

# **BARRIERS TO ACCESSING SAFE AND LEGAL ABORTION SERVICES BY WOMEN WITH DISABILITIES IN CAMEROON**

A dissertation submitted in partial fulfilment of the requirements of  
Master of Philosophy (Mphil) in Sexual and Reproductive Rights in Africa in the Centre for  
Human Rights, Faculty of Law, University of Pretoria

By

**Langsi Emmanuella Mbongeh**

**Student Number: u17404348**

Prepared under the supervision of

**Dr. Satang Nabaneh**

**October 2022**

## **PLAGIARISM DECLARATION**

I declare that this mini dissertation ‘Barriers to accessing safe and legal abortion services by women with disabilities in Cameroon’ is my work, that all sources used or quoted have been indicated and acknowledged by means of complete references, and that this dissertation was not previously submitted by me for a degree at another university.

Student Number: u17404348

Date: 31 May 2022

## ACKNOWLEDGEMENT

I thank the Centre for Human Rights at the University of Pretoria for funding my studies and making it possible for me to pursue this MPhil programme.

To my parents- Thank you for the sacrifices and for instilling in us the importance of education. Thanks to my mother – Mrs Helen Langsi, for the encouragement and unconditional love.

To my dearest daughter - Charlene, thank you for pushing me to work so hard. For being such a calm and responsible child. You made this journey seamless.

To my confidant and bestie, Major General OM Bello, thank you for being an awesome human. This journey would not have been accomplished without your constant support, love, and encouragement. Thank you for always believing in me.

To my siblings - OJ, Terry and Val, thank you guys for being my pillars of support, for always teasing me and above all for your prayers.

To my supervisor - Dr Satang Nabaneh, thank you for the guidance and encouragement throughout the work. Your valuable feedbacks and resources helped and kept me on track.

To all my friends who encouraged and wished me good luck during the journey, I appreciate you all.

Finally, to God almighty for the strength to combine full time work with studies and for His grace to remain focused on this intensive programme despite my very tight schedules. Thank you for the fulfilment of Psalms 138 in my life.

## **DEDICATION**

This research is dedicated to;

my parents - Mr & Mrs Langsi Marius,

my daughter – Andinwo Charlene,

and

all women with disabilities in Cameroon

## TABLE OF CONTENTS

Title page -----	1
Declaration -----	2
Acknowledgement -----	3
Dedication -----	4
Table of contents -----	5
List of acronyms and abbreviations -----	8
<b>CHAPTER 1: Introduction</b> -----	<b>9</b>
1.1. Background-----	9
1.2. Problem statement-----	12
1.3. Research objectives-----	13
1.4. Research questions-----	13
1.5. Significance of the study-----	14
1.6. Research method-----	14
1.7. Theoretical framework-----	14
1.7.1 Intersectional human rights-based approach-----	15
1.7.2 Intersectionality and models of disability-----	16
1.8. Literature review -----	20
1.8.1 Sexual and reproductive health and rights and women with disabilities-----	20
1.9. Scope and limitation-----	24
1.10. Chapter outline-----	24
<b>CHAPTER 2: International Treaties, Abortion and Disability</b> -----	<b>26</b>

2.1. Introduction -----	26
2.2. Access to safe and legal abortion services for woman with disabilities from an international human rights-based approach-----	27
2.3. Universal declaration on human rights -----	27
2.4. International covenant on economic, social, and cultural rights and the international covenant on civil and political rights -----	28
2.5. Convention on the elimination of all forms of discrimination against women. -----	30
2.6. Convention on the rights of persons with disabilities. -----	32
2.7. Access to safe and legal abortion services by women with disabilities from the African regional human rights-based approach. -----	33
2.8. Protocol to the African Charter on Human and Peoples’ Right on the Rights of Women in Africa. ----	34
2.9. The Protocol on Disability Rights -----	36
 <b>Chapter 3: National framework-----</b>	 <b>38</b>
3.1. Background -----	38
3.2. The Constitution of Cameroon -----	40
3.3. Penal Code -----	42
3.4. National Health Policies -----	45
3.5. National laws on disability rights -----	47
 <b>Chapter four: Barriers faced by women with disabilities -----</b>	 <b>49</b>
4.1. Introduction -----	49
4.2. Policy-level barriers -----	50
4.3. Service delivery barriers and financial implications for procuring abortion. -----	51
4.4. Conscientious objection -----	53
4.5. Lack of access to education and information on reproductive rights -----	57

