigmatising self-managed abortion and promoting dignity, freedom from cruel treatment, and non-discrimination in abortion care.[36][37] Also, self-managed abortion offers empowerment and access, providing individuals with greater control over their reproductive health decisions, especially up to the 12th week of pregnancy, as recognised by the World Health Organisation.[38]

Research indicates the safety and effectiveness of self-managed abortion, mainly when supported by community groups and linked to the healthcare system, contributing to improved access to reproductive care in regions like Africa.[39] Interestingly, amidst the COVID-19 pandemic, limited access to clinical care has highlighted the significance of

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[36] E S Muzokura *et al,* 'Rape related pregnancy: concept analysis' (2020) 3 (1) *International journal of advance research in nursing* 102–7.
[37] O Eni *et al*, 'The right to participate in political and decision-making process under the Maputo protocol: Normative Masculinity and Nigerian Women' (2022) (18) *The Age of Human Rights Journal* 397–423.
[38] Maputo Protocol, *The Multimedia Encyclopedia of Women in Today's World Encyclopedia of Women in Today's World*, 2013, https://doi.org/10.4135/9781452270388.n251.
[39] Maputo protocol (n 38)

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self-managed abortion as a viable option during times of healthcare service restrictions.[40] It is worth noting that, in Nigeria, drug sellers play a crucial role in providing information and access to medication abortion, particularly misoprostol, despite legal restrictions.[41]

Despite challenges in knowledge and practices, drug sellers remain a critical resource for individuals seeking abortion services in Nigeria.[42] Efforts to improve access to misoprostol, an essential medication for abortion, have been successful in Nigeria, particularly in settings where home-based deliveries are standard and uterotonic coverage is limited.[43] This underscores the importance of community-based distribution strategies involving drug sellers to enhance access to essential medications for reproductive health needs. Strengthening the knowledge and training of these providers can improve the quality of care and safeguard women's health and well-being, underscoring the relevance and significance of exploring a rights-based approach to self-managed abortion and self-care in Nigeria.

1.8 LITERATURE REVIEW:

A human rights-based approach to self-managed abortion and self-care in Nigeria is crucial for ensuring access to quality reproductive care while upholding individuals' rights. Self-managed abortion has the potential to revolutionise access to reproductive care in Africa, where abortion-related mortality is high and abortion remains criminalised.[44] The Maputo Protocol, an African regional human rights instrument, provides a normative basis for the decriminalisation of abortion, including self-managed abortion, by articulating rights to dignity, freedom from cruel, inhuman, and degrading treatment, and non-discrimination.[45] Despite such frameworks, the criminalisation of

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[40] Maputo protocol (n 38)
[41] Maputo protocol (n 38)
[42] A Akinyemi *et al*, 'Quality of information offered to women by drug sellers providing medical abortion in Nigeria: evidence from providers and their clients' (2022) 3 *Frontiers in Global Women's Health*.
[43] Amir Ali Samnani *et al*, 'Barriers or gaps in implementation of misoprostol use for post-abortion care and post-partum haemorrhage prevention in developing countries: A systematic review' (2017) 14 (1) *Reproductive health*.
[44] Pizzarossa *et al* (n 10)
[45] Pizzarossa *et al* (n 10)

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abortion in Nigeria poses significant challenges to ensuring rights-based access to reproductive healthcare services.[46][47] For instance, the Nigerian Penal Code allows abortion only when necessary to save the pregnant person's life, leading to widespread self-managed abortions despite limited access to clinical abortion care.[48] Grassroots organisations provide counselling and support for self-managed abortions, highlighting the importance of safe, self-managed abortions.[49]

However, during the COVID-19 pandemic, access to clinical abortion care was restricted, leading to an increased reliance on self-managed abortion in Nigeria.[50] Also, individuals in Nigeria faced difficulties in obtaining and taking abortion pills, highlighting the importance of safe abortion hotlines in expanding access to safe abortion.[51] Self-managed abortion is increasingly safe and effective. Studies like those by Egwuatu and Stillman have delved into the effectiveness and safety of self-managed abortion practices using medications like misoprostol obtained outside traditional healthcare settings in Nigeria.[52] This highlights the importance of understanding the experiences and outcomes of individuals resorting to self-managed abortion methods. A human rights-based approach can empower marginalised or vulnerable groups, such as women and girls, to access safe abortion care and address issues of inequality.[53] This approach emphasises principles such as participation, inclusion, non-discrimination, equality, and accountability, which can be integrated into policy and practice to influence reproductive health initiatives in Nigeria, particularly concerning self-managed abortion and self-care.[54]

[46] Pizzarossa *et al* (n 10)
[47] The conversation 'restrictive abortion laws put Nigerian women in danger' 19 May 2020 https://theconversation.com/restrictive-abortion-laws-put-nigerian-women-in-danger-183153, accessed 4 October 2024.
[48] I Egwuatu *et al,* 'Effectiveness of self-managed abortion during the COVID-19 pandemic: results from a pooled analysis of two Prospective, observational cohort studies in Nigeria," PLOS Global Public Health, https://journals.plos.org/globalpublichealth/article?id=10.1371%2Fjournal.pgph.0001139, accessed 24 February, 2024.
[49] Egwuatu *et al* (n 48)
[50] Stillman *et al* (n 32)
[51] Stillman *et al* (n 32)
[52] Stillman *et al* (n32)
[53] A Tiew *et al,* 'The Impact of COVID-19 on safe abortion access in Africa: an analysis through a framework of reproductive justice and lens of structural violence' (2022) 3 *Frontiers in Global Women's Health*
[54] Tiew *et al* (n 53)

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Additionally, the demand for self-managed abortion has been observed in various settings, emphasising the importance of ensuring safe and accessible options for individuals seeking abortion.[55] The role of healthcare professionals in promoting clinical and legal safety in abortion care, including support for self-managed abortion, is crucial.[56] Furthermore, the quality of information and practices of drug sellers and providers offering medical abortion in Nigeria has been identified as an essential factor in ensuring safe, self-managed abortion.[57] The legal and policy framework surrounding self-managed abortion needs to align with medical evidence to ensure the safety and well-being of individuals seeking abortion care.[58] The WHO's Abortion Care Guidelines emphasise the importance of enabling access to quality abortion care, which includes considerations for self-managed abortion.[59] This aligns with the need for coherent healthcare policy and regulation supporting self-care interventions, as highlighted in the literature on self-medication.[60] It is essential to address the barriers to abortion care and consider the implications of restrictive abortion laws on access to safe abortion options, particularly in the context of self-managed abortion.[61] Gbagbo has studied the legal and medico-legal aspects of self-managed abortion in countries like Ghana, highlighting the potential of self-managed abortion as a medico-legal intervention within the existing legal framework.[62] Another study by Moseson focused on the effectiveness of self-

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[55] A Aiken *et a*l, 'Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 Pandemic: a regression discontinuity analysis' (2021) 47(4) *BMJ Sexual & Reproductive Health* 238.
[56] P Skuster *et el*, 'Self-managed abortion: aligning law and policy with medical evidence' (2022) 160(2) *International journal of gynaecology & obstetrics,* 720-725.
[57] A Adojutelegan *et el,* 'Drug sellers' knowledge and practices, and client perspectives after an intervention to improve the quality of safe abortion care outside of formal clinics in Nigeria' (2021) 48(1) *BMJ Sexual &, reproductive health*.
[58] P Skuster *et al,* 'Self-managed abortion: aligning law and policy with medical evidence' (2022) 160 (2) *International journal of gynaecology & Obstetrics* 720–25.
[59] C R Kim *et al,* 'Enabling access to quality abortion care: WHO's abortion care guideline' (2022) 10 (4) *The Lancet Global Health*.
[60] U May *et al,* 'Self-medication in Europe: economic and social impact on individuals and society' (2023) 28 (6) *Gesundheitsökonomie & Qualitätsmanagement* 298–310.
[61] P I Okonta *et al,* 'Liberalization of abortion and reduction of abortion related morbidity and mortality in Nigeria' (2010) 89 (8) *Acta obstetricia et gynecologica Scandinavica* 1087–90.
[62] H Moseson *et al,* 'Self-managed abortion: a systematic scoping review' (2020) 63 *Best practice & Research clinical obstetrics & gynaecology* 87–110.

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managed medication abortion in various regions, including Nigeria, providing insights into the practical aspects of self-managed abortion practices.[63]

The concept of self-managed abortion has been evolving, as evidenced by the scoping review by Moseson, which emphasises the need to consider various approaches to self-managed abortion beyond traditional methods.[64] Studies by Jayaweera and Bercu have focused on the accompaniment model, where grassroots organisations provide support through the self-managed abortion process, highlighting the importance of counselling and guidance in such practices.[65]

Moreover, the discourse on self-managed abortion extends to issues of health inequity, harm reduction, and social change, as discussed by Erdman.[66] This commentary underscores how self-managed abortion can challenge existing paradigms and contribute to broader discussions on reproductive rights and activism.

Implementing a human rights-based approach to self-managed abortion in Nigeria faces several challenges and barriers. These include restrictions imposed by the criminalisation of abortion, limited access to clinical abortion care, and the COVID-19 pandemic.[67] Strategies proposed to address these issues include expanding access to safe abortion hotlines, providing information on self-managed abortion, and advocating for the decriminalisation of abortion access in broad and self-managed abortion based on human rights principles.[68][69] It is essential to improve rights-based sexual and reproductive health services, especially for vulnerable populations.

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[63] H Moseson *et al* 'Self-managed medication abortion outcomes: results from a prospective pilot study' (2020) 17 (1) *Reproductive health*.
[64] Moseson *et al* (n 63)
[65] C Bercu *et al,* 'A qualitative exploration of how the COVID-19 pandemic shaped experiences of self-managed medication abortion with accompaniment group support in Argentina, Indonesia, Nigeria, and Venezuela' (2022) 30 (1) *Sexual and reproductive health matters*.
[66] J N Erdman *et al,* 'Understandings of self-managed abortion as health inequity, harm reduction and social change' (2018) 26 (54) *Reproductive health matters* 13–19.
[67] C Moreau et al, 'Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses' (2020) 47 (4) *BMJ sexual & reproductive health*.
[68] K Qaderi and *et al,* 'Abortion services during the COVID-19 pandemic: a systematic review' (2023) 20 (1) *Reproductive health*.
[69] K Brandell *et al,* 'Telemedicine as an alternative way to access abortion in Italy and characteristics of requests during the COVID-19 pandemic' (2021) 48 (4) *BMJ Sexual & reproductive health* 252–58.

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1.9 THEORETICAL APPROACH:

Focusing the theoretical approach solely on the human rights-based perspective provides a comprehensive framework for comprehending and advocating for a rights-based approach to self-managed abortion in Nigeria. Focusing on human rights principles such as self-determination, health, dignity, freedom from torture, cruel, inhumane or degrading treatment and non-discrimination, this approach offers a robust foundation for analysing the legal, social, and systemic factors influencing reproductive healthcare practices. This narrowed focus enables a more nuanced examination of how human rights violations, policy gaps, and societal norms intersect to shape individuals' ability to exercise their reproductive rights, thus facilitating a deeper understanding of the challenges and opportunities for promoting equitable access to self-managed abortion and self-care services in Nigeria.

1.10 PROVISIONAL OUTLINE OF CHAPTERS:

This study is divided into six chapters. Chapter One introduces the research topic and provides background information, outlining the aims, objectives, questions, and theoretical framework guiding the study. Additionally, it discusses the significance of the study in addressing reproductive health issues. Chapter two explores the theoretical framework of the study. It examines the human rights-based approach and concepts of agency and empowerment in the context of reproductive rights and self-managed abortion. It also discusses the barriers women face when accessing self-managed abortion in Nigeria. The third chapter focuses on international and regional standards and guidelines related to self-managed abortion. Chapter four analyses the legal and policy landscapes concerning reproductive rights and access to abortion in Nigeria. It reviews laws, policies, and regulations governing abortion care, including the legal and policy framework on access to medicines for self-managed abortion in Nigeria. Chapter five draws lessons from other African jurisdictions on this topic. The final chapter summarises critical insights from the study and proposes recommendations for improving reproductive health services.

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CHAPTER 2: THEORETICAL FRAMEWORK: HUMAN RIGHTS-BASED APPROACH TO SELF-MANAGED ABORTION.

2.1 Introduction to a rights-based Approach.

A rights-based approach to self-managed abortion is grounded in the principle that individuals have the fundamental right to self-determination, health, and access to safe and legal reproductive healthcare services.[70] This approach empowers individuals, particularly women and girls, to make informed decisions about their reproductive health and bodies. Within the Nigerian context, this rights-based framework aims to address the significant challenges posed by the country's restrictive abortion laws and deeply entrenched societal norms that have led to limited access to safe abortion procedures.[71] The criminalisation of abortion, except in cases where the mother's life is in danger, has created a climate of fear and secrecy, jeopardising the health of those seeking abortions and perpetuating a cycle of misinformation and clandestine practices.[72] A rights-based approach to self-managed abortion in Nigeria recognises that the freedom of individuals to control their fertility is not only a fundamental human right but also the basis for other essential liberties.[73] It acknowledges that the ability to make informed decisions about reproductive healthcare directly impacts individuals' overall health, economic empowerment, and autonomy.[74] By centring on these human rights bases, the aim is to empower marginalised or vulnerable groups, such as women and girls, to access safe abortion care and address issues of inequality.

In the context of reproductive rights and self-managed abortion, a rights-based approach serves as a foundational framework that upholds the fundamental principles of self-

[70] Pizzarossa *et al* (n 10)
[71] A O Lilian 'A critical appraisal of women's reproductive rights in Nigeria' (2020) 10 (2) *Journal of Sustainable Development Law and Policy* 257.
[72] A Bankole *et al,* 'The incidence of abortion in Nigeria' (2015) *International perspectives on sexual and reproductive health*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4970740/.
[73] Pizzarossa *et al* (n 10)
[74] Pizzarossa *et al* (n 10)

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determination, health, and access to safe and legal reproductive healthcare services.[75] The foundation of this approach is the recognition of individuals' inherent right to make informed decisions about their bodies and reproductive health, free from coercion, discrimination, and stigma.[76] In this context, the human rights-based approach highlights the importance of adhering to fundamental human rights principles, such as self-determination, health, dignity, equality, and non-discrimination, when addressing issues related to abortion and reproductive care.[77] This approach emphasises duty-bearers accountability, rights-holders participation, and the need for non-discriminatory, inclusive policies to ensure comprehensive reproductive healthcare.[78] This ensures that individuals have access to quality reproductive care while respecting their dignity, freedom from cruel treatment, and non-discrimination.[79] It highlights the need to decriminalise abortion, including self-managed abortion, in regions like Nigeria, where it is restricted by criminal laws, aligning with internationally and regionally recognised human rights.

By integrating human rights principles into reproductive healthcare practices, including self-managed abortion, societies can move towards a more equitable, just, and rights-based approach to healthcare that prioritises the dignity and well-being of all individuals.[80] This chapter will explore deeper into the application of human rights principles in the context of self-managed abortion, exploring how these principles can inform policies, practices, and advocacy efforts to advance reproductive rights and health equity in Nigeria.

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[75] L B 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' (2021) *Health and human rights*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8233026/.
[76] Pizzarossa *et al* (n 10)
[77] Applying a rights-based approach, https://www.humanrights.dk/files/media/migrated/applying-a-rights-based-approach-2007-an-inspirational-guide-for-civil-society.pdf, accessed 2 June 2024.
[78] UNSDG | Human rights-based approach, https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach, accessed 2 June 2024.
[79] UNSDG (n 78)
[80] Reproductive rights are human rights, https://www.ohchr.org/Documents/Publications/NHRIHandbook.pdf, accessed 2 June 2024.

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2.2 Human Rights Principles and Reproductive Rights

Here is a discussion of how the human rights principles of self-determination, health, dignity, freedom from torture, cruel, inhuman or degrading treatment and non-discrimination relate to self-managed abortion in Nigeria.

2.2.1 Self-Determination-

The right to self-determination is a fundamental human right that empowers individuals to make informed decisions about their bodies and reproductive health. In Nigeria, a right-based approach to self-managed abortion recognises that individuals' freedom to control their fertility is not only a fundamental human right but also the foundation for other essential freedoms.[81] By focusing on self-determination, individuals are empowered to make autonomous choices about their reproductive health, including decisions regarding self-managed abortions.[82] Studies have shown that a rights-based approach can empower marginalised or vulnerable groups, such as women and girls, to access safe abortion care and address issues of inequality.[83]

Article 14 of the Maputo Protocol states that the parties shall take all appropriate measures to ensure the right of women to decide freely and responsibly on matters related to reproductive health and shall ensure that this right is respected.[84] Women can freely and responsibly determine their children's number and spacing in all cases.[85] This emphasises individuals' right to decide about their reproductive health and well-being, including whether to have children, the number of children, and the spacing of children. It recognises the importance of autonomy and self-determination in reproductive decision-making, aligning with the principles of self-determination and agency in the context of self-managed abortion. This alignment with the principle of self-determination

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[81] Lilian (n 71)

[82] V Sabina and B Budiarsih, 'Empowering women: abortion regulations and the right to self-determination' (2023) 6 (1) *Musamus Law Review*, 13-25.