4.6. Religious and social stigmatization -----	59
<b>Chapter 5: Conclusion and recommendation -----</b>	<b>54</b>
5.1. Conclusion -----	62
5.2. Recommendation -----	62
<b>Bibliography -----</b>	<b>68</b>

## LIST OF ACRONYMS AND ABBREVIATIONS

AU	African Union
African Charter	African Charter on Human and Peoples' Rights
ACHPR	African Charter on Human and Peoples' Rights
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CO	Conscientious Objection
CRPD	Convention on the Rights of Persons with Disabilities
CESCR	Committee on Economic Social and Cultural Rights
ESOG	Ethiopian Society of Gynecologists
FIGO	International Federation of Gynecologists and Obstetrics
GC	General Comment
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
MVA	Manual Vacuum Aspiration
PWD	Persons with Disabilities
SRHR	Sexual and Reproductive Health Rights
UDHR	Universal Declaration on Human Rights
UNGA	United Nations General Assembly
WHO	World Health Organisation

## CHAPTER ONE

### INTRODUCTION

#### 1.1. Background

Women's right to health, including sexual and reproductive health rights (SRHR) was affirmed during the 1994 International Conference on Population and Development (ICPD).<sup>1</sup> The ICPD recognised the right of everyone, including women with disabilities to make informed choices on their reproductive autonomy, access sexual and reproductive health care services, including access to safe and legal abortion services, and to have universal access to sexual and reproductive health information.<sup>2</sup> While sexual and reproductive health rights are an integral part of the health and wellbeing of every human being, they, however, remain sensitive and controversial issues particularly when they concern persons with disability (PWDs) and women with disabilities in particular.<sup>3</sup> An estimated 1 billion people live with disabilities, which makes up 15 per cent of global population<sup>4</sup> and though PWDs make up a considerable percentage of the population, they are often grossly underserved and their SRHR needs remain unmet, particularly those focused on access to safe abortion.<sup>5</sup>

Abortion, whether legal or illegal, safe, or unsafe, is a universal phenomenon that has existed for ages.<sup>6</sup> According to Bearak et al, an estimated 73 million abortions are carried out globally each year.<sup>7</sup> Similarly, Ganatra et al opine that developing countries account for 97 per cent of all unsafe abortions, and in Africa, almost half of these abortions happen under the least possible safe conditions.<sup>8</sup> In the context of Cameroon, a 2015 studies conducted by Ngowa et al in urban and rural areas of Cameroon, evidenced that 134 of the

---

<sup>1</sup> United Nations International Conference on Population and Development 1994, A/CONF.171/13 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N94/404/86/PDF/N9440486.pdf?OpenElement> (accessed 7 September 2021).

<sup>2</sup> As above.

<sup>3</sup> SS Mavuso, & P Maharaj 'Access to sexual and reproductive health services: Experiences and perspectives in Durban, South Africa. (2015) 29. *Agenda* 79-88.

<sup>4</sup> World Health Organisation, <https://www.afro.who.int/health-topics/disabilities> (accessed 7 June 2021).

<sup>5</sup> Addlakha et al 'Disability and sexuality: Claiming sexual and reproductive rights' (2017) 25 (50) *Reproductive Health Matters* 4-9.

<sup>6</sup> C Jeffe 'Abortion and medicine: a sociopolitical history' in M Paul et al.(eds) *Management of unintended and abnormal pregnancy: Comprehensive abortion care* (2019) 1-9.

<sup>7</sup> Bearak et al 'Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019' (2020) 8 (9) *The Lancet Global Health* 1.

<sup>8</sup> Ganatra et al 'Global, regional, and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian hierarchical model' (2017) 390 *The Lancet* 2372.

509 respondents (26.3 per cent) admitted having had a voluntary induced abortion.<sup>9</sup> The study further revealed that 65 of the respondents (25.6 per cent) in the urban setting and 69 per cent (27.1 per cent) in the rural settings had had an induced abortion.<sup>10</sup> In spite of scientific advancement that enables the procurement of safe abortion at primary care levels, there is still an upsurge in unsafe abortion, which results in high burden of complications and, maternal mortality: with a significant impact on women, families and health care systems.<sup>11</sup>

In the last two decades, there has been significant development in international norms which has recognised that the denial of safe abortion services constitutes a violation of human rights.<sup>12</sup> International human rights standards recognise access to safe and legal abortion as part of SRHR which is critical to the exercise of reproductive autonomy.<sup>13</sup> For example, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is one of the very first treaties within the African human rights system to recognise the right to safe and legal abortion under certain conditions.<sup>14</sup> The Maputo Protocol recognises the right to abortion, which implies women, including women with disabilities can procure safe and legal abortion without restriction, or fear of persecution.<sup>15</sup> Historically, women and girls with disabilities have often been denied their reproductive freedom.<sup>16</sup> This is because they are often perceived as asexual and less likely to marry or have children than people without disability.<sup>17</sup>

Globally, most countries have liberal laws on abortion, and grounds on which abortion can be granted.<sup>18</sup> However, in no country is access to safe and legal abortion completely without barriers, including

---

<sup>9</sup> JDK Ngowa et al 'Voluntary induced abortion in Cameroon: Prevalence, reasons, and complications' (2015) 5 *Open Journal of Obstetrics and Gynaecology* 475-480.

<sup>10</sup> As above.

<sup>11</sup> Singh et al. 'Adding it up: The costs and benefits of investing in family planning and maternal newborn health' Guttmacher Institute and United Nations Population Fund (2009).

<sup>12</sup> Fine et al, 'The role of international human rights norms in the liberalization of abortion laws globally' (2017) 19 (1) *Health and Human Rights Journal* 69-80.

<sup>13</sup> Convention on the Rights of the Child Committee (CRC) General Comment 20 (2016) on the implementation of the rights of the child during adolescence, 6 December 2016 (CRC/C/GC/20).

<sup>14</sup> Article 14 (2)(c) Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/ProtocolontheRightsofWomen.pdf> (accessed 12 January 2022).

<sup>15</sup> General Comment 2 on art14(1), (a), (b)(c) and f & art14 (2) (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Para 12 <https://www.achpr.org/legalinstruments/detail?id=13> (accessed 18 January 2022).

<sup>16</sup> C Ngwena 'Reproductive autonomy of women and girls under the Convention on the Rights of Persons with Disabilities' (2018) 140 (1) *International Journal of Gynecology and Obstetrics* 128-133.

<sup>17</sup> P Anderson & R Kitchin 'Disability, space, and sexuality: access to family planning services' (2005) 51 (8) *Social Science and Medicine* 1163-73.

<sup>18</sup> International Planned Parenthood Federation 'Access to safe abortion: A tool for assessing legal and other obstacles (1996).

Cameroon.<sup>19</sup> These barriers become incredibly complex when it involves women with disabilities.<sup>20</sup> Cameroon operates a highly restrictive abortion regime. Article 337 (a)(b) (c) of the Penal Code provides that any woman who has an abortion, or consents to it, maybe punished by imprisonment of 15 days to 5 years and/ or a fine of 5000 CFA Francs to 200.000 CFA Francs, while the medical professional who performs an illegal abortion may be forced to close their practices.<sup>21</sup> However, the Penal Code grants abortion on circumscribed grounds, to save the life of the mother, where the pregnancy endangers the woman's physical and mental health or where the pregnancy is a result of rape or incest.<sup>22</sup> While disability rights is not expressly recognised in the country's year Constitution, there are however a few existing policies and laws that protect the rights of PWDs in Cameroon. However, the drafters of the various policies and laws have been silent on the SRHR of women with disabilities, particularly on access to safe and legal abortion for women with disabilities. Peta *et al* posit that the stereotypes that PWDs, including women with disabilities face, creates barriers for the realisation of their sexual and reproductive rights to which they are entitled under national constitutions, international laws and prominently the CRPD.<sup>23</sup>

This study, therefore, aims at contributing to the academic literature by researching barriers faced by women in general and with particular focus on women with disabilities in accessing safe and legal abortion services within the context of Cameroon.

## 1.2 Problem statement

In the last two decades, there has been significant development with international norms which has recognised that the denial of safe abortion services constitutes a violation of human rights.<sup>24</sup> Despite international and regional human rights instruments such as the Maputo Protocol, calling on State Parties to ensure access to safe and legal abortion for women, this has not been a reality. Generally, women still face myriad of barriers to accessing safe and legal abortion in almost every country globally. This is more complex for women with disabilities where multiple factors intersect with their disability, which restricts their ability to access safe and legal abortion, even on circumscribed grounds.

---

<sup>19</sup> Ander & Kitchin (n 17 above)1163-73

<sup>20</sup> Ander & Kitchin (n 17 above) 1163-73.