[83] E Durojaye *et al* 'Advancing Sexual and Reproductive Health and Rights in Africa: Constraints and Opportunities' Routledge & CRC Press, January 8, 2023, https://www.routledge.com/Advancing-Sexual-and-Reproductive-Health-and-Rights-in-Africa-Constraints-and-Opportunities/Durojaye-Mirugi-Mukundi-Ngwena/p/book/9781032006284, accessed 10 June 2024.

[84] Protocol to the African charter on human and - OHCHR, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/ProtocolontheRightsofWomen.pdf, accessed 17 May 2024.

[85] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the AU in 2003 entered into force 27 November 2005 (African Women's Protocol)

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is crucial in promoting access to safe abortion care and enabling individuals to exercise their reproductive rights.

2.2.2 Health-

The right to health is a crucial aspect of reproductive rights, encompassing access to safe and legal reproductive healthcare services.[86]

Article 14 of the Maputo Protocol explicitly emphasises the right to health and reproductive rights, stating that state parties shall respect and promote women's right to health, including sexual and reproductive health.[87] The article further elaborates that states should authorise medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother, her life, or the foetus.[88]

Article 14 of the Women's Protocol is pivotal, not only consolidating the right to health but also expanding its content by explicitly recognising women's rights to control their fertility, choose contraception, and access safe abortion under specific conditions.[89] This provision is noteworthy because it is the first human rights instrument to recognise a woman's right to a safe abortion, in contrast to more restrictive global standards.[90] Recognising these rights is critical to addressing the high rates of maternal mortality due to unsafe abortions, particularly in Africa. Ngwena argues that liberalising abortion laws and ensuring access to safe services can significantly reduce health inequalities and promote women's reproductive rights.[91]

This provision in the Maputo Protocol directly links the right to health with access to safe and legal abortion services. By recognising the importance of access to safe abortion services for protecting women's health, the Maputo Protocol provides a strong foundation for promoting a rights-based approach to self-managed abortion. The

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[86] The right to health, https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf, accessed 1 June 2024.
[87] African women protocol (n 85)
[88] African women protocol (n 85)
[89] E Durojaye, 'An analysis of the contribution of the African human rights system to the understanding of the right to health' (2021) 21 (2) *African Human Rights Law Journal* 1–31.
[90] Durojaye (n 89)
[91] C Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 Human Rights Quarterly 783.

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Committee on Economic, Social and Cultural Rights (CESCR), responsible for monitoring the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR), issued General Comment 14 to clarify the implications of the right to health guaranteed in Article 12.[92] According to the CESCR, the right to health should not be interpreted merely as the right to be healthy but as an obligation on states to ensure access to healthcare services for all.[93] This encompasses essential elements such as availability, accessibility, acceptability, and quality (often called the '3As and Q').[94] The '3As and Q' framework emphasises that healthcare services, including those for reproductive health and self-managed abortion, must be:

Available: Sufficient in quantity and functioning publicly and privately.

Accessible: Non-discriminatory, physically accessible, economically affordable, and accessible information.

Acceptable: Respectful of medical ethics and culturally appropriate.

Quality: Scientifically and medically appropriate and of good quality.

General Comment 14 also outlines the minimum core content of the right to health, which includes access to healthcare services without discrimination, access to essential medicines, and the involvement of civil society in monitoring state obligations.[95] States have obligations to respect, protect, and fulfil the right to health. This implies that they must not adopt laws or policies that interfere with access to healthcare services, ensure third parties do not undermine this right, and take necessary measures to realise it.[96]

General Comment 22 on the right to sexual and reproductive health integrates these principles, emphasising that sexual and reproductive health is an integral part of the highest attainable standard of physical and mental health.[97] This means states must

[92] UN Committee on Economic, Social and Cultural Rights (ESCR Committee) General Comment 14: The Right to the Highest Attainable Standard of Health (Art 12 of the Covenant) 11 August 2000, E/C12/2000/4
[93] General comment 14 (n 92)
[94] General comment 14 (n 92) para 12.
[95] General comment 14, para 36.
[96] General comment 14 (n 95)
[97] ESCR Committee General Comment 22 (2016) on the right to sexual and reproductive health (art 12 ICESCR).

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ensure these services are available, accessible, acceptable, and of good quality, particularly for vulnerable and marginalised groups.[98]

Similarly, the Committee on the Elimination of Against Women (CEDAW) in General Recommendation 24 on women and health underscores states' obligations to ensure access to healthcare services women need on an equal basis with men.[99] A failure to ensure access to these services constitutes discrimination under the Convention.[100] States are also encouraged to allocate resources, train healthcare providers, and provide redress for women who experience violations of their rights in healthcare settings.[101]

Upholding the human rights principles to health is crucial in addressing the ethical and legal dimensions of self-managed abortion. It ensures that women's rights to autonomy, informed consent, and non-discrimination are respected and that they can safely and effectively manage their reproductive health without undue barriers or risks.

2.2.3 Dignity-

The principle of dignity is closely linked to reproductive rights, as it encompasses the inherent worth and respect that every individual deserves.[102] Within the framework of a rights-based approach, the goal is to uphold dignity through the de-stigmatization of self-managed abortion and the provision of respectful and discrimination-free treatment to individuals seeking reproductive healthcare services.

This is done by aligning with the provisions outlined in Maputo Article 3, which explicitly defines and protects the right to human dignity.[103] The Maputo Protocol emphasises the interconnectedness of dignity with other rights, demonstrating that dignity is not just an abstract concept but a fundamental principle supporting the enjoyment of other rights.[104]

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[98] ESCR (n 97)
[99] CEDAW Committee General Recommendation 24: Art 12 of the Convention (Women and Health) 1999, A/54/38.
[100] CEDAW (n 99)
[101] CEDAW (n 99)
[102] Pizzarossa *et al* (n 70)
[103] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: A Commentary, The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: a commentary - Pretoria University Law Press (PULP), accessed June 5, 2024, https://www.pulp.up.ac.za/component/edocman/the-protocol-to-the-african-charter-on-human-and-peoples-rights-on-the-rights-of-women-in-africa-a-commentary.
[104] Pizzarossa *et al* (n 70)

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Therefore, when discussing self-managed abortion within the framework of human rights principles, ensuring the dignity of women is paramount. This includes addressing systemic barriers, societal attitudes, and legal restrictions that undermine women's dignity and autonomy in making decisions about their reproductive health. This means that any discussion or approach regarding self-managed abortion must uphold the dignity of women, respecting them as individuals entitled to autonomy and self-determination over their bodies and reproductive health decisions.

The African Commission recognises that the right to dignity encompasses the freedom to make personal decisions without interference from state or non-state actors.[105] Also, General Comment 2 explicitly states that the right to dignity is intrinsically linked to women's autonomy in making personal decisions regarding their sexual and reproductive lives.[106] The right to dignity extends to a woman's free development of personality, emphasising the importance of allowing women the freedom to make choices about their reproductive health without fear of coercion or judgment, including the option to pursue self-managed abortion when faced with limited access to safe and legal healthcare services. This principle is fundamental in addressing the societal stigma surrounding abortion in Nigeria, which contributes to underreporting and a lack of transparency regarding abortion practices.

2.2.4 Freedom from torture, cruel, inhuman or degrading treatment-

The right to freedom from torture and cruel, inhumane, or degrading treatment is a core human rights principle that protects individuals from suffering severe physical or mental harm. In the context of self-managed abortion (SMA) in Nigeria, this right is critical as restrictive abortion laws and stigmatisation often force women to resort to unsafe methods, exposing them to significant health risks and psychological trauma.[107] When women are denied access to safe abortion services and subjected to unsafe procedures or are criminalised for exercising their reproductive rights, they endure treatment that violates this fundamental right.[108]

[105] African Commission on Human and Peoples' Rights (2014, see note 41), para. 24
[106] ACHPR (n 85)
[107] PLOS (n 19)
[108] Pizzarrosa *et al* (n 10)

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A rights-based approach to SMA emphasises that denying women access to safe abortion care or punishing them for seeking abortions can result in severe, degrading treatment that exacerbates their vulnerability and violates their dignity.[109] These restrictive conditions often lead to dangerous health outcomes, mental distress, and, in some cases, death, which can be considered forms of cruel treatment under human rights standards.[110]

Article 5 of the Universal Declaration of Human Rights and Article 7 of the International Covenant on Civil and Political Rights both provide that no one shall be subjected to torture or cruel, inhuman, or degrading treatment or punishment.[111][112] These international standards emphasise the importance of protecting individuals from such treatment, aligning with the need to ensure safe and rights-based access to abortion care. Applying this in the context of SMA, forcing women to endure unsafe conditions or criminal penalties for seeking abortion is a form of degradation. By ensuring that women can access safe abortion care, mainly through self-managed abortion, Nigeria would align with the principles of protecting individuals from cruel treatment and ensuring their health, dignity, and well-being are respected.

2.2.5 Non-Discrimination-

The principle of non-discrimination is essential in ensuring equitable access to reproductive healthcare services, including self-managed abortion.[113] A rights-based approach recognises that marginalised or vulnerable groups, such as women and girls, may face additional barriers to accessing safe abortion care. By applying the principle of non-discrimination, this approach aims to address issues of inequality and ensure that all individuals, regardless of their social, economic, or cultural background, have access to safe and legal reproductive healthcare services.[114]

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[109] Pizzarossa *et al* (n 10)
[110] Pizzarossa *et al* (n 10)
[111] Universal Declaration of Human Rights (1948), Art 5.
[112] International Covenant on Civil and Political Rights (1996), United Nations General Assembly, Art 7.
[113] Pizzarossa *et al* (n 10)
[114] Pizzarossa *et al* (n 10)

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Specifically, Article 2 of the Maputo Protocol requires states to combat all forms of discrimination against women through appropriate legislative, institutional, and other measures and to enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination, particularly harmful practices that endanger women's health and general well-being.[115]

In the context of self-managed abortion, this principle is critical in ensuring that all individuals, particularly marginalised groups, have equitable access to safe abortion services. The Maputo Protocol's emphasis on non-discrimination aligns with the goals of a rights-based approach to self-managed abortion in Nigeria, which seeks to address issues of inequality and promote inclusive reproductive healthcare services.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) also addresses the right to discrimination in the context of abortion, though not as explicitly as the Maputo Protocol. Article 12 of CEDAW requires states to take all appropriate measures to eliminate discrimination against women in health care to ensure, based on equality of men and women, access to health care services, including those related to family planning.[116] Although CEDAW does not explicitly address abortion, we can interpret this provision on the right to discrimination to encompass access to comprehensive reproductive healthcare services, including safe abortion care, as a component of eliminating discrimination against women in the healthcare sector.

General Recommendation 24 of CEDAW further elaborates on this by stating that access to reproductive health services is essential to women's equality.[117] It emphasises that it is discriminatory for a State Party to refuse to provide legally for the performance of certain reproductive health services needed by women.[118] This recommendation underscores the importance of removing legal and practical barriers to accessing abortion services to ensure non-discrimination and equality in healthcare.

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[115] Protocol to the African Charter on Human and Peoples' Rights on Women's Rights in Africa (Maputo Protocol), OAU Doc. CAB/LEG/66.6 (2003), art. 2.
[116] CEDAW Committee General Recommendation 24: Art 12 of the Convention (Women and Health) 1999, A/54/38
[117] CEDAW (n 116)
[118] CEDAW (n 116)

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The African Charter on Human and Peoples' Rights reinforces the right to non-discrimination in Articles 2 and 3, asserting that every individual is entitled to the equal enjoyment of the rights and freedoms recognised in the charter without discrimination based on sex, among other factors, and that everyone is equal before the law and entitled to equal protection of the law.[119] General Comment 2 from the African Commission explicitly states that laws, policies, procedures, practices, and sociocultural attitudes that impede access to sexual and reproductive rights violate the right to non-discrimination.[120] 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 criminalisation of or failure to provide services required only by women, such as abortion and emergency contraception, constitutes impermissible sex-based discrimination.[121]

The Commission also applauded a decision by the High Court in Kenya that declared the withdrawal of guidelines promoting women's sexual and reproductive health unconstitutional, highlighting that such withdrawal was prejudicial to women and violated their rights to health, non-discrimination, and information.[122] The African Commission noted 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.[123] Ngwena argues that the Maputo Protocol's provisions on abortion offer a pathway to

[119] Protocol to the African Charter on Human and Peoples' Rights on Women's Rights in Africa (Maputo Protocol), OAU Doc. CAB/LEG/66.6 (2003), art. 2 and 3.
[120] African Commission on Human and Peoples' Rights (2014) para 27.
[121] 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.
[122] 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.
[123] African Commission on Human and People's Rights (n 122)

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achieving substantive equality for women by empowering them to exercise their right to sexual and reproductive autonomy.[124]

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 reserved for them, such as abortion and post-abortion care.[125] This paragraph builds on the call for decriminalisation and aligns with the international standards set by the United Nations Committee on the Elimination of Discrimination against Women (CEDAW). CEDAW regards the provision of reproductive health services as essential to women's equality and notes that it is discriminatory for a State Party to refuse to provide legally for the performance of certain reproductive health services for women.[126] Additionally, General Comment 2 explains that the right to health care without discrimination requires State parties to remove impediments to health services reserved for women, including ideology or belief-based barriers.[127]

This showcases the inextricable connection between sexual and reproductive rights and the right to equality and non-discrimination. Thus, a comprehensive rights-based approach to self-managed abortion in Nigeria must incorporate these principles to ensure that all women, particularly those from marginalised groups, have equitable access to safe and legal reproductive healthcare services.

2.3 Significance of applying human rights principles to Reproductive Healthcare practices.

The significance of applying human rights principles to reproductive healthcare, mainly focusing on self-determination, health, dignity, and non-discrimination, is crucial in the context of self-managed abortion in Nigeria. These principles provide a robust foundation for analysing the legal, social, and systemic factors influencing reproductive healthcare

[124] Ngwena C, 'Inscribing abortion as a human right: Significance of the protocol on the rights of women in Africa' (2010) 32 *Human Rights Quarterly* 783.
[125] African Commission on Human and Peoples' Rights (2014, see note 41), para. 32.
[126] 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)
[127] African Commission on Human and Peoples' Rights (2007, see note 34)

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practices and promoting equitable access to self-managed abortion and self-care services.

Applying human rights principles to reproductive healthcare practices is crucial to empower individuals to exercise their rights and access essential healthcare services. Grounding reproductive healthcare in human rights emphasises the importance of dignity, autonomy, and equality in decision-making processes related to reproductive choices. This approach not only safeguards individuals' rights but also promotes a healthcare system that is respectful, inclusive, and responsive to diverse needs and circumstances. In the area of self-managed abortion, a rights-based approach underscores the importance of respecting individuals' agency and autonomy in making decisions about their reproductive health. It advocates for policies and practices that prioritise the well-being and rights of individuals, ensuring that access to safe and comprehensive reproductive healthcare is a fundamental human right.

2.4 Concepts of Agency and Empowerment in Reproductive Health Choices:

The concept of agency refers to individuals' ability to choose and act based on their values, desires, and needs. In reproductive health, agency is the ability to decide about one's body and reproductive choices.[128] It encompasses the right to access information, services, and resources supporting informed reproductive health decision-making.[129] Conversely, empowerment enables individuals to exercise their agency and make decisions in their best interest.[130] Empowerment plays a crucial role in allowing individuals to make informed decisions about self-managed abortion.[131] It involves providing individuals with the knowledge, resources, and support they need to

[128] UNFPA Gender Strategy (2022-2025), United Nations Population Fund, https://www.unfpa.org/genderstrategy. accessed 14 May 2024

[129] A conceptual framework for reproductive empowerment - ICRW, https://www.icrw.org/wp-content/uploads/2018/10/Reproductive-Empowerment-Background-Paper_100318-FINAL.pdf , accessed 14 May 2024.

[130] ICRW (n 129)

[131] P McReynolds and R Julia, Abortion as empowerment: reproductive rights activism in a legally restricted context - BMC pregnancy and childbirth, BioMed Central, November 8, 2017, https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1498-y.

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understand the risks and benefits of self-managed abortion, as well as ensuring they have the confidence and autonomy to make their own choices.[132]

Agency and empowerment are crucial factors in reproductive health decision-making, particularly in Nigeria, where socio-cultural norms and legal restrictions can impact individuals' access to safe abortion services. According to Kabeer, agency refers to the ability to make decisions and act upon them, while empowerment involves having the resources and capacity to make informed choices.[133] In Nigeria, women's agency and empowerment are essential for navigating reproductive health decisions, including those related to abortion. Research has shown that women's empowerment significantly influences reproductive health outcomes in Nigeria.[134] Empowerment allows individuals to control their reproductive choices, access family planning services, and make informed decisions about their health. Women's internal motivations, such as their value on motherhood, also shape their reproductive choices, highlighting the importance of empowerment in decision-making. Measuring women's empowerment in reproductive health involves evaluating factors like reproductive decision-making agency and sexual and reproductive empowerment. These assessments aim to gauge the extent to which women have the autonomy and resources to make decisions regarding their reproductive health. Women's empowerment is crucial for enhancing reproductive health outcomes, well-being, and quality of life.

2.5 Conclusion:

In Nigeria, where legal restrictions on abortion exist, women's agency and empowerment are critical for accessing safe abortion services.[135] Gender inequality and cultural norms can restrict women's ability to make reproductive choices and access necessary healthcare services.[136] Empowering women to make informed decisions about their reproductive health can improve maternal and child health outcomes and contribute to

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[132] McReynolds and Julia (n 131)

[133] Reflections on the measurement of Women's empowerment, https://weehub.ku.ac.ke/wp-content/uploads/2021/06/Naila-Kabeer-Empowerment.pdf. Accessed 19 May 2024.

[134] C Meghan *et al,* 'The role of gender empowerment on reproductive health outcomes in urban Nigeria' (2014) 18 (1) *Maternal and Child Health Journal* 307–15, https://doi.org/10.1007/s10995-013-1266-1.

[135] B O Suzanne *et al,* 'Inequities in the incidence and safety of abortion in Nigeria' (2020) 5 (1) *BMJ Global Health*, https://doi.org/10.1136/bmjgh-2019-001814.

[136] Suzanne *et al* (135)

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overall well-being. During the COVID-19 pandemic, self-managed abortion practices became more common in Nigeria due to limited access to clinical care.[137] Women's agency in seeking alternative methods for reproductive healthcare, such as self-managed abortion, underscores the importance of empowerment in making choices that were previously unavailable. Empowering women with accurate information and resources for self-managed abortion can enhance their reproductive autonomy and decision-making.

[137] Suzanne *et al* (n 135)

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CHAPTER THREE

THE INTERNATIONAL AND REGIONAL STANDARDS AND GUIDELINES RELATED TO SELF-MANAGED ABORTION

3.1. Introduction

This chapter explores and presents the international and regional standards and guidelines related to self-managed abortion, drawing links to the rights-based approach that individuals have the fundamental right to self-determination, health, and access to safe and legal reproductive healthcare services. The discussion in this chapter of the study evaluates the principles and legislations around self-managed abortion from the perspectives of different legislations at the regional and international levels while also examining the barriers associated with self-managed abortion in Nigeria.

3.2. Overview of International Human Rights Obligations

Nigeria is bound to uphold and promote reproductive rights by the various international human rights treaties it has ratified, which aim to safeguard and promote these rights. Nigeria has committed to international human rights obligations such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[138] the International Covenant on Economic, Social, and Cultural Rights (ICESCR),[139] and the Maputo Protocol,[140] which emphasises protecting reproductive rights and advocating for the recognition of individuals' rights to make decisions about their bodies, including reproductive choices. The Convention on the Elimination of All Forms of Discrimination (CEDAW)[141] recognises the importance of eliminating discrimination against women in all areas of life, including healthcare. It calls for the eradication of discrimination against

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[138] OHCHR, https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf, accessed 19 May 2024.
[139] International Covenant on Economic, social, and cultural rights | OHCHR, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights, accessed 18 May 2024.
[140] Protocol to the African charter on human and - OHCHR, https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/ProtocolontheRightsofWomen.pdf, accessed 16 May 2024.
[141] OHCHR (n 138)

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women in all spheres, including healthcare, stressing the importance of access to family planning and pregnancy-related services while also emphasising the right of women to make decisions about their reproductive health and well-being without facing discrimination.[142]

In the context of self-managed abortion, CEDAW's principles align with the promotion of access to safe and legal abortion services, advocating for women's autonomy and agency in making informed decisions about their reproductive health. The Covenant on Economic, Social, and Cultural Rights (CESCR);[143] General Comment No. 14 on the right to the highest attainable standard of health, issued in 2000, provides a comprehensive understanding of this right. According to Paragraph 8, the right to health is not simply the right to be healthy but includes both freedoms and entitlements.[144] The freedoms entail the right to control one's health and body, including sexual and reproductive freedoms, and the right to be free from interference such as torture, non-consensual medical treatment, and experimentation. Conversely, the entitlements involve the right to a health protection system that offers equal opportunities for all to achieve the highest attainable standard of health. This emphasises the essence of the rights-based principle that individuals have the fundamental right to self-determination, health, and access to safe and legal reproductive healthcare services.

Paragraph 9 expands on this by explaining that the right to health must be understood as the right to access a variety of facilities, goods, services, and conditions necessary to achieve the highest attainable standard of health.[145] This inclusive interpretation encompasses timely and appropriate healthcare and extends to the underlying determinants of health, as detailed in Paragraph 11.[146] These determinants include access to safe and potable water, adequate sanitation, safe food, nutrition, housing, healthy occupational and environmental conditions, and health-related education and information, including sexual and reproductive health. Additionally, Paragraph 11 highlights the importance of the population's participation in all health-related decision-

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[142] OHCHR (n 138)
[143] Documents and publications | OHCHR, https://www.ohchr.org/en/instruments-and-mechanisms/human-rights-indicators/documents-and-publications, accessed 17 May 2024.
[144] OHCHR (n 139)
[145] OHCHR (n 139)
[146] OHCHR (n 139)

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making at community, national, and international levels, emphasising the need for inclusive and participatory approaches in health governance.[147] It underscores the importance of ensuring that individuals have access to comprehensive reproductive healthcare services, including safe and legal abortion care.

Also, the ICESCR's provisions on the right to health align with the principles of non-discrimination, equality, and access to healthcare services, which are essential in promoting reproductive rights and health equity. By advocating for the protection and promotion of reproductive rights within the framework of the right to health, the ICESCR contributes to advancing a rights-based approach to reproductive healthcare, including access to safe and legal abortion services.

Nigeria is a party to the Maputo Protocol, explicitly addressing women's reproductive rights. General comment 2 of article 14 of the protocol authorises medical abortion in cases of sexual assault, rape, incest, or when the continued pregnancy jeopardises the mother's health.[148] The Maputo Protocol is ground-breaking in recognising and expanding the scope of reproductive rights, including the right to safe abortion under certain circumstances. It also emphasises the right to health, including sexual and reproductive health, and calls for measures to ensure adequate, affordable, and accessible health services. Nigeria is a signatory to CEDAW, ICESCR, and the Maputo Protocol, all promoting access to comprehensive reproductive healthcare services and protecting women's rights. However, there has been limited translation of these international obligations into domestic law and policy.

3.3. International Human Rights Standards

Human rights criteria established at the international level lay the groundwork for legislative changes that will permit Self-Managed Abortion (SMA) to take place. For years, organisations concerned with human rights have been pushing for standards that address all aspects of SMA, including the right to reproductive health care (including

[147] OHCHR (n 139)

[148] 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' African Commission on Human and Peoples' Rights, https://achpr.au.int/index.php/en/node/854, accessed 18 May 2024.

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abortion) and the right to reap the benefits of scientific achievements.[149] To help state parties carry out their international responsibilities with the right to sexual and reproductive health, the Committee on Economic, Social and Cultural Rights approved General Comment 22 on the subject. Among other things, General Comment 22 emphasises that nations must take "appropriate legislative" steps to ensure that everyone's rights to sexual and reproductive health are fully realised.[150] It is acknowledged in this broad statement that access to abortion services is a component of the right to health, which in turn confirms the right to sexual and reproductive health. It points out that states should get rid of statutes, rules, and regulations that make it hard for people to get the healthcare they need, including abortion.[151]

In addition, states are obligated to consider gender when determining who is entitled to reap the benefits of scientific advancements, according to the recently approved General Comment 25 on science and economic, social, and cultural rights by the Committee on Economic, Social and Cultural Rights.[152] This perspective emphasises the need for governments to guarantee access to modern scientific technology, such as "medication for abortion," which is particularly pertinent to the right to sexual and reproductive health.[153] This overarching statement was preceded by the UN Special Rapporteur on cultural rights, stressing that "the rights to science and culture should both be understood as including a right to access and use information and communication and other technologies in self-determined and empowering ways.[154] Adherence to these international human rights norms lays the groundwork for an enabling environment for self-managed abortion, which encompasses the abolition of all abortion-related legal and regulatory hurdles, the provision of abortion-essential pharmaceuticals, and the dissemination of objective, evidence-based information. There is a definite trend towards

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[149] L B Pizzarossa, Abortion, health and gender stereotypes: A critical analysis of the Uruguayan and South African abortion laws through the lens of human rights (University of Groningen, 2019).
[150] Committee on Economic, Social and Cultural Rights, General Comment No. 22: Right to Sexual and Reproductive Health, UN Doc. E/C.12/GC/22 (2016).
[151] L B Pizzarossa *et al,* 'Toward human rights and evidence-based legal frameworks for (self-managed) abortion' (2021) 23 (1) *Health and Human Rights*, 199–212, www.ncbi.nlm.nih.gov/pmc/articles/PMC8233026/.
[152] Pizzarossa *et al* (n 151)
[153] Committee on Economic, Social and Cultural Rights, General Comment No. 25 on Science and Economic, Social and Cultural Rights, UN Doc. E/C.12/GC/25 (2020).
[154] Human Rights Council, report of the special rapporteur in the field of cultural rights, Farida Shaheed, UN Doc. A/HRC/20/26 (2012).

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using international standards to pressure nations to implement change, even if international bodies have limited authority over the punishments they can order and have work to be done to develop global standards better.[155]

3.4. Right to Self-Managed Abortion and the Right to Health in African Regions

A safe space for women to choose whether to have an abortion is fundamentally based on their right to health. To promote and safeguard human and people's rights, the African Commission was established, and the right to enjoy "the best attainable state of physical and mental health" is guaranteed in the African Charter on Human and Peoples' Rights (ACHPR).[156] Sexual and reproductive health and rights (SRHR), like all other health services, must be rendered obtainable, attainable, justified, and of good quality.[157] This means to make it generally acceptable and accessible. The African Commission's General Comment No. 2 (GC 2) suggests that this item encompasses mental and physical health. It goes on to say that the right to non-discrimination and equality, which are indivisible rights, must be defined by SRHR.[158] Furthermore, the Maputo Protocol, the first instrument to specifically safeguard women's SRHR, including the right to abortion, was adopted by the African Commission.[159] This protocol offers extensive guidance in this area. Most African governments have achieved ratification or accession to this treaty.[160] In cases when the woman's bodily or mental health is in danger, the life of the mother or the unborn child is in jeopardy, or if the pregnancy is the consequence of sexual assault, rape, or incest, the right to abortion is guaranteed in Article 14(2)(c) of the

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[155]Pizzarossa et al (n 151).
[156] L B Pizzarossa *et al*. 'Exploring the African regional human rights standards as the basis for an enabling environment for self-managed abortion' (2023) 30 (1) *Washington and Lee Journal of Civil Rights and Social Justice*, 1.
[157] African Charter on Human and Peoples' Rights, art. 16, June 27, 1981, 3269 U.N.T.S. 2363
[158] African Commission on Human & People's 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, Preface, (Nov. 28, 2014) [hereinafter General Comment No. 2] (highlighting the importance of protecting the women's sexual and reproductive rights).
[159] African Commission on Human and Peoples' Rights (ACHPR) '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' *African Commission on Human and Peoples' Rights*, 28 Nov. 2014, achpr.au.int/index.php/en/node/854.
[160] C Heyns & K Magnus, (2016) 6 *Compendium of key human rights documents of the African Union* 431–32.

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Protocol. This right encompasses both the woman's right to choose whether to have an abortion and the state's obligation to provide the necessary resources.

In addition to the right to health and reproductive rights, several other vital rights can be leveraged. The right to dignity and freedom from inhuman treatment, enshrined in Articles 3 and 5 of the ACHPR, is violated when women are denied access to safe abortion services, including SMA.[161] Forcing women to carry pregnancies to term or seek unsafe abortions due to restrictive laws subjects them to cruel, inhuman and degrading treatment that fails to respect their inherent dignity. The rights to non-discrimination and equality, protected under Article 2 of the ACHPR and Article 2 of the Maputo Protocol, are also highly relevant.[162] Restricting access to abortion, including SMA, disproportionately impacts women and perpetuates gender inequality. Denying women the ability to make decisions about their own bodies and reproductive lives is a form of discrimination that violates their right to be treated equally before the law. The right to life, guaranteed in Article 4 of the ACHPR, is another critical right that is undermined by unsafe abortion.[163] When women are unable to access safe abortion services, including SMA, they may resort to dangerous methods that put their lives at risk. Unsafe abortion is a leading cause of maternal mortality in Africa, and states must take measures to protect women's right to life. Finally, the right to health, including reproductive health, which is protected in Article 16 of the ACHPR and Article 14 of the Maputo Protocol, provides a solid basis for advocating for access to safe abortion, including SMA.[164][165] The African Commission's General Comment No. 2 clarifies that the right to health encompasses mental and physical health and must be interpreted considering the rights to non-discrimination and equality.[166]

Article 5 of the African Charter on Human and Peoples' Rights guarantees the right to human dignity and prohibits torture and other cruel, inhuman, or degrading treatment.[167] This right is non-derogable, meaning it cannot be suspended. The Committee for the

[161] L B Pizzarossa *et al* (n10)
[162] Pizzarossa (n 156)
[163] African Charter on Human and Peoples' Rights, art. 4
[164] The Protocol to the African Charter on Human and Peoples' Rights, art. 14
[165] African Charter on Human and Peoples' Rights, art. 16
[166] Pizzarossa *et al* (n 10)
[167] Pizzarossa *et al* (n 10)

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Prevention of Torture in Africa has recognised the link between abortion and torture, noting in its 2017 report that denying women their sexual and reproductive health rights, including access to abortion and post-abortion care, can amount to torture and violate Article 5 of the Charter.[168]

Similarly, the African Commission has called on some ACHPR states to re-evaluate their legislation regarding abortion access and safety.[169] To bring their abortion laws in line with regional and international norms and duties, the Commission has requested that Mauritius, the Federal Republic of Nigeria, Uganda, Malawi, and Kenya reform them.[170] Reproductive health services, including legal medical abortions, should be freely accessible to women, and the African Commission emphasised this point during its 41st Ordinary Session in 2007, calling on states to reduce maternal mortality and implement the Protocol.[171] State responsibility to prevent deaths and disease has been linked to unsafe abortion on multiple occasions by the African Commission. To minimise needless fatalities caused by unsafe abortion, authorities are implicitly obligated to take proactive steps, such as recognising SMA. African states need to adopt self-managed abortion to fulfil their responsibility to decrease rates of unsafe abortion and maternal mortality. This will ensure that everyone has access to the best possible health care, as SMA has already been linked to a decrease in abortion-related morbidity and mortality worldwide.[172] A critical step towards ending needless deaths caused by unsafe abortion methods is for states to recognise self-managed abortion (SMA).

To fulfil their responsibility to decrease maternal mortality and unsafe abortion rates, states must recognise SMA as a legal and safe option for people seeking to end pregnancies.[173] This will ensure that their populations can access the best possible

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[168] Pizzarossa *et al* (n 10)

[169] L Asuagbor, 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).

[170] Lawrence Mute, 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, African Commission on Human & People's Rights. (Nov. 1, 2017)

[171] Pizzarossa *et al* (n 156)

[172] K Manisha, *et al*. 'Now is the time: a call for increased access to contraception and safe abortion care during the COVID-19 Pandemic' (2020) 5 (7) *BMJ Global Health*, e00317.

[173] de Londras Fiona, *et al*. 'The impact of provider restrictions on abortion-related outcomes: A synthesis of legal and health evidence' (2022) 19 (1) *Reproductive Health*.

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health standards. The potential of health task-sharing and task-shifting approaches—which include redistributing health responsibilities within workforces and communities—must also be considered when interpreting these standards, particularly considering Africa's chronic lack of health workers.[174] The African Commission acknowledges in General Comment 2 that many African nations do not have access to enough medical professionals with the necessary training to perform safe abortions; instead, they recommend that obstetricians and other healthcare professionals receive such training.[175] In keeping with new human rights norms, this duty can encompass non-professional health care providers such as feminist networks and hotlines.[176] Unsafe abortion is a significant public health concern, and African states can take the initiative to solve it by adopting this new and simplified approach to abortion care. State responsibilities to safeguard and advance the health and welfare of its inhabitants are congruent with SMA's acknowledgement as a feasible and risk-free alternative.[177] It represents a determination to make sure that people can end pregnancies without having to risk their health or lives by using dangerous procedures.