<sup>21</sup> Penal Code of Cameroon Law No.65 LF/24 of 12 November 1965 and No.67/LF/1 of 12 June 1967, art.337 (a), (b), (c).

<sup>22</sup> As above, art 339.

<sup>23</sup> C Peta et al 'Facilitating the voice of disabled women: The biographic narrative interpretive method (BNIM) in action' (2019) 4 *Journal of the Academy of Social Sciences* 515.

<sup>24</sup> Fine et al (n12 above) 69-80.

According to research conducted in Cameroon, it was revealed that among women of childbearing, aged 12 to 19 years, 20 per cent of respondents had used an abortion method and at least 14 per cent had procured abortion at least once.<sup>25</sup> According to Calves, 35 per cent of pregnancies among adolescents and early adulthood do end up in clandestine abortion.<sup>26</sup> In a study conducted by Tebeu et al, 25 per cent of maternal deaths recorded at the university teaching hospital resulted from complications of unsafe abortion.<sup>27</sup> This study, therefore, aims to investigate and discuss on the barriers that intersect with disability and restrict women with disabilities from accessing safe and legal abortion services in Cameroon.

### **1.3. Research objectives**

The main objective of this study is to have an in-depth understanding of the barriers faced by women with disabilities in accessing safe and legal abortion services in Cameroon. The study will be guided by the following objectives:

1. To examine the right to access legal and safe abortion services by women with disabilities within international, regional, and national legal frameworks.
2. To examine how law, policies, social, economic, and institutional factors act as barriers preventing women with disabilities from accessing safe and legal abortion services; and
3. To generate recommendations that would inform policy makers to develop effective mechanisms, including legal and policy reforms to address the gaps in accessing safe and legal abortion services for women with disabilities.

### **1.4. Research questions**

The main research question of this study is:

*What are the barriers faced by women with disabilities in accessing safe and legal abortion services in Cameroon?*

Also, the study will answer the following sub-questions.

---

<sup>25</sup> Centre for African Family Studies (CAFS) ‘Determinants and consequences of adolescent pregnancies in Cameroon’ 1996 (8) CAFS News.

<sup>26</sup> AE Calves ‘Abortion risk and decision-making among young people in urban Cameroon’ (2002) 33 (3) *Studies in Family Planning* 249-60.

<sup>27</sup> Tebeu et al ‘Maternal mortality in Cameroon: a university teaching hospital report’ (2015) 21 (16) *Pan African Medical Journal*.

1. How do international and regional human rights frameworks guarantee the right to access safe abortion services for women with disabilities?
2. How do national legal frameworks guarantee the right to access safe and legal abortion services for women with disabilities?
3. What are the barriers that intersect with disability to prevent women with disabilities from accessing safe and legal abortion services in Cameroon?
4. What are the legal, policy and behavioral changes that can be advocated for to ensure access to safe and legal abortion services for women with disabilities?

### **1.5. Significance of the study**

This study, therefore, aims to examine how laws guarantee access to safe and legal abortion as part of SRHR for women with disabilities. The study establishes how several factors intersect with disability and gender and prevent women with disabilities from accessing safe and legal abortion services within the context of Cameroon. With a dearth of research, the study's findings would significantly contribute to the existing literature on barriers to accessing safe and legal abortion for women in general, and with a particular focus on women with disabilities in Cameroon. Several international and regional human rights instruments and treaty bodies guarantee access to safe and legal abortion services for women, including women with disabilities. However, in the context of Cameroon, studies on the barriers that limit access to safe and legal abortion for women with disabilities remain limited. This study is significant, as it will highlight the barriers faced by women with disabilities in accessing safe and legal abortion services. This study's findings and recommendations will contribute equally to comprehensive policy reforms to strengthen access to safe and legal abortion services for women with disabilities.

### **1.6. Research methodology**

To provide answers to the research questions, the study would adopt a desk-based review and analytical approaches which includes the review of relevant international, regional, and national legal frameworks on disability and abortion rights. Relevant secondary sources would include sourcing information from textbooks, journals and, internet sources. The analysis focuses on obtaining information on the right to abortion and the barriers to accessing safe and legal abortion services by women with disabilities in Cameroon. Other secondary sources would be information from reputable websites such as the UN, WHO, Guttmacher institute, the International Planned Parenthood Federation, and other development partners

working on curbing unsafe abortion. The information would be sourced from other local websites such as the ministry of public health, and civil society organisations working in the field of sexual and reproductive rights and the rights of PWDs.