3.5. WHO Guidelines on Safe Abortion

3.5.1. Overview of WHO's Recommendations on Self-Managed Abortion

The World Health Organization (WHO) provides authoritative guidance on health-related matters through its guidelines. While not legally binding on states, these guidelines serve as valuable and influential resources for shaping national health policies and practices, especially on SRHR/ safe abortion-related issues.

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[174] A Bankole *et al*. 'From unsafe to safe abortion in sub-Saharan Africa: Slow but steady progress' *Www.guttmacher.org*, Dec. 2020, https://doi.org/10.1363/2020.32446.
[175] O Aaron *et al*, Conceptual framework for task shifting and task sharing: An International Delphi study, (2021) 19 (1) *hum. res. for health*.
[176] G Claire, *et al,* Implementation Considerations When Expanding Health Worker Roles to Include Safe Abortion Care: A Five country case study synthesis*, (2017) 17 BMC pub. Health* 730, 737
[177] C M Roberts *et al*. 'Health care provider reporting practices related to self-managed abortion' *BMC Women's Health*, (2023) 23 (1), *BioMed Central*, https://doi.org/10.1186/s12905-023-02266-7 .

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For nearly 20 years, the World Health Organisation has offered advice on the topic of abortion.[178] In March 2022, the W.H.O. issued its Abortion Care Guideline (the guideline), which updated and replaced all prior recommendations based on the most recent research and data available on the clinical execution of services and legal and human rights components of abortion care. The evidence-based recommendations in the guideline are grounded in human rights and public health. As the guideline points out, induced abortions account for one-third of all pregnancies and six out of ten unwanted pregnancies in the world. The guide stresses that abortion is a medical procedure that can be safely performed with drugs or a minor outpatient operation.

Safe abortions can be achieved using either pharmaceutical or surgical procedures, provided that the technique is adapted to the gestational age of the pregnancy and that the person doing the surgery has the proper training and experience. Still, estimates put the percentage of safe abortions at a little over half (55%) globally.[179] For many women, access to safe abortion treatment is severely limited or non-existent due to factors such as a shortage of physicians and facilities, high fees, stigma, and legislative restrictions. As a result, they may resort to hazardous techniques to get an abortion. This guideline restates the long-standing belief that a woman's accessibility to safe abortion is greatly affected by the legal condition of abortion, regardless of whether she seeks an induced abortion. To help ensure that evidence-based abortion care is available, including pre-abortion, abortion, and post-abortion care, the guideline offers 54 specific evidence-based suggestions on best practices for national and subnational legislators, programme leaders, medical professionals, grassroots organisations, expert communities and other stakeholders in reproductive and sexual health and rights.[180]

The spectrum of areas pertinent to abortion care provision is addressed by the suggestions, which include policy and law, clinical services, and service delivery. As part

[178] C Gerdts *et al*. 'Beyond safety: The 2022 WHO abortion guidelines and the Future of abortion safety measurement' (2023) 7 (6) *BMJ Global Health*,) e009557, https://doi.org/10.1136/bmjgh-2022-009557 .
[179] Gerdts *et al* (n 178).
[180] PAHO/WHO. 'WHO issues new guidelines on abortion to help countries deliver lifesaving care - PAHO/WHO|Pan American Health Organization' *Www.paho.org*, 9 Mar. 2022, www.paho.org/en/news/9-3-2022-who-issues-new-guidelines-abortion-help-countries-deliver-lifesaving-care , accessed 17 May 2024.

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of an all-encompassing approach to abortion, this new guideline examines the underlying determinants of health. It places a far more significant emphasis on human rights than earlier WHO guidelines. This change demonstrates the WHO's significant acknowledgement that abortion is a matter of human rights and health. It is essential to address the heightened risks to sexual and reproductive health in humanitarian circumstances, especially during armed conflict. According to the guideline, an environment that is supportive of abortion care must have three main components: "(1) respect for human rights, including a supportive framework of law and policy; (2) the availability and accessibility of information; and (3) a supportive, universally accessible, affordable, and well-functioning health system."[181] As an example, it acknowledges that the standard approach to human rights-based health care is for all abortion-related norms, standards, and clinical practice to promote and protect the following: individuals' health and human rights; autonomy in decision-making; non-discrimination (including intersectional discrimination); confidentiality and privacy; appropriate referral mechanisms; and the continuum of care.

3.5.2. WHO's Recommendations on Medical Abortion, Self-Managed Abortion, Post-Abortion Contraception, and Telemedicine

The WHO has acknowledged medical abortion as a reliable and safe way to end a pregnancy for quite some time. A new guideline acknowledges the ground-breaking impact of medical abortion on women's access to safe and legal abortion services around the world. By suggesting that medical abortion be offered at the primary-care level, either as an outpatient procedure or through a pharmacy, it broadens the accessibility options. Abortion medication was included on its list of essential medicines, and human rights organisations have long held that states must guarantee that abortion medication is both accessible and available to all people.[182] Safe and successful self-administration of abortion medications outside of a facility (e.g., at home) is acknowledged in the guideline, recognising the fundamental importance of

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[181] Centre for Reproductive Rights, and WHO. 'WHO's New Abortion Guideline: Highlights of Its Law and Policy Recommendations' *Centre for Reproductive Rights*, 2022.
[182] Centre for Reproductive Rights and WHO (n 181)

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autonomy in abortion treatment and providing evidence to support it. It observes that there are several factors relating to personal circumstances and preferences that allow individuals to self-manage any or all abortion procedures. However, if the health system is not working, self-management should not be seen as a replacement.[183] It might be a powerful tool for enhancing healthcare delivery and fostering collaboration among healthcare providers.

Suppose a woman wants a medical abortion at less than 12 weeks. In that case, she can choose to handle any or all the following tasks on her own: figuring out how long her pregnancy is, assessing her eligibility, administering the medication outside of a healthcare facility without a trained health worker's supervision, managing the abortion itself, and finally, evaluating whether the abortion was successful.[184] Everyone who chooses to handle their medical abortion must have access to reliable resources, such as up-to-date information, high-quality drugs (including pain relievers), the encouragement of medical professionals, and, if necessary or wanted, a medical facility and referral services.[185] Women who want to use contraception after having an abortion should be able to quickly obtain and be connected to services that can help them do so. From a policy and legal standpoint, the WHO notes that women should have the option to self-manage their abortions and suggests that the current regulations governing the distribution of abortion drugs could need some tweaks or new safeguards to allow for self-management within the existing framework.[186]

There is also a mention that age and other non-clinical factors should not be used to criminalise or limit self-management. Also included are suggestions for self-management methods of post-abortion contraception, such as emergency methods and over-the-counter oral contraceptive pills.[187] A telemedicine recommendation to improve access to early medical abortion and self-care methods is included in the publication.

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[183] International campaign for women's right to safe abortion. 'World Health Organization issues new guidelines on safe abortion to help countries deliver life-saving care' *International Campaign for Women's Right to Safe Abortion*, 9 Mar. 2022, www.safeabortionwomensright.org/press-releases/world-health-organization-issues-new-guidelines-on-safe-abortion-to-help-countries-deliver-life-saving-care/ , accessed 17 May 2024.
[184] Gerdts et al (n 178).
[185] International campaign for women's right to safe abortion. (n 178)
[186] Gerdts et al (n 178).
[187] PAHO/WHO (n 180)

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More significantly, it suggests that medical abortion services, in whole or in part, can be provided by telemedicine rather than requiring patients to visit a healthcare provider physically. Notably, this recommendation encompasses the following areas: determining eligibility for medical abortion; counselling and instruction regarding the abortion process; delivering medication administration instructions and actively facilitating their administration; and post-abortion care follow-up via telemedicine.[188] It notes that the evidence for this suggestion did not include alternative forms of communication that only give information, such as hotlines, digital applications, or monologue forms of communication.

3.5.3. Safe and Acceptable Methods for Self-Managed Abortion

It appears that some pregnant women, transgender males, and others will attempt to self-abort outside of a medical facility as a solution to the growing shortage of abortion services available in clinics.[189] Herbs, teas, vitamins, pharmaceuticals, harmful substances, or self-harm are among the many ways people attempt to abort a pregnancy.[190] Online information sharing has led to an increase in the practice of self-managed medication abortion, in which a woman gets abortion pills from a pharmacy and uses them to terminate her pregnancy.[191] Aid Access was the first US-based online telemedicine organisation to provide a low-cost pharmaceutical abortion alternative for self-management in 2018.[192] To this day, no other telemedicine provider covers all 50 states like this one does. With the implementation of abortion restrictions at the state

[188] Centre for reproductive rights and WHO (n 181)
[189] G E Raymond *et al*. 'Efficacy of misoprostol alone for first-trimester medical abortion' (2019) 133 (1) *Obstetrics & Gynecology*, 137–47, https://doi.org/10.1097/aog.0000000000003017 .
[190] H von Hertzen *et al*. 'Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: A randomised controlled equivalence trial' (2007) 369 (9577), *The Lancet* 1938–46, https://doi.org/10.1016/s0140-6736(07)60914-3 .
[191] M Honor *et al*. 'Mifepristone and misoprostol for early pregnancy loss and medication abortion' (2021) 103 (8) *American Family Physician*, 473–80, www.aafp.org/pubs/afp/issues/2021/0415/p473.html , accessed 14 May 2024.
[192] J M Dana *et al*. 'Safety and effectiveness of self-managed abortion using misoprostol alone acquired from an online telemedicine service in the United States' (2023) 55 (1) *Perspectives on Sexual and Reproductive Health*, 4–11, https://doi.org/10.1363/psrh.12219 .

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level, Aid Access saw an increase in the number of requests for medication in their first two years of existence.

The World Health Organization (WHO) guidelines recommend self-management of medication abortion up to 12 weeks' gestation, using a combination of mifepristone plus misoprostol or using misoprostol alone.[193] Typically, Aid Access provides medications such as mifepristone and misoprostol. Still, due to challenges shipping mifepristone internationally during the COVID-19 pandemic, the service temporarily adjusted its model to give prescriptions for the medication abortion regimen using misoprostol alone.[194] Misoprostol alone used for self-managed abortion has been studied throughout the world, and recent research has found that self-managed abortion with accompaniment group support and for gestations below nine weeks is no inferior to the effectiveness of medication abortion managed and administered in a clinical setting.[195] In a study in Argentina and Nigeria, of the 593 participants who self-managed their abortion using misoprostol alone, 99% had a successful abortion without instrumentation intervention.[196] Community-based distribution models have yielded high rates of effectiveness as well.[197]

In a study of 918 women living along the Thailand-Burma border, 96% were not pregnant 1month after taking the medication. In a survey of 120 women in Pakistan, none were pregnant after a 4-week follow-up period.[198] In Lagos State, Nigeria, a study of 394 women who acquired misoprostol from drug sellers and completed two follow-up interviews reported that 95% had a complete abortion without instrumentation intervention after a 4-week follow-up period. In Bangladesh, in a study of pharmacy-distributed medication abortion pills, 75% of the subsample of 20 women who had acquired only misoprostol

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[193] Dana *et al* (n 192)
[194] J T Ruvani *et al*, 'Misoprostol in the era of COVID-19: A love letter to the original medical abortion pill' (2020) 28 (1) *Sexual and Reproductive Health Matters*, 1829406, https://doi.org/10.1080/26410397.2020.1829406 .
[195] Ruvani *et al* (n 194)
[196] Dana et al (n 192)
[197] R G Elizabeth *et al*. 'Efficacy of misoprostol alone for first-trimester medical abortion' (2019) 133 (1) *Obstetrics & Gynecology*, 137–47, https://doi.org/10.1097/aog.0000000000003017 .
[198] F M Angel *et al*. 'Community-based distribution of misoprostol for early abortion: evaluation of a program along the Thailand–Burma border' (2017) 96 (4) *Contraception*, 242–47, https://doi.org/10.1016/j.contraception.2017.06.006.

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reported they were not pregnant after a 15-day follow-up period.[199] Models of self-managed abortion have emerged as an expression of reproductive autonomy and self-determination, as well as a necessary response to the lack of abortion access. Misoprostol's straightforward use, low cost, and availability in pharmacies make it particularly well-suited for assisted self-managed abortion.[200]

Despite the progressive stance of these international treaties, Nigeria's legal framework on abortion remains highly restrictive. These laws create significant barriers to accessing safe and legal abortion services, forcing many women to resort to clandestine and unsafe procedures, which often result in severe health complications and even death. The societal norms and cultural stigmas surrounding abortion further exacerbate the challenges faced by women seeking reproductive healthcare services. The lack of comprehensive sexuality education and family planning programs perpetuates misconceptions and misinformation about abortion, contributing to unsafe practices and reproductive health disparities. In this context, Nigeria's international commitments to reproductive rights stand in stark contrast to the restrictive legal environment and pervasive societal attitudes towards abortion. The misalignment between international obligations and domestic laws underscores the urgent need for legal reforms and policy interventions to ensure that women have access to safe and legal abortion services in line with their reproductive rights.

3.6 Barriers to self-managed abortion access in Nigeria:

Examining the obstacles to self-managed abortion in Nigeria is essential for decriminalising the procedure and removing any remaining hurdles to access. Those who choose to self-abort or who aid another person in doing so run the danger of facing arrest, harassment by law enforcement, prosecution, and jail time under the current national

[199] Dana et al (n 192)
[200] A Aiken *et al*. 'Factors associated with use of an online telemedicine service to access self-managed medical abortion in the US' (2021) 4 (5) *JAMA Network Open*, e2111852, https://doi.org/10.1001/jamanetworkopen.2021.11852 .

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legislation[201]. Criminalising abortion, even if it does not lead to a conviction, can still have adverse effects, such as limiting access to information and lifesaving medications and discouraging healthcare practitioners from providing innovative abortion treatment.[202]

The adverse effects of criminalisation and obstacles to abortion access have been extensively studied and proven. Discrimination against and prohibition of abortion put women's bodily and emotional health at risk while limiting their freedom of choice. The fact that they subject them to different types of brutality and oppression is on top of the unfairness of not allowing them to live with respect and equality among other humans.[203] As a result of criminalisation, medical professionals may be hesitant to carry out abortions unless necessary, even under the limited circumstances allowed by some countries' legal exemptions. Even in legitimate abortion situations, medical professionals may refuse to perform the procedure out of fear of criminal prosecution, and evidence is that prohibition does not stop or even affect people's decisions to get an abortion, but it facilitates unsafe practices.[204]

3.6.1 Socio-Cultural Barriers-

3.6.1.1 Influence of Religion and Cultural Beliefs on Abortion Access

Religious and cultural factors must be considered in any discussion on sexual and reproductive rights and health. Sexuality, marriage, gender, having children, and the connection between parents and children are all profoundly impacted by religious teachings.[205] Furthermore, religious morality is the foundation upon which secular ideas

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[201] African Commission on Human and Peoples' Rights (ACHPR), '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.' *African Commission on Human and Peoples' Rights*, 28 Nov. 2014, achpr.au.int/index.php/en/node/854.
[202] A Bankole *et al* 'From unsafe to safe abortion in Sub-Saharan Africa: Slow but steady progress' www.guttmacher.org, Dec. 2020, https://doi.org/10.1363/2020.32446.
[203] A Sorhaindo and S Gilda, 'Scoping review of research on self-managed medication abortion in low-income and middle-income countries, (2021) 6 (5) *BMJ Global Health*, e004763, https://doi.org/10.1136/bmjgh-2020-004763.
[204] H Moseson *et al*, 'It just seemed like a perfect storm': A multi-methods feasibility study on abortion-seeking experiences from people who considered but did not obtain abortion care in the United States' *PLOS ONE*, edited by Godwin Otuodichinma Akaba, (2022) 17 (3), e0264748, https://doi.org/10.1371/journal.pone.0264748
[205] O A Ayanleye, 'Women and reproductive health rights in Nigeria' *OIDA International Journal of Sustainable Development*, 2013, staff.oouagoiwoye.edu.ng/uploads/359_COURSES_Women_and_Reproductive_Health_Rights_in_Nigeria__11444.

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of rights and justice rest. Religion influences societal norms and personal beliefs and can even affect official policies. The religious views of public officials, lawmakers, and executives, as well as the role of religion in the political process, impact public policy.[206] Religion affects every level of society, from the federal government to rural towns. Several culturally acceptable practices violate the reproductive health rights of women.[207] As an example, despite official efforts to outlaw it, female genital mutilation persists due to the practice's entrenched cultural roots. Female genital mutilation sufferers would prefer the agony to the stigma and shame of society's rejection.[208] The abortion debate has been one of the most contentious in recent memory, pitting religious views against those of reproductive health advocates.[209] Legal, social, political, and religious discussions have surrounded abortions in nearly every region of the world. Furthermore, many Nigerians' attitudes towards healthcare concerns are impacted by their traditional beliefs, which have serious repercussions. For many Nigerians, conventional medical care is out of the question since they attribute illness and injury to supernatural forces such as witches or evil spirits. Instead, they seek out alternative remedies from herbalists or spiritual homes.[210]

3.6.1.2 Societal Attitudes and Stigma Surrounding Abortion

Research indicates that the stigma surrounding abortion is more prevalent among young women who are not married.[211] While specifics varied by country, research suggested that a woman's marital status and age upon seeking an abortion could amplify judgement

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[206] O Gbadamosi and T O Aderibigbe, 'Justification of women's right of access to safe and legal abortion in Nigeria' (2014) 7 (2) *The African Journal of Legal Studies*, 177–202.
[207] C P Okorie and A A Olubusola, 'Annual survey of international & comparative law annual survey of international & comparative law volume 23 Issue 1 Article 7 2019 Reform' (2019) 23 (1) *Annual Survey of International & Comparative Law*.
[208] Ayanleye (n 205).
[209] L O Omo-Aghoja *et al*, 'The story of abortion: Issues, controversies and a case for the review of the Nigerian national abortion laws' (2010) 7 (4) East *African Journal of Public Health*, 323–30, https://doi.org/10.4314/eajph.v7i4.64772.
[210] L Akhirome-Omonfuegbe, 'A critical appraisal of women's reproductive rights in Nigeria' (2020) 10 (2) *Journal of sustainable development law and policy (The)*, 257, https://doi.org/10.4314/jsdlp.v10i2.6.
[211] J Abongile *et a*l, 'Stigma towards women requesting abortion and association with health facility staff facilitation and obstruction of abortion care in South Africa' (2023) 4, *Frontiers in global women's health*, (2023) 4, https://doi.org/10.3389/fgwh.2023.1142638.

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or lead to diminished service quality in most African nations, in particular Nigeria.[212] Being unmarried was deemed as the more significant element impacting stigma in regions where women are married by the age of 25.[213] This is in line with a different study conducted in India that indicated that young women who are not married often experience fear of exposure. Not only are they more prone to prioritise confidentiality when selecting an abortion facility, but they also face more obstacles to receiving timely care.[214] Studies conducted in Kenya, on the other hand, indicated that women frequently cited their youth, rather than their marital status, as a possible justification for judging them and that younger women specifically highlighted concealing their abortion from their parents.[215]

Exploring the experiences of "compound stigma" among younger and unmarried women seeking care requires taking context into account, as the distinct emphasis noticed by women in different nations seems to align with social norms in each country.[216] Teenage pregnancy and sexuality are taboo topics for unmarried women, giving more room to the spread of abortion stigma.[217] Probably, younger women's lack of access to reliable information regarding abortion contributes to their heightened concerns about the safety of the procedure.[218] This could be because young individuals who seek abortions face compound stigma, which discourages them from seeking help and often causes them to keep the abortion a secret.[219] The findings reveal that developing youth-friendly services and contextually relevant policies can increase access to sexual and reproductive health

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[212] S Makleff *et al,* 'Exploring stigma and social norms in women's abortion experiences and their expectations of care' (2019) 27 (3) *Sexual and reproductive health matters*, 50–64, https://doi.org/10.1080/26410397.2019.1661753.
[213] Gbadamosi and Aderigbe (n 206)
[214] A Akinyemi *et al*. 'Quality of information offered to women by drug sellers providing medical abortion in Nigeria: evidence from providers and their clients' (2022) 3, *Frontiers in Global Women's Health*, https://doi.org/10.3389/fgwh.2022.899662.
[215] Makleff *et al* (n 212)
[216] R J Adebimpe, 'Liberalisation of Nigeria's abortion laws with a focus on pregnancies resulting from rape: An empirical analysis' (2021) 21 (1) *African human rights law journal*, (2021) 21 (1), https://doi.org/10.17159/1996-2096/2021/v21n1a20 . accessed 5 October 2021.
[217] Makleff (n 212)
[218] A M Sorhaindo and F L Antonella, 'Why does abortion stigma matter? A scoping review and hybrid analysis of qualitative evidence Illustrating the role of stigma in the quality of abortion care' (2022) 311 *Social science & medicine*, 115271, https://doi.org/10.1016/j.socscimed.2022.115271.
[219] O W Akande *et al*, 'Unsafe abortion practices and the law in Nigeria: Time for change' (2020) 28 (1) *Sexual and reproductive health matters*, 1758445, https://doi.org/10.1080/26410397.2020.1758445.

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services; clinics in countries might use this strategy.[220] A method to educate younger and unmarried women on their rights to abortion care and how to get it could be to implement comprehensive sexuality education, which has been shown to enlighten young people about sexual health services and improve care-seeking behaviour in diverse circumstances.[221]

3.6.2 Legal and Policy Barriers

Several laws violate women's right to reproductive health care, in addition to cultural forms of discrimination. For example, the Nigeria Police Regulation specifies the requirements that a female candidate must meet to be considered for the position of recruit Constable in the Nigerian Police Force.[222] Subsection (g) requires that the lady not be married. Therefore, women who are married cannot enlist. However, the male equivalent is not covered by any such rule. Unmarried female police officers who become pregnant are to be removed from duty and not allowed to re-enlist without the Inspector General of Police's consent, as stated in Section 127 of the rule. If a female police officer wants to tie the knot, she must notify the state command's commissioner of her intention to marry, along with the prospective groom's name, address, and job. The woman must have served for at least three years, and the prospective husband must be seen to have a good reputation for permission to be given. Any comparable provision does not cover the male equivalent.

Another big obstacle to promoting and protecting reproductive rights is the lack of explicit legislation on the subject. The clause in section 17 of the Nigerian Constitution cannot be enforced because it cannot be brought before a court.[223] The current laws contain provisions at odds with the National Health Policy and Strategy, 1988, even though it could be pertinent. The current legal framework is inadequate to provide the groundwork for the protection and enforcement of reproductive rights for women.[224] It lacks detail and is riddled with delimiting clauses. The importance of a well-established

[220] Gbadamosi and Aderigbe (n 206)
[221] Omo-Aghoja (n 209)
[222] S A Fagbemi, 'Abortion law in Nigeria: A comparative analysis' (2020) 5 *African journal of criminal law and jurisprudence*, journals.ezenwaohaetorc.org/index.php/AFJCLJ/article/view/1028.
[223] Ayanleye (n 205)
[224] Ayanleye (n 205)

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institutional framework for the advancement and execution of fundamental rights should not be understated.

3.6.3 Healthcare System Barriers:

Healthcare system barriers significantly hinder access to safe self-managed abortion (SMA) in Nigeria.[225] A significant challenge is the lack of accessible, reliable information on SMA methods and the proper use of misoprostol and mifepristone.[226] Provider reluctance, driven by fear of legal repercussions and stigma, further exacerbates the issue, leaving many women without critical guidance or post-abortion care (PAC).[227] Access to these essential medications is limited, especially in rural areas, due to regulatory restrictions, poor distribution, and high costs.[228] Inadequate healthcare infrastructure and a shortage of trained personnel also limit the capacity to support SMA, with many providers lacking the training to offer safe advice or services.[229][230] Economic barriers, particularly for young girls, rural women, and homemakers, further restrict access to both SMA medications and necessary healthcare services.[231] These systemic barriers, coupled with stigma and criminalisation, make it difficult for women to manage their abortions safely, highlighting the urgent need for a human rights-based approach that ensures access to affordable care, accurate information, and non-discriminatory support.[232]

Nigeria's infrastructure, facility, and capacity-building issues are foundational to the accessibility challenge. In many countries where access to legal abortion services is limited, unsafe abortions occur alongside these challenges. While most nations with

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[225] Pizzarossa *et al* (n 10)
[226] Jayaweera R *et al,* 'The potential of self-managed abortion to expand abortion access in humanitarian contexts' (2021) *Front. glob. womens health* 2:681039.
[227] Oni, T O *et al,* 'Perceived health facility-related barriers and post-abortion care-seeking intention among women of reproductive age in Osun state, Nigeria' (2023) 23 (311) *BMC Women's Health*.
[228] Jayaweera *et al* (n 226)
[229] Muga W *et al,* 'Barriers to post-abortion care service provision: a cross-sectional analysis in Burkina Faso, Kenya and Nigeria' (2024) 4 (3) *PLOS glob public health*.
[230] Loi U R *et al*, (2015). Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and southeast Asia: a systematic literature review of qualitative and quantitative data. (2015) 15 (1) *BMC Public Health*.
[231] Jayaweera *et al* (n 226)
[232] Pizzzarossa *et al* (n 10)

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long-standing legalised abortion have incorporated abortion services into their health infrastructure, those in the process of moving from more stringent to less restrictive abortion legislation must invest in the necessary infrastructure and training.[233]

3.6.4 Economic Barriers:

Economic barriers play a significant role in restricting access to self-managed abortion (SMA) in Nigeria, impacting women and girls' ability to afford and utilise safe abortion options.[234] One of the most pressing issues is the high cost of abortion pills, such as misoprostol and mifepristone, which are difficult to obtain due to the restrictive legal environment.[235] Women, especially those from low-income households, face inflated prices from private or underground providers, as the lack of regulated, affordable access forces many to turn to informal networks.[236] This financial burden is further compounded by the absence of health insurance coverage for abortion services, as public health insurance schemes in Nigeria do not typically cover abortion or related healthcare services.[237] Women are often left to bear the total cost of not only the pills but also any necessary post-abortion care, which can be prohibitively expensive for those with limited financial means.

Homemakers and non-working women often rely on their partners for financial support, which can limit their ability to make autonomous decisions about their reproductive health, including accessing funds for abortion services.[238] Even if the direct costs of abortion services are covered, there are often hidden costs such as transportation, childcare, and time off from household responsibilities, which can be significant barriers for non-working women.

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[233] Akande *et al* (n 219)
[234] Byrne M E *et al,* 'Determinants of women's preferred and actual abortion provision locations in Nigeria, (2023) 18 (240) *Reprod Health*.
[235] Bell S O *et al*, 'Inequities in the incidence and safety of abortion in Nigeria' (2020) 5 (1) *BMJ Global Health* e001814.
[236] Bell *et al* (n 235)
[237] Katz A J *et al*, 'I just have to hope that this abortion should go well: Perceptions, fears, and experiences of abortion clients in Nigeria' (2022) 17 (2) *PLoS* e0263072.
[238] Anjur-Dietrich *et al,* 'Partner involvement in abortion trajectories and subsequent abortion safety in Nigeria and Côte d'Ivoire' (2022) 22 (1) *BMC Women's Health*.

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The socioeconomic inequality and widespread poverty in Nigeria intensify these challenges. Poor women, particularly in rural or marginalised areas, often cannot afford to travel to urban centres where abortion services or medications may be more accessible.[239] This geographic and financial inaccessibility leads many to delay care or resort to unsafe alternatives, significantly increasing their health risks. In many cases, economic dependence on male partners or family members exacerbates the problem, as women without financial autonomy may be unable to secure the resources for SMA or face opposition from those who control household finances.[240]

Nigeria's restrictive legal framework adds another layer of economic pressure, as the criminalisation of abortion limits the availability of affordable and safe options, forcing women to rely on clandestine services that are often more expensive. The overall economic impact of these barriers highlights the urgent need for legal reform, affordable healthcare, and greater financial independence for women. Addressing these economic obstacles is essential to making SMA accessible and safe for all women, particularly those from economically disadvantaged backgrounds.

3.7. Conclusion

In this chapter, we saw how the criminalisation of abortion undermines people's right to self-determination, health, and access to legal reproductive healthcare and how this, in turn, undermines a rights-based approach to self-managed abortion. According to the World Health Organization and other international standards, based on the right-based principle, everyone has the inherent right to choose how they live, be healthy, and have access to legal reproductive healthcare. These human rights considerations formed the basis of this recommendation: Services related to sexual and reproductive health (SRH) must be regulated with an emphasis on accessibility, quality, timeliness, and acceptability. It is unacceptable to criminalise seeking, having, or giving an abortion when the pregnant individual has given their free and informed permission. The reporting of abortions or suspected abortions by health care providers must not be mandatory in

[239] Byrne *et al* (n 234)
[240] Anjur-Dietrich *et al* (n 238)

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any state. Access to safe, legal post-abortion care should never be in question. The pursuit or dissemination of impartial, factually sound information regarding abortion should never be made a crime. Reducing maternal morbidity and mortality and protecting women and girls from the psychological and physiological hazards of unsafe abortion requires states to act, including changing laws. Everyone has the right to receive SRH services in an inclusive and non-discriminatory manner. Ensuring privacy and confidentiality is of the utmost importance when providing SRH services.

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CHAPTER FOUR

THE LEGAL AND POLICY LANDSCAPE CONCERNING REPRODUCTIVE RIGHTS AND ACCESS TO ABORTION IN NIGERIA

4.1. Introduction

This chapter analyses the legal and policy landscapes concerning reproductive rights and access to abortion in Nigeria. It reviews laws, policies, and regulations governing abortion care, including the legal and policy framework on access to medicines for self-managed abortion in Nigeria.

4.2. Historical Context of Abortion Laws in Nigeria

4.2.1. Historical background of abortion laws in Nigeria

As far back as Nigerian women can remember, they have been having abortions. To intentionally end an undesired pregnancy, Indigenous Nigerian women would use native medicines and methods.[241] This means abortion practices did not come from the West. However, abortion restrictions, on the other hand, have their roots in colonial law. Most nations that Europe colonised imposed stringent legal regulations both during and after the era of colonisation.[242] It was in the 12th century when the Roman Catholic Church's Code of Canon Law first condemned abortion.[243] The Church had already proclaimed abortion to be a sin punishable by ex-communication by the late 19th century, regardless of when the pregnancy began.[244]

The moral, cultural, and religious aspects of Nigerian society still play a role in the country's unchanging abortion legislation. The pregnant woman loses control of her body and her right to choose when an abortion is necessary; instead, the decision is made by

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[241] T O Aderibigbe, 'My womb is tired: a socio-legal perception of the reproductive autonomy of women in south-west Nigeria with a focus on abortion' (Ph.D. Thesis, Kent Law School, University of Kent, Canterbury, 2006), 187.
[242] IPAS, the evidence speaks for itself: ten facts about abortion, available online at http://www.ipas.org/~/media/Files/Ipas%20Publications/TENFACE10.ashx, accessed 14 July 2012.
[243] C Francome, 'United Kingdom', in: P. Sachdev (ed.), *International handbook on abortion* (Greenwood Press, New York, NY, 1988), pp. 458–459.
[244] Gbadamosi and Aderigbe (n 206)
[244] Gbadamosi and Aderigbe (n 206)

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the doctor based on whether the woman's life is in danger.[245] Even though abortions carried out on women without their consent are illegal and constitute feticide, medical doctors are not required to get a woman's consent before performing an abortion, even if the procedure is necessary to save her life.[246] This is an apparent case of a fundamental human rights issue, and the legislation is lacking. If a pregnant minor daughter desires an abortion in Nigeria, the standard procedure is to get her parents' permission, particularly the father's. This goes against the ruling in the English case of *R (Axon) v Secretary of State for Health*, where the high court in London acknowledged the inherent right of a 16-year-old girl to obtain an abortion even without her parent's permission.[247]

Another point to consider is that, as the European Court of Justice ruled in the case of *Paton v. United Kingdom*, certain governments respect a woman's autonomy and do not demand the foetus' father's agreement before an abortion.[248] However, it is standard procedure in Nigeria for doctors to notify the person claiming paternity when an abortion is urgently needed.[249] Unlike in other jurisdictions, Nigeria does not allow abortion in circumstances of rape or incest, if the foetus has developmental delays, is at risk of being born with a disability, if the mother's physical or mental health is in danger, or if socioeconomic factors are to be considered.[250] In Nigeria, women's constitutionally protected rights to equality and human dignity are undermined by several problems.[251] These issues are becoming more pressing because women who cannot afford safe abortions often seek out hazardous abortion providers or try to do the procedure on their own.