## 1.7. Theoretical framework

### 1.7.1 Intersectional human rights-based approach

This study would utilise an intersectional human rights-based approach to address the research question on the barriers experienced by women with disabilities in accessing safe and legal abortion. As posited by Price, the term ‘intersectionality’ was first coined by women of colour scholars in the 1970s and 1980s, with Kimberle Crenshaw amongst them.<sup>28</sup> It became a core concept amongst feminist scholars.<sup>29</sup> Saxe is of the opinion that though intersectionality emerged from the need to gain a profound understanding of the barriers faced by women with colour, research has been expanded to understand the experiences of people from other races and different identities, including those living with a disability.<sup>30</sup> According to Crenshaw, intersectionality suggests that individuals who possess several disadvantaged identities will have vastly different experiences than people with only one, or few of these disadvantaged identities.<sup>31</sup> Crenshaw further asserts that intersectional oppression is a term that captures the different forms of oppression and discrimination faced by women with disabilities based on their gender and disability.<sup>32</sup>

Positing Crenshaw’s argument within the disability context, it is my opinion that women with disabilities face unique forms of oppression and discrimination in accessing SRHR than their disabled male counterparts. This is because men with disabilities do not often have to access abortion services. Crenshaw further argues that the theory of intersectionality is not only vital for increasing awareness of individual experiences based on their identities but it also helps researchers to gain an in-depth understanding of how to encourage the inclusion of PWDs who are subjugated by societal barriers.<sup>33</sup> It is in keeping with this that Ballan opined that it is imperative for research on disability rights to utilise the theory of intersectionality

---

<sup>28</sup> K Price ‘It’s not just about abortion: Incorporating intersectionality in research about women of color and reproduction’ (2011) 21 (3). *Women’s Health Issues*, 55-57.

<sup>29</sup> K Price (n 28 above).

<sup>30</sup> A. Saxe ‘The theory of intersectionality: A new lens for understanding the barriers faced by autistic women’ (2017) 6 (4) *Canadian Journal of Disability Studies*, 153-154.

<sup>31</sup> K Crenshaw ‘Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics’ (1989) 129 *University of Chicago Legal Forum* 139.

<sup>32</sup> K Crenshaw ‘Mapping the margins: Intersectionality, identity politics, and violence against women of color’ (1991) 43 (6) *Stanford Law Review* 1241-1299.

<sup>33</sup> K Crenshaw (n 32 above).

as PWDs, including women with disabilities, are one of the marginalised population.<sup>34</sup> Laisidou notes that including disability in an intersectional framework is imperative given that through its intersection with other identities such as race, gender and social class, it becomes evident how social structures and institutions promote inequality.<sup>35</sup> This study utilises this approach as I am of the view that the intersection of the multiple identities of women with disabilities results in the multiple forms of discrimination they encounter within policy, social, cultural and health care frameworks.

As elicited by Kayess and French, PWDs experience different forms of oppression as social structures segregate and discriminate against them which prevents them from inclusion and participation.<sup>36</sup> According to Acker-Verney et al, PWDs are often considered as recipients of support and beneficiaries of social programs rather than recognised as right holders who are important to the development of inclusive programs and policies.<sup>37</sup> In most instances, disability is not the only reason for discrimination, but includes other factors such as gender, sexual orientation, and socio-economic class, which when interwoven could trigger discrimination against PWDs. One can therefore posit that intersectionality is relevant to research on disability and reproductive autonomy as it is a useful tool to develop an appraisal on the multiple layers of barriers which women with disabilities face to realise their SRHR, including access to legal and safe abortion services.

### 1.7.2 Intersectionality and models of disability

While there has been growing consensus concerning disability and reproductive rights, there exists different models which surround the definition of disability from a moral-religious, medical, charity, social and rights-based lens. Pardeck and Murphy are of the opinion that the oldest conceptualisation of disability is built on the religious and moral models, which had their foundation in Judeo-Christian transition.<sup>38</sup> Retiel and Letsosa posit that according to the religious and moral models of disability, disability is regarded as

---

<sup>34</sup> MS Ballan 'Disability and sexuality within social work education in the USA and Canada: The social model of disability as a lens for practice (2008) 27 (2) *Social Work Education* 194-202 as cited in Saxe (n32).

<sup>35</sup> A Laisidou 'Intersectional understandings of disability and implications for a social justice reform agenda in education policy and practice' (2013) 28 (3) *Disability and Society* 299-312.