[245] Gbadamosi and Aderigbe (n 206)
[246] Gbadamosi and Aderigbe (n 206)
[247] The Guardian, 'Mother loses abortion 'right to Know' case,' January 23, 2006, https://www.theguardian.com/society/2006/jan/23/childrensservices.uknews, accessed 27 June 2024.
[248] P v United Kingdom (1980) 3 EHRR 408
[249] Gbadamosi and Aderigbe (n 206)
[250] Gbadamosi and Aderigbe (n 206)
[251] Akande *et al* (n 219)

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4.2.2. Evolution of Legal and Policy Frameworks Concerning Reproductive Rights

By passing the Irish Chalking Act in 1803, the United Kingdom became the first nation to outlaw abortion throughout the whole gestational period.[252] Life in prison without the possibility of parole was the penalty for lawbreakers. The criminalisation of abortion in England and other Commonwealth countries, including Nigeria, began with this law, which in turn served as a foundation for the 1861 Offences against the Persons Act.[253] For the first time in 1959, Nigeria passed a law outlawing abortion – a Penal Code Law and a Criminal Procedure Code Law. In Nigeria, most Muslim northern states account for approximately half of the country's population, and the Penal Code governs abortion rights.[254] Most people practice Christianity in the southern states, which comprise half of the population, and the Criminal Code is in effect there.[255] Though the exact language varies slightly between the two statutes, they both expressly forbid abortion unless the mother's life is in imminent danger.

The scope of this provision was broadened in 1938 when a British landmark court case called *Rex v Bourne*—also known as The King v Aleck Bourne or the Bourne Judgment—happened about an abortion that obstetric surgeon Aleck Bourne had done on a girl who was fourteen years old and had become pregnant after being raped.[256]. A judge guided the jury to consider the possibility that abortion could save a mother's life in some instances. The ruling that Bourne was not guilty of carrying out the surgery unlawfully established a precedent for other abortion cases that followed and the Abortion Act 1967 (UK).

[252] Francome (n 243)
[253] R Cook and B Dickens, Abortion laws in Commonwealth countries (Geneva: WHO, 1979).
[254] Laws of the federal republic of Nigeria, no. 18 of 1959.
[255] As above (n 254)
[256] Bourne, Aleck. *'Rex V. Bourne'* (1938) 232 (5996) *The Lancet*, 280, https://doi.org/10.1016/s0140-6736(00)98287-4.

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4.3. Current Legal Framework Governing Abortion

4.3.1. Examination of Current Abortion Laws in Nigeria

In Nigeria, the procedure of having an abortion is essentially outlawed by both the criminal and penal code. Like the criminal codes of Pakistan and India, the Penal Code states that a woman may lawfully have an abortion if the procedure is necessary to preserve her life.[257] Except in this case, a person can face a fine and fourteen years in prison for intentionally causing a pregnant woman to miscarry.[258] There is the same punishment for a lady who intentionally causes her miscarriage.[259] If the woman passes away due to the miscarriage, a severe punishment is imposed on the physician who carried out the abortion. A woman may lawfully have an abortion if the risk to her life is too significant, according to the Criminal Code Act, which is based on the 1861 Offences against the Person Act in England.[260] A person who performs a surgical operation on an unborn child in good faith and with reasonable care and skill to preserve the mother's life is not criminally responsible under Section 297 of the Act, provided that the operation is reasonable considering the patient's condition at the time and all the relevant circumstances.[261]

Additionally, it is explicitly forbidden to procure an abortion according to section 228 of the Criminal Code Act.[262] This section states that anyone who unlawfully administers or causes a woman to take poison or another toxic substance, uses force of any kind, or employs any other means whatsoever with the intent to procure a miscarriage, regardless of whether the woman is pregnant or not, is guilty of a felony and faces a seven-year

[257] S A Fagbemi, 'Abortion law in Nigeria: a comparative analysis' (2020) 5 (0) *African journal of criminal law and jurisprudence*, journals.ezenwaohaetorc.org/index.php/AFJCLJ/article/view/1028.
[258] C P Okorie and A O Abayomi, 'Annual survey of international & comparative law annual survey of international & comparative law volume 23 Issue 1 Article 7 2019 Reform' (2019) 23 (1) *Annual survey of international & comparative law*, digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1215&context=annlsurvey.
[259] Gbadamosi and Aderigbe (n 206)
[260] Akande *et al* (n 219)
[261] C C Chigbu *et al,* 'Impact of abortion laws on women 's choice of abortion service providers and facilities in south-eastern Nigeria, (2018) 21 *Niger J Clin Pract* 1144-20:1114.
[262] Fagbemi (n 257)

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prison sentence.[263] A woman faces seven years in prison if she does or consents to the same act regarding herself. A person is also susceptible to three years in jail under this provision if they knowingly offer something with the intent to cause a miscarriage illicitly.[264] Based on the information provided, it may be concluded that if the mother's life is being saved, abortion is sanctioned and permitted under the Criminal and Penal Code Acts.

The restrictive nature of Nigerian abortion laws limits women's ability to make autonomous decisions about their reproductive health. The severe legal penalties for abortion-related activities impede self-determination and highlight a disconnect between the human rights principles and the legal framework.

4.3.2. Criminal Code (applicable in southern Nigeria)

The Criminal Code in southern Nigeria, much like the Penal Code in the north, imposes stringent prohibitions on abortion. Under Section 228, anyone who attempts to procure a miscarriage, whether the woman is pregnant, commits a felony and is liable to fourteen years of imprisonment. The law states: "Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, is guilty of a felony and is liable to imprisonment for fourteen years."[265] According to this regulation, all individuals, including healthcare providers, are subject to a 14-year prison sentence for attempting to end a pregnancy through any method, regardless of whether the lady is officially pregnant or not.

Section 229 of the Criminal Code criminalises a woman's attempt to induce her miscarriage. The provision states: "Any woman who, with intent to procure her miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony, and is liable to imprisonment for seven years."[266]

[263] Okorie and Abayomi (n 258)
[264] Akande *et al* (n 219)
[265] Okorie and Abayomi (n 258)
[266] Okorie and Abayomi (n 258)

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Any method by which a pregnant woman attempts to end her pregnancy is illegal under this article and carries a maximum sentence of seven years in jail. It makes no difference if the woman is or isn't pregnant. So, theoretically, it would be a crime under this clause if, for instance, a woman suspected of being pregnant (maybe because she has not had her period in a while) drank salt water to induce a miscarriage, even if it ends up that she was never pregnant.

Section 230 penalises anyone who supplies or procures drugs or instruments to induce an abortion. According to the provision: “Any person who unlawfully supplies to or procures for any person anything whatever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a felony, and is liable to imprisonment for three years.”[267]

Anyone who knowingly provides or procures anything with the intent to procure an abortion, regardless of the woman's pregnancy status, has committed an offence under the clause. Consequently, the provision may make an errand boy or a local pharmacy guilty of a crime if he sells medications to a pregnant lady or mixes salt water, knowing the intended usage.

4.3.3. Penal Code (applicable in northern Nigeria)

In northern Nigeria, the Penal Code sets stringent limits on access to abortion, in line with conservative legal traditions. Under Section 232 of the Penal Code, abortion is generally prohibited, with the only exception being that it is performed in good faith to save the life of the pregnant woman. The provision reads: “Whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage is not caused in good faith to save the life of the woman, be punished with imprisonment for a term which may extend to fourteen years or with fine or with both.”

The only circumstances in which an induced abortion could be lawful are when the woman's life is in imminent danger, and this provision states as much. This provision likewise covers a woman who intentionally had a miscarriage. This provision merges the criminal offence of inducing a miscarriage with the good faith defence sought to save the

[267] Okorie and Abayomi (n 258)

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life of the mother, as outlined in section 297 of the criminal code. In contrast to the criminal code, however, the procedure for obtaining a legal abortion is not as perplexing here.

Section 233 of the Penal Code further addresses instances where a woman dies because of an abortion. It specifies that "Whoever with the intent of causing the miscarriage of a woman, whether with a child or not, does any act which causes the death of such woman, shall be punished- a. with imprisonment for a term which may extend to fourteen years and shall also be liable to fine; and b. if the act is done without the consent of the woman, with imprisonment for life, or any less term and shall also be liable to fine."[268]

In contrast to the Criminal Code, which can classify the death of an abortion victim as either manslaughter or murder,[269] - this clause establishes a distinct crime for intentionally causing a woman's miscarriage fatality. Given the circumstances, permission cannot be used as an excuse. Nevertheless, consent is outlined in the Penal Code as a mitigating aspect.

Section 234 criminalises the use of force to induce miscarriage, regardless of whether the miscarriage was intended or not. The provision reads: "Whoever uses force to any woman and thereby unintentionally causes her to miscarry shall be punished a. with imprisonment for a term which may extend to three years or with fine or with both; and b. If the offender knew that the woman was with a child, he shall be imprisoned for a term which may extend to five years or with a fine or both."

If someone uses force on a pregnant woman and accidentally causes her to miscarry, it is now a crime according to this law. The miscarriage doesn't need to have been intentional, for the force to have been unlawful, or for the defendant to have known that the lady was pregnant. Thus, it appears that this constitutes a strict liability offence.

The Penal Code and Criminal Code in Nigeria severely restrict access to safe abortion services, undermining the right to health. The policy framework's failure to adequately support safe abortion practices highlights a significant gap between human rights principles and the existing legal and policy environment. These restrictive laws and harsh

[268] Okorie and Abayomi (n 258)
[269] Criminal Code Act (1916) sec. 316, 319.

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penalties contribute to stigma and create barriers that compromise women's dignity and access to safe abortion services. Consequently, the impact on women's health and dignity is evident in the high rates of unsafe abortions.

4.4. Policy Framework on Reproductive Rights and Abortion in Nigeria

4.4.1. National Reproductive Health Policy

There are a variety of Nigerian health policies that address issues of reproductive wellness. National Health Policy and Strategy 1988–1998 is at the top of the list,[270] but was later updated in 2004 with a new National Health Policy based on the lessons learned from the country's previous health policies, including the Revised National Health Policy 2004 and the National Strategic Health Development Plan (2010-2015). If the National Health Policy's many provisions had been strictly enforced, more people from all walks of life would have had more access to reproductive health care and other essential health services. Unfortunately, the present degree of access does not seem to align with this policy. Adhering to primary health care as the cornerstone of health development in Nigeria, the Nigerian health policy establishes the parameters within the country's reproductive health policy.[271] The policy also acknowledges that primary health care should be the setting in which reproductive health is implemented.[272] One of the goals of the Nigerian policy statement on reproductive health is to ensure that all people can make informed decisions about their reproductive health without fear of violence or coercion, using all relevant information and adhering to acceptable ethical standards.[273] Another goal is to create a legal environment supporting reproductive rights by revoking and amending laws contradicting reproductive rights principles and passing suitable legislation.[274] The acknowledgement that primary health care should be the setting in

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[270] R J Adebimpe, 'Liberalisation of Nigeria's abortion laws with a focus on pregnancies resulting from rape: an empirical analysis' (2021) 21 (1) African *human rights law journal*, https://doi.org/10.17159/1996-2096/2021/v21n1a20.
[271] C O Aimakhu et al, 'Attitudes towards abortion law reforms in Nigeria and factors influencing its social acceptance among female undergraduates in a Nigerian university' (2014) 43 (4) *African journal of medicine and medical sciences*, 327–32.
[272] Akande *et al* (n 219)
[273] L A Omonfuegbe, 'A critical appraisal of women's reproductive rights in Nigeria' (2020) 10 (2) *Journal of sustainable development law and policy (the)* 257, https://doi.org/10.4314/jsdlp.v10i2.6.
[274] Adebimpe (n 270)

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which reproductive health is implemented and ascertaining that all people can make informed decisions about their reproductive health without fear of violence or coercion, using all relevant information and adhering to acceptable ethical standards is support for women having the right to make decisions on abortion without coercion.

In addition, there is a policy in place to support efforts to end harmful practices like female genital mutilation and other types of gender-based violence, such as sexual violence and rape. This will be achieved through increased efforts to educate the public and involve healthcare providers in recognising and managing these problems.[275] Additionally, the public will have access to HIV/AIDS prevention and treatment based on scientific evidence, and they will be protected from unproven claims.[276] There is a policy in place to ensure that everyone has access to high-quality, all-encompassing reproductive health care; health facilities are being redesigned to include reproductive health as an integral part of primary care by increasing and improving community outreach; and there are systems in place to review and update relevant medical, nursing, and health technology school curricula and training manuals to include reproductive health principles, guidelines, and methodologies.[277]

While Nigeria does have policies and legislation in place to safeguard reproductive health, the disparity between the two is apparent.[278] The ability to enforce one's rights is distinct from simply being aware of them. Awareness of one's rights is complex in this setting since people don't know how to demand them. Intellectuals in the last several decades have pushed for gender-specific legislation. Obstacles on this path stem mainly from society's failure to grasp the need to safeguard reproductive rights. Considering the above, the necessity of legislative reform to enable safe, legal abortions to combat the epidemic of unsafe abortions is extremely under-discussed. This is true even though Nigeria appears to be ratifying most regional and international treaties that aim to protect

[275] O Ayanleye, 'Women and reproductive health rights in Nigeria' SSRN, January 20, 2014, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2381324, accessed 26 June 2024.
[276] Adebimpe (n 270)
[277] Aimakhu *et al* (n 271)
[278] F R Adegbite, 'Rethinking abortion laws in Nigeria: The trauma of rape victims of boko haram' (2021) 21 (2) *African Human Rights Law Journal*, 1–22.

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women's reproductive health and urge nations to abolish some of the sanctions associated with abortion.[279]

4.4.2. National Guidelines on Safe Termination of Pregnancy for Legal Indications 2018

For safe termination of pregnancy, the guidelines recommend the use of mifepristone combined with misoprostol before 12 weeks of gestation, as this combination tends to be more effective than using misoprostol alone.[280] Although a minimum gestational age for medical abortion is not specified, the guidelines acknowledge that home administration of a medical abortion within the first 12 weeks can be as safe and effective as procedures carried out in a healthcare facility. It also offers greater comfort and privacy for women.

The recommended dosage involves taking 200 mg of mifepristone orally, followed 24-48 hours later by 800 micrograms of misoprostol, which can be administered vaginally, buccally, or sublingually. If the pregnancy is not terminated after four hours, an additional dose of 400 micrograms of misoprostol may be administered through the same route.[281] The guidelines emphasise the importance of having additional doses accessible if home administration is chosen. It should also be noted that after nine weeks of pregnancy, a dose of 800 micrograms of misoprostol starts to lose effectiveness, making follow-up doses even more critical.[282]

In cases where mifepristone is unavailable, 800 micrograms of misoprostol should be used, administered either vaginally, buccally, or sublingually. Following this, 400 micrograms of misoprostol should be given every three hours until the uterus is fully evacuated.

For pregnancies beyond 12 weeks, the procedure typically requires a hospital setting. The combination of mifepristone and misoprostol, where available, is still recommended to

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[279] Gbadamosi and Aderibigbe (n 206)
[280] National guideline for safe termination of pregnancy, Federal Ministry of Health, 2018.
[281] National guideline for safe termination of pregnancy (n 280)
[282] National guideline for safe termination of pregnancy (n 280)

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reduce the time needed for the abortion to take effect and to minimise the chances of ongoing pregnancy and side effects.[283] The optimal approach includes 200 mg of mifepristone orally, followed two hours later by 800 micrograms of misoprostol administered either vaginally, buccally, or sublingually, and subsequent doses of 400 micrograms every three hours until the abortion is complete. When mifepristone is unavailable, the regimen relies on repeated doses of 800 micrograms of misoprostol, followed by 400 micrograms every three hours until completion.

Additionally, for women with uterine scars or pregnancies beyond 24 weeks, the guidelines recommend using reduced doses of misoprostol and increasing the interval between doses, as the sensitivity of the uterus to the drug increases in the later stages of pregnancy.[284]

4.5. The Legal Landscapes Concerning Access to Medicines for Self-Managed Abortion in Nigeria

The criminalisation of abortion contributes to a climate of fear and secrecy, exacerbating the risks associated with self-managed abortion and perpetuating human rights violations. Under the Criminal Code, Sections 228 to 230 criminalise abortion, imposing severe penalties.[285] The Criminal Code punishes abortion service providers with up to fourteen years of imprisonment and sentences women who procure abortions to seven years.[286] Additionally, anyone who unlawfully assists in procuring an abortion is liable to three years' imprisonment. Sections 232 to 236 of the Penal Code mirror these stringent provisions, imposing similar penalties, including a fourteen-year imprisonment term for abortion providers in the event of the woman's death.[287] The Penal Code also classifies any act causing the quick death of an unborn child as culpable homicide, punishable by life imprisonment, among other penalties.[288]

[283] National guideline for safe termination of pregnancy (n 280)
[284] National guideline for safe termination of pregnancy (n 280)
[285] Sec 228, 229, 230 Criminal Code Act
[286] Criminal Code Act 2004
[287] Sec 232 to 236 Penal Code Act
[288] Penal Code Act 1990

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Due to these restrictive laws, women frequently undergo unsafe abortions, risking severe physical and mental health complications.[289] Studies show that Nigeria performs approximately six hundred thousand illegal abortions annually, leading to up to twenty thousand maternal deaths due to complications from unsafe procedures.[290][291] Between 21% and 49% of women who undergo such procedures require post-abortion care due to complications such as incomplete abortion, sepsis, bleeding, and intra-abdominal injury.[292] Long-term health problems may include chronic pelvic pain, pelvic inflammatory disease, tubal blockage, and secondary infertility.[293] According to the World Health Organization, restrictive abortion laws are associated with higher rates of unsafe abortion and correspondingly high maternal mortality.[294]

4.5.1 Policy Frameworks

The policy framework surrounding reproductive health in Nigeria plays a pivotal role in shaping access to abortion care and reproductive services, including self-managed abortion. Nigeria's reproductive health policies are instrumental in determining the availability, accessibility, and quality of reproductive healthcare services. Also, the availability and regulation of medication abortion drugs, such as misoprostol, through formal and informal drug sellers in Nigeria highlight the role of policy in facilitating access to safe abortion care.

Reproductive health policies: Nigeria has implemented several policies aimed at enhancing reproductive healthcare, yet their effectiveness in improving reproductive health and access to abortion services remains limited due to the restrictive legal environment surrounding abortion. One of the key policy frameworks is the National

[289] S Makinwa-Adebusoye and A W Audam (n 189), 'Africa: Saving Nigerians from risky abortions' BBC News 7 April 2008, http://news.bbc.co.uk/2/hi/africa/7328830.stm, accessed 23 June 2020.
[290] Centre for reproductive law and policy report on reproductive rights: Moving Forward (2002) 27.
[291] Population council 1991 report on prevention of morbidity and mortality for unsafe abortions in Nigeria.
[292] World Health Organization Abortion: A tabulation of available information (1997) 24 (2) 3rd ed. *Geneva in Care for postabortion complications: Saving women's lives population reports*, September 1997 in World Health Organization address unsafe abortion 7 April 1998 World Health Day 1.
[293] Care for post-abortion complications: saving women's lives population reports, (1997) 24 (2) in World Health Organization.
[294] World Health Organization (n 293)

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Reproductive Health Policy,[295] Which focuses on enhancing reproductive health services, including family planning and maternal health, and preventing sexually transmitted infections. However, this policy does not explicitly address safe abortion services due to legal constraints, thereby limiting its impact on abortion access.[296]

The National Health Act of 2014 is a significant law that aims to regulate and develop the national health system.[297] While it establishes a framework for providing comprehensive health services, including reproductive health, it does not offer specific guidance on abortion services. This omission reflects the legal barriers to abortion access within Nigeria, hindering the implementation of comprehensive reproductive healthcare services.

In Nigeria, the availability and regulation of medication abortion drugs, such as misoprostol, through both formal and informal drug sellers underscore the critical role of policy in facilitating access to safe abortion care—policies governing the distribution and use of these medications are intricately linked to the dynamics of self-managed abortion practices.[298] Efforts to increase awareness about the availability of medication abortion drugs can contribute to safer self-managed abortion practices and help reduce the toll of unsafe abortion-related morbidity and mortality.[299]

The regulatory framework surrounding these medications has a significant impact on self-managed abortion practices and plays a crucial role in shaping access to safe abortion care. However, Nigeria lacks comprehensive policies that specifically address the distribution and use of medication and abortion drugs. Formal healthcare facilities often face legal restrictions and cultural barriers that limit the provision of abortion

[295] National Reproductive Health Policy of 2001.
[296] Gbadamosi and Aderibigbe (n 206)
[297] National health act 2014
[298] Y A Adojutelegan *et al*, 'Drug sellers' knowledge and practices, and client perspectives after an intervention to improve the quality of safe abortion care outside of formal clinics in Nigeria' BMJ sexual & reproductive health, January 2022, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8685617/ , accessed 20 June 2024.
[299] Guttmacher Institute, 'Women's experiences with self-managed misoprostol abortions in Lagos state, Nigeria' August 24, 2022, https://www.guttmacher.org/fact-sheet/womens-experiences-with-misoprostol-abortions-nigeria, accessed 22 June 2024.

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services, including medication abortion.[300] As a result, many individuals turn to informal drug sellers, pharmacies, and online sources to obtain these drugs, bypassing formal healthcare channels.[301] While misoprostol is legally available for postpartum haemorrhage treatment and termination of pregnancy within the clinical setting, for cases that fall under the law, its use for abortion purposes outside the clinical setting remains contentious due to restrictive regulations.[302]

4.5.2. Status of medications used for Self-Managed Abortion in Nigeria

The use of tablets to terminate a pregnancy or medication abortion, is a practice that is becoming more accessible globally due to its safety and effectiveness.[303] According to the World Health Organisation (WHO), pharmaceutical abortions should be performed using a combination of mifepristone and misoprostol or with misoprostol alone in situations when mifepristone is unavailable.[304] When a woman's life is in imminent danger, an abortion can be lawfully performed in Nigeria. Nevertheless, 1.25 million abortions occur each year, according to 2012 research.[305] Newer estimates put the yearly abortion rate in Nigeria at 1.8 million, or 41.1 per 1000 women of childbearing age; when respondents' closest confidantes' experiences are considered, the figure rises to 2.7 million.[306] Among the leading causes of maternal illness and death in Nigeria, which ranks among the world's highest, is unsafe abortion. Despite the low cost of care, public hospitals in Nigeria do not provide easy access to safe abortion procedures due to the country's stringent abortion laws.[307] As an alternative, many go to other sources for medical attention, such as buying drugs from street vendors.

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[300] U Menakaya *et al*. 'Experience with misoprostol in the management of missed abortion in the second trimester' (2005) 25 (6) *Journal of Obstetrics and Gynaecology*, 583–585. https://doi.org/10.1080/01443610500239354
[301] Adojutelegan *et al* (n 298)
[302] Menakaya *et al* (n 300)
[303] Adojutelegan *et al* (n 298)
[304] M Stillman *et al*, 'Women's self-reported experiences using misoprostol obtained from drug sellers: a prospective cohort study in Lagos state, Nigeria' (2020) 10 (5) *BMJ Open* e034670, https://doi.org/10.1136/bmjopen-2019-034670.
[305] Stillman *et al* (n 283).
[306] A Akinyemi *et al*. 'Quality of information offered to women by drug sellers providing medical abortion in Nigeria: evidence from providers and their clients' (2022) 3 *Frontiers in global women's health*, https://doi.org/10.3389/fgwh.2022.899662.
[307] L O Omo-Aghoja *et al*. 'The story of abortion: Issues, controversies and a case for the review of the Nigerian national abortion laws' (2010) 7 (4) *East African Journal of public health* 323–30, https://doi.org/10.4314/eajph.v7i4.64772.

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Although little is known about their involvement in abortion care, patent and proprietary medication vendors (PPMVs) in Nigeria play a significant role in providing essential healthcare services, including reproductive health.[308] Those who sell conventional medicinal products in retail for profit are known as PPMVs, and they do not have a degree in pharmacy.[309] While not mandatory, many PMVs have medical backgrounds and often work out of retail locations.[310] In 2006, misoprostol was registered and made lawful in Nigeria for the treatment of postpartum haemorrhage.[311] In 2006, researchers in Nigeria discovered that misoprostol was not readily available or extensively known at pharmacies and drug stores in Abuja and Lagos.[312] Research conducted more than ten years later indicates that misoprostol is increasingly being available in drug stores and is being used for abortions at a higher rate.[313] PPMVs were authorised to carry misoprostol 2014 under the national task-shifting recommendations to treat postpartum haemorrhage.[314] Among the several abortion options available in Nigeria, mifepristone has been on the market since its 2017 registration.[315]

The legal framework disproportionately impacts minors and women in vulnerable situations, underscoring a lack of equitable access to reproductive healthcare. Restrictive laws exacerbate inequalities and discrimination, hindering women's empowerment by limiting access to safe abortion methods and medications. The absence of supportive policies restricts women's ability to exercise their agency and access safe abortion options.

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[308] Stillman *et al* (n 304).
[309] L M Prach *et al*, 'Care-seeking at patent and proprietary medicine vendors in Nigeria' (2015) 15 (1*) BMC Health services research*, https://doi.org/10.1186/s12913-015-0895-z.
[310] K Footman *et al*, 'Medical abortion provision by pharmacies and drug sellers in low- and middle-income countries: A systematic review' (2018) 49 (1) *Studies in family planning*, 57–70.
[311] N Beyeler *et Al*, 'A systematic review of the role of proprietary and patent medicine vendors in healthcare provision in Nigeria' (2015) 10 (1) *PLOS ONE*, edited by Ulla Kou Griffiths, e0117165, https://doi.org/10.1371/journal.pone.0117165.
[312] Akinyemi *et al* (n 306).
[313] Adojutelegan *et al* (n 298).
[314] F A Bello *et al*, 'Trends in misoprostol use and abortion complications: A cross-sectional study from nine referral hospitals in Nigeria' (2018) 13 (12) *PLOS ONE*, edited by Clement A Adebamowo, e0209415, https://doi.org/10.1371/journal.pone.0209415.
[315] Akinyemi *et al* (n 298).

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4.6. Conclusion.

The legal and policy landscape in Nigeria presents significant barriers to accessing safe abortion care, primarily due to restrictive laws and inconsistent enforcement. These legal frameworks, steeped in colonial-era legislation and influenced by moral and cultural norms, contribute to a high incidence of unsafe abortions and related health risks. The prevailing legal environment, characterised by severe penalties and limited allowances for abortion, exacerbates these challenges.

Considering the human rights-based approach to self-managed abortion, it is evident that the current legal and policy frameworks fall short of upholding essential human rights principles, such as self-determination, health, dignity, and non-discrimination. The restrictive nature of Nigeria's abortion laws undermines the right to self-determination by denying individuals the autonomy to make informed choices about their reproductive health. The lack of access to safe abortion services contravenes the right to health, as outlined in the Maputo Protocol and other international human rights instruments.

Moreover, the existing legal and policy structures fail to respect the dignity of individuals seeking abortions, often leading to stigmatisation and unsafe practices. The principle of non-discrimination is also compromised, as the restrictive laws disproportionately affect marginalised groups, including those from lower socioeconomic backgrounds.

By looking into the nuances of reproductive health policies and the regulation of medication abortion drugs, policymakers and stakeholders can identify opportunities to enhance access to safe and legal abortion services, address barriers to reproductive healthcare, and promote comprehensive reproductive rights in Nigeria. This thorough examination of the policy landscape is vital for advancing reproductive health equity, ensuring the well-being and autonomy of individuals seeking abortion care, and fostering a rights-based approach to self-managed abortion in the country.

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CHAPTER FIVE

COMPARATIVE LESSONS ON ABORTION LAWS AND IMPLEMENTATION FROM OTHER JURISDICTION.

5.1 Introduction

This chapter explores how lessons from Kenya can inform the ongoing discourse on SMA, emphasising the need for decriminalisation and removing barriers to access. By examining this jurisdiction's legal frameworks and policy reforms, we can draw valuable insights for Nigeria, particularly in the context of a rights-based approach to reproductive health.

5.2 Kenya's Legal and Policy Framework on Self-Managed Abortion (SMA)

Kenya's legal and policy framework on self-managed abortion (SMA) represents a significant area of focus within the broader context of reproductive rights in Africa. The country has undergone notable developments regarding abortion laws, particularly considering the increasing recognition of women's rights and the need for safe, accessible reproductive healthcare. This discussion will explore the legal landscape surrounding SMA in Kenya. It will examine the relevant laws, policies, and judicial interpretations that shape the current framework and evaluate how they align with the human rights principles of self-determination, health, dignity, and non-discrimination.

5.2.1 Legal Framework

5.2.1.1 The Constitution of Kenya 2010:

Abortion in Kenya is primarily governed by the Constitution adopted in 2010, the Penal Code, and various health policies. Under Article 26(4) of the Kenyan Constitution, abortion is permitted when the life or health of the mother needs to be protected or if the pregnancy results from rape or defilement, as determined by the opinion of a trained

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health professional.[316] This provision aligns with the Maputo Protocol, emphasising women's health and reproductive autonomy rights.[317] However, the criminalisation of abortion under the Penal Code- articles 158- 160, 228 and 240, poses significant challenges to the realisation of these rights, as it creates a legal environment that discourages safe and self-managed abortion practices.[318]

Kenya's progressive Constitution has been pivotal in shaping the country's approach to reproductive rights. It enshrines fundamental human rights, including health, dignity, and non-discrimination. Article 43 of the Constitution guarantees the right to the highest attainable standard of health and has been instrumental in advocating for safer reproductive health services, including abortion.[319]

5.2.1.2 The Reproductive Health Care Bill (2019):

The Reproductive Health Care Bill (2019), a significant legislative advancement, aims to expand and protect reproductive health services, including abortion.[320] The bill seeks to align Kenya's legal framework with international human rights standards by clarifying conditions under which abortion is permitted and ensuring comprehensive reproductive health services.

5.2.1.3 Judicial Interpretations:

Kenya has witnessed progressive judicial interpretations that have expanded the understanding of reproductive rights. In the landmark case *PAK and Salim Mohammed v. Attorney General et al.*, the High Court of Kenya affirmed that abortion care is a constitutional right. The court ruled that forcing a woman to carry an unwanted pregnancy to term or to seek unsafe abortion services violates her rights to privacy and bodily autonomy.[321] This decision emphasised that arbitrary arrests and prosecutions of women seeking abortion services, especially when their health is at risk, are illegal under the Kenyan Constitution.[322] Additionally, the Kenyan judiciary recognised the right to

[316] Constitution of Kenya, 2010, art 26(4)
[317] Protocol to the African Charter on Human and People's Rights.
[318] Penal Code, Law of Kenya, Cap 63, revised edition 2009 (2008), art 158 – 160, 228, 240.
[319] Constitution of Kenya, 2010, art 43.
[320] Reproductive Healthcare Bill, 2019.
[321] *PAK and Salim Mohammed v. Attorney General et al,* 2022
[322] *PAK and Salim Mohammed v. Attorney General et al* (n 322)

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privacy and dignity as fundamental to exercising reproductive rights.[323] Courts have affirmed that women should not face criminal prosecution for seeking abortion services, mainly when their health is at risk.[324] These judicial decisions reflect a growing acknowledgement of the need to protect women's autonomy and to ensure that they can make informed choices regarding their reproductive health.

5.2.2 Policy Developments:

In response to the evolving legal landscape, Kenya has implemented several policies aimed at improving access to reproductive health services, including self-managed abortion.

5. 2.2.1 The National Reproductive Health Policy:

The National Reproductive Health Policy emphasises the importance of providing safe and legal abortion services, aligning with international standards and human rights commitments.[325]

5.2.2.2 The National Guideline for Self-Care in Reproductive Health:

Approved by the Ministry in January 2023, it further underscores the commitment to expanding access to reproductive health services, including abortion care, by empowering various healthcare providers to participate in delivering essential services.[326] This guideline promotes task-sharing approaches, allowing trained healthcare providers, including nurses and midwives, to offer abortion services within the legal framework.

5.3 Self-Managed Abortion in Practice in Kenya

In Kenya, self-managed abortion involves the use of approved medications, primarily misoprostol and mifepristone, which can be obtained from pharmacies with a

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[323] Centre for Reproductive Rights, 'Kenyan high court affirms the right to abortion under the constitution and directs parliament to enact reforms' June 7, 2022, https://reproductiverights.org/malindi-kenya-court-affirms-abortion-right-pak/, accessed 31 July 2024.
[324] Centre for Reproductive Rights (n 323)
[325] Ministry of Health, National Reproductive Health Policy 2022 - 2032, Government of Kenya, July 2022.
[326] Ministry of Health, National Guideline to self-care in reproductive health, Government of Kenya, 2023.

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prescription.[327] Women often rely on community networks for information and support.[328] Despite the legal restrictions, the availability of these medications and the involvement of healthcare providers in recognising the need for abortion have made it possible for women to manage abortions more safely.[329][330] In Kenya, both misoprostol and mifepristone, essential medications for medical abortion, are approved and included in Kenya's essential medication list.[331] This approval ensures that women have access to safe and effective abortion medications. This practice aligns with the World Health Organisation's recommendations, which advocate for self-managed abortion as a safe and effective option within the first trimester of pregnancy.[332]

5.4 Alignment with Human Rights Principles

Kenya's reproductive rights framework integrates vital human rights principles, notably self-determination, health, dignity, and non-discrimination, grounded in a rights-based theoretical approach. The High Court's ruling in *PAK and Salim Mohammed v. Attorney General et al*. emphasises the state's duty to provide comprehensive reproductive health services, including safe abortion care, thus supporting individuals' right to self-determination.[333] This legal perspective aligns with constitutional provisions and regional human rights standards, advocating for the decriminalisation of self-managed abortion (SMA) and affirming the right of individuals to make informed reproductive choices.

The legal framework, including Article 26(4) of the Kenyan Constitution, permits abortion when necessary to protect the life or health of the mother, underscoring the right to

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[327] Ouma O J *et al,* 'Pathways to medical abortion self-use (MASU): results from a cross-sectional survey of women's experiences in Kenya and Uganda' (2023) 23 (412) *BMC Women's Health*.
[328] Ouma *et al* (n 327)
[329] 'Understanding the cost of abortion pills in Kenya, 2022' https://medshun.com/article/how-much-are-abortion-pills-in-kenya?formCode=MG0AV3 accessed 9 October 2024
[330] Centre for reproductive rights, https://reproductiverights.org/self-managed-abortion/kenya/?formCode=MG0AV3 accessed 9 October 2024
[331] Centre for reproductive rights (n 330)
[332] PAHO/WHO. 'WHO issues new guidelines on abortion to help countries deliver lifesaving care - PAHO/WHO|Pan American Health Organization' *Www.paho.org*, 9 Mar. 2022, www.paho.org/en/news/9-3-2022-who-issues-new-guidelines-abortion-help-countries-deliver-lifesaving-care , accessed 17 May 2024.
[333] *PAK and Salim Mohammed v. Attorney General et al* (n 322)

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health.[334] This right is further supported by the National Reproductive Health Policy, which promotes safe and legal abortion services in compliance with international standards.[335] The availability of safe abortion medications and comprehensive post-abortion care within Kenya's healthcare system addresses both medical and psychological aspects of reproductive health, ensuring the overall well-being of individuals seeking SMA.

Moreover, the Kenyan judiciary has acknowledged the right to privacy and dignity, affirming that women should not face criminal prosecution for seeking abortion services, mainly when their health is at risk. This recognition reinforces the principle of dignity, ensuring that abortion care is provided respectfully and without stigma. The Reproductive Health Care Bill and National Guideline for self-care in reproductive care further emphasise non-discrimination, aiming to eliminate barriers to accessing reproductive health services and ensuring equitable care for all individuals, regardless of socio-economic status or background.[336][337] This comprehensive approach reflects Kenya's commitment to upholding human rights principles and creating a supportive environment for reproductive autonomy and health.

5.5. Barriers to Access

Despite the advancements in Kenya's legal and policy framework, significant barriers remain that hinder equitable access to self-managed abortion (SMA) services. One major challenge is the stigma surrounding abortion, which, coupled with fear of legal repercussions, often deters healthcare providers from offering these services even in legally permissible cases. This stigma is compounded by cultural resistance and negative societal attitudes towards abortion, discouraging individuals from seeking the care they need and impacting the implementation of supportive policies.

[334] Constitution of Kenya (n 316)
[335] National Reproductive Health Policy (n 325)
[336] Reproductive healthcare bill (n 320).
[337] National guideline for self-care in reproductive health (n 326)

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5.6 Lessons Learned and Best Practices: Adapting Kenya's Strategies to Improve Nigeria's Framework for Self-Managed Abortion

Legal framework and medication approval: Kenya has approved the use of misoprostol and mifepristone for medical abortions, and these medications are included in the Kenya Essential Medicines List.[338] This approval is crucial as it ensures that women have access to safe and effective medicines for self-managed abortions. The medications can be obtained from level 2 healthcare facilities, such as dispensaries and clinics run by nurses or clinical officers. Nigeria could benefit from a similar approach by approving and making these medications widely available, streamlining procurement processes, and addressing regulatory challenges to facilitate access.

Healthcare Provider Involvement: While the law requires healthcare provider involvement to recognise the need for an abortion, the availability of approved medications facilitates safer self-managed abortions.[339] Healthcare providers play a critical role in ensuring that women receive the correct information and support needed for self-managed abortions. Nigeria could adopt policies that allow trained healthcare providers to support self-managed abortions, ensuring safety and reducing complications.

Judicial Support: In a landmark ruling, the High Court of Kenya in Malindi in *PAK and Salim Mohammed v. Attorney General et al,* affirmed that abortion care is a fundamental right under the Constitution[340]. This ruling protects women and healthcare providers from arbitrary arrests and prosecution, reinforcing the legal framework that supports safe abortion practices.

Community Support and Information: Studies in Kenya have shown that friends and family are crucial sources of information about medical abortion.[341] This community-based support system can be vital in disseminating accurate information and reducing

[338] Centre for reproductive rights (n330)
[339] Centre for reproductive rights (n 330)
[340] *PAK and Salim Mohammed v. Attorney General et al* (n 322)
[341] Ouma *et al* (n 327)

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stigma. Nigeria could enhance community education and support networks to empower women with the knowledge needed for safe, self-managed abortions.

Guided Self-Administration: Although individuals can self-manage their abortions, Kenya's healthcare system is gradually incorporating task-sharing where trained healthcare providers, including nurses and midwives, support women by providing accurate information on how to administer these drugs safely.[342] The task-sharing model ensures that even with minimal medical involvement, individuals can receive guidance on dosage and timing.

Integrated Support Systems: Kenya's success in integrating support systems, including training healthcare providers, providing counselling services, and offering post-abortion care, highlights the importance of a comprehensive support network.[343] Nigeria should develop a similar infrastructure to support individuals throughout the process, addressing medical and emotional needs.

5.7 CONCLUSION:

In recent years, Kenya has made significant strides in reforming its legal and policy framework to address better reproductive health needs, including self-managed abortion (SMA). These changes reflect a growing recognition of the importance of human rights principles in shaping reproductive health policies and ensuring equitable access to safe abortion services.

Kenya's legal and policy framework on self-managed abortion reflects both progress and ongoing challenges in the pursuit of reproductive rights. While the constitutional provisions and judicial interpretations provide a foundation for expanding access to safe abortion services, significant barriers remain due to stigma, fear of prosecution, and restrictive laws. By drawing on the lessons learnt from Kenya's evolving legal landscape, other African nations, like Nigeria, can better understand the importance of

[342] Ouma *et al* (n 327)
[343] Ouma *et al* (n 327)

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decriminalising self-managed abortion and ensuring that individuals have the autonomy and support necessary to make informed decisions about their reproductive health.

In conclusion, Kenya's experience with self-managed abortion provides valuable insights and strategies that Nigeria can adopt to enhance its legal and policy framework. By adopting clear legal guidelines, integrating support systems, improving medication availability, and addressing stigma, Nigeria can improve access to safe, self-managed abortion services and uphold the fundamental rights of individuals seeking reproductive health care.

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CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Brief Summary:

The purpose of this study is to advocate for the adoption of a rights-based approach to self-managed abortion in Nigeria. It posits that recognising and implementing this approach is crucial for advancing reproductive rights, improving health outcomes, and addressing the socio-cultural, legal, and systemic barriers that women face in accessing safe abortion services. The study emphasises the need to align Nigeria's abortion laws and practices with international human rights standards, ensuring that individuals have the autonomy to make informed decisions about their reproductive health.

Chapter one of the study introduces the concept of a rights-based approach to self-managed abortion (SMA) in Nigeria, highlighting the restrictive legal landscape and societal stigma that limit access to safe reproductive healthcare. It emphasises the need for policy reforms to address the high rates of maternal morbidity and mortality due to unsafe abortions. The chapter outlines the research aims to explore the intersection of human rights principles with access to SMA, identifying legal, socio-cultural, and systemic barriers.

Chapter two explores the application of a human rights-based approach to self-managed abortion in Nigeria, emphasising the principles of self-determination, health, dignity, and non-discrimination. It underscores individuals, particularly women and girls, have the fundamental right to make informed decisions about their reproductive health without coercion or stigma. The chapter discusses how Nigeria's restrictive abortion laws and societal norms limit access to safe procedures, creating a climate of fear and misinformation. By advocating for the decriminalisation of abortion and the implementation of non-discriminatory, inclusive policies, this approach seeks to uphold individuals' autonomy and health rights. The significance of integrating human rights principles into reproductive healthcare practices is highlighted, focussing on ensuring equitable access to safe abortion services and addressing systemic barriers. The

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concepts of agency and empowerment are also emphasised, showing that providing individuals with the necessary knowledge and resources enables them to make informed decisions about their reproductive health, ultimately promoting better health outcomes and overall well-being.

Chapter three underscores the discrepancy between international recommendations and Nigeria's legal and cultural context, which hampers effective abortion care and access. It provides an overview of the WHO's guidelines on safe abortion, including their recommendations for medical and self-managed abortion.[344] It highlights the WHO's emphasis on human rights and evidence-based practices, detailing the safe use of medical abortion methods like misoprostol and mifepristone. Despite these provisions, Nigeria's restrictive legal framework and socio-cultural barriers significantly hinder access to safe abortion services. The chapter highlights how religious and cultural beliefs, legal and policy constraints, and healthcare system deficiencies contribute to the stigma and limitations surrounding abortion. It argues that criminalisation and inadequate infrastructure undermine reproductive rights and emphasises the need for legal and systemic reforms to ensure safe, legal, and accessible abortion services in line with international standards.

Chapter Four examines the legal and policy landscape surrounding reproductive rights and access to abortion in Nigeria. It begins with a historical overview, noting that while indigenous abortion practices existed before colonial rule, stringent restrictions were imposed by colonial laws influenced by Roman Catholicism. The chapter highlights the evolution of Nigeria's abortion laws, starting with the Penal Code of 1959 and the Criminal Procedure Code Law, which criminalised abortion except when the mother's life is at risk.[345] The current legal framework, as outlined in both the Criminal and Penal Codes, imposes severe penalties for abortion-related activities, severely restricting women's autonomy and contributing to unsafe abortion practices. The chapter also discusses the National Reproductive Health Policy[346] and National Guidelines on Safe

[344] PAHO/WHO. 'WHO issues new guidelines on abortion to help countries deliver lifesaving care - PAHO/WHO|Pan American Health Organization' *Www.paho.org*, 9 Mar. 2022, www.paho.org/en/news/9-3-2022-who-issues-new-guidelines-abortion-help-countries-deliver-lifesaving-care , accessed 17 May 2024.
[345] Criminal Code Act (1916) sec. 316, 319.
[346] National Reproductive Health Policy of 2001.

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Termination of Pregnancy for Legal Indications,[347] noting that while these frameworks aim to improve reproductive health, they fall short in addressing the legal constraints on abortion. Finally, it addresses the status of medication used for self-managed abortion, such as misoprostol and mifepristone, emphasising that restrictive laws and inadequate regulation impact access to safe abortion care, pushing many women towards unsafe practices.

Chapter Five explores how Kenya's legal and policy framework on self-managed abortion (SMA) can inform Nigeria's approach to reproductive health, emphasising the need for decriminalisation and the removal of barriers to access. The chapter begins with an overview of Kenya's progressive legal framework, including constitutional provisions, the Reproductive Health Care Bill (2021), and judicial interpretations that align with international human rights standards. Kenya's Constitution permits abortion under specific conditions, while recent legislative reforms and policies, such as the National Reproductive Health Policy and National Guidelines for Safe Abortion Services, support safe abortion practices and the use of medications like mifepristone and misoprostol.

Despite these advancements, challenges persist, including stigma, cultural resistance, and regional disparities that impact access to SMA services. The study outlines facilitators of access, such as legal reforms, medication availability, and support systems, but also highlights barriers like stigma and regulatory issues. The analysis concludes with lessons for Nigeria, recommending the development of comprehensive legal frameworks, strengthening support systems, and improving access to medications. By adopting these strategies, Nigeria can enhance its reproductive health policies and better support individuals seeking self-managed abortion services.

[347] B D Adinma *et al*, 'Nigeria best practice paper on post-abortion care' (2023) *Federal ministry of health, Nigeria*, www.lasuth.org.ng/assets/img/blog/Nigeria%20Best%20Practice%20Paper%20on%20Post-Abortion%20Care.pdf,

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6.2 Recommendations:

According to the World Health Organization and other international standards, the right-based principle opines that everyone has the inherent right to choose how they live their lives, to be healthy, and to have access to legal reproductive healthcare. These human rights considerations served as the foundation for our recommendation. Regulations about sexual and reproductive health (SRH) should prioritise accessibility, quality, timeliness, and acceptability. It is unacceptable to criminalise seeking, having, or giving an abortion when the pregnant person has given free and informed consent. The reporting of abortions or suspected abortions by health care providers must not be required to report abortions or suspected abortions in any state. Access to safe, legal post-abortion care should never be in question. We should never criminalise the pursuit or dissemination of impartial, factually sound information about abortion. Reducing maternal morbidity and mortality and protecting women and girls from the psychological and physiological hazards of unsafe abortion requires states to act, including changing laws. Everyone has the right to receive SRH services in an inclusive and non-discriminatory manner. Ensuring privacy and confidentiality is of the utmost importance when providing SRH services.

To advance reproductive rights and access to self-managed abortion in Nigeria, several targeted recommendations should be considered.

1. **Legal and Policy Reforms**

- **Nigerian National Assembly:** Review and amend existing restrictive abortion laws to align with international human rights standards such as those established in the Maputo Protocol,[348] Including the decriminalisation of abortion and the expansion of access to safe abortion services, including self-managed abortion, ensuring laws explicitly define conditions under which self-managed abortions (SMA) are permitted and protect the rights to autonomy, health, and dignity.
- **Federal Ministry of Health:** Develop comprehensive policies that integrate WHO guidelines on safe abortion into national health strategies, including revising the

[348] Protocol to the African charter on human and people's right.

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National Reproductive Health Policy and the National Guidelines on Safe Termination of Pregnancy for Legal Indications to provide clear guidelines for safe abortion practices and improve access to safe abortion services, including SMA.

- **National Agency for Food and Drug Administration and Control (NAFDAC):** Regulate and ensure the availability of safe abortion medications, such as mifepristone and misoprostol, through approved channels, streamlining procurement processes, preventing the misuse of drugs, and ensuring they are accessible for safe SMA.

2. **Judicial and Human Rights Advocacy**

- **Judiciary, including the Supreme Court of Nigeria:** Interpret abortion laws in a manner consistent with human rights principles, ensuring the protection of individuals' rights to health, privacy, dignity, and reproductive autonomy, facilitating judicial rulings that support decriminalisation, and safeguarding access to safe abortion services.

- **National Human Rights Commission:** Should advocate for reproductive rights as fundamental human rights and monitor compliance with international standards. Ensuring accountability for violations and promoting legal reforms that protect reproductive health rights.

3. **Healthcare System Strengthening**

- **State and Federal Ministries of Health:** Strengthen health infrastructure and capacity to provide safe abortion services, including training healthcare providers and patent and proprietary medicine vendors (PPMVs) in safe abortion methods, including SMA, ensuring facilities are equipped, and incorporating comprehensive post-abortion care programs and counselling services within the healthcare system.

- **Healthcare Training Institutions:** Integrate training on safe abortion practices, including SMA, into medical and nursing curricula, equipping healthcare professionals, including PPMVs, with the knowledge and skills necessary to provide safe and non-discriminatory reproductive healthcare.

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4. **Public Awareness and Education**

- **Ministry of Education:** Implement comprehensive sexuality education that includes information on reproductive rights and safe abortion practices, educating young people on their rights and health options, thereby reducing stigma and misinformation.

- **Ministry of Health**: Implement culturally sensitive health campaigns through mass and social media and engage in community outreach to reduce stigma. Train healthcare professionals on safe abortion practices and patient care, aligning with WHO guidelines.

- **Civil Society Organisations and NGOs:** Conduct public awareness campaigns to educate communities about the importance of safe abortion services—self-managed abortion, according to WHO guidelines and reproductive rights—providing accurate information, supporting advocacy for legal reforms, and assisting individuals seeking safe abortion care.

5. **International Cooperation and Support**

- **International Development Partners and Human Rights Bodies** (e.g., African Commission on Human and Peoples' Rights, United Nations Human Rights Council): Provide technical support and guidance to Nigeria in aligning its reproductive health policies with international human rights standards, supporting capacity-building initiatives, policy advocacy, and public awareness efforts to promote safe and legal reproductive healthcare.

6.3. Conclusion

The research has been able to affirm the need for the effective implementation of the right to self-managed abortion because it is discriminatory to deny Nigerian women the right to have an abortion. The goal and impact of anti-abortion legislation is to deny women the same fundamental freedoms and human rights enjoyed by men. Restrictions on abortion result in depriving women of a technique that may be essential for them to enjoy their right to health equally. The study confirms that unsafe abortions contribute

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significantly to maternal death and morbidity in Nigeria. The current abortion laws in Nigeria do not decrease the number of abortions; instead, they force many women to seek out unqualified practitioners, which leads to high rates of morbidity and mortality—an unacceptable cost for a pregnancy. Women in Nigeria are still dealing with the fallout of restrictive abortion laws, even though arguments about a mother's right to autonomy over her own body and a foetus's right to life are ongoing. Even though there is a lot of information available on this subject, women are still losing their lives because of unsafe abortion practices. Our story is just one more step along a well-trodden route. Numerous degrees of change, including the possibility of legislative reform, are required to facilitate the present situation.

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