<sup>36</sup> R Kayess & P French 'Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008)8 *Human Rights Law Review* 8.

<sup>37</sup> J Acker-Verney et al 'Intersectionality and rights of persons with disabilities in global development.', Center for International Policy Studies, <https://www.cips-cepi.ca/2016/04/28/intersectionality-and-the-rights-of-persons-with-disabilities-in-global-development/> (accessed 12 July 2021).

<sup>38</sup> JA Pardeck & JW Murphy (eds) *Disability issues for social workers and human services professionals in the twenty-first century* (2012).

a reprimand from God, for transgressions by PWDs.<sup>39</sup> Drawing from the African narrative, Ndlovu argues that understandings of disability were drawn from incidents that occurred under the auspices of prayer rituals, religious teaching, healing and behaviour.<sup>40</sup>

As posited by Retiel and Letšosa, from the mid-1800s, the medical model of disability began to gradually replace the moral and religion model in lieu of significant advances in the field of medical science.<sup>41</sup> According to Olkin, the medical model describes disability as a medical problem that resides in the individual which could be a defect or failure of a bodily system and is inherently abnormal and pathological.<sup>42</sup> The medical model further describes disability based on a person's physical and mental limitations, which are unconnected to their geographical or social environment.<sup>43</sup> Creamer is of the opinion that terms such as handicapped, cripple, retarded, spastic, and invalid are derived from the medical model of disability.<sup>44</sup> This notion of disability reinforces the notion that PWDs are non-comparable with their able-bodied counterparts.<sup>45</sup> Carlson further posits that, the medical model regards disability as objectively bad, a pitiable condition, wherein the person with a disability is seen as a personal tragedy for both the individual and their family, where the disability needs to be prevented, fixed or cured.<sup>46</sup> As pointed out by Carlson, the negative conception of disability has contributed to some of the questionable medical treatments experienced by PWDs,<sup>47</sup> for example in accessing safe and legal abortion services by women with disabilities. The charity model of disability perceives PWDs as victims of their impairment, who need special services and institutions and should rely on able-bodied people for assistance.<sup>48</sup> Seale further states that the charity model depicts PWDs as helpless and reliant on able-bodied people for assistance, which contributes to the harmful stereotypes and misconceptions about PWDs.<sup>49</sup> Both the medical and charity models are the two most common models used by non-disabled people to define and explain disability.<sup>50</sup>

---

<sup>39</sup> M Retiel & R Letšosa 'Models of disability: A brief overview' (2018) 74 (1) *HTS Teologiese Studies/Theological Studies* 4788.

<sup>40</sup> H Ndlovu 'African beliefs concerning people with disabilities: Implications for theological education' (2016) 20 *Journal of Disability & Religion* 31.

<sup>41</sup> Retiel & Letšosa (n 39 above).

<sup>42</sup> R Olkin 'What psychotherapists should know about disability' (1999).

<sup>43</sup> K Amponsah Bediako 'Relevance of disability models from the perspective of a developing country: An analysis' (2013) 3 (1) *Disabilities Country Studies, E-Journals* 123.

<sup>44</sup> D Creamer *Disability and christian theology: embodied limits and constructive possibilities* (2009).

<sup>45</sup> Retiel & Letsosa (n 39 above).

<sup>46</sup> See L Carlson *The faces of intellectual disability' Philosophical reflections* (2009).

<sup>47</sup> As above.

<sup>48</sup> V Duyan 'The community effects of disabled sports' in Centre of excellence defence against terrorism (ed) *Amputee sports for victims of terrorism* (2007) 70-77.

<sup>49</sup> J Seale 'E-learning and disability in higher education' (2006).

<sup>50</sup> Amponsah Bediako (n 43 above).

The social model of disability which began in the 1960s and 1970s was inspired by the activism of the British disability movement in reaction to the limitations of the medical model of disability.<sup>51</sup> The social model of disability was coined in 1981 by Oliver Mike, who emphasised on the need to focus on the social aspects of disability especially how social and physical environments imposed limitations upon certain categories of people.<sup>52</sup> Retiel and Letsosa opine that fundamental to the social model is the notion disability is ultimately a socially construed phenomenon.<sup>53</sup> Giddens is of the view that the social model of disability has been instrumental in influencing the way disability is understood in contemporary times, and plays a crucial role in shaping social policy vis-à-vis PWDs, at both national and international levels.<sup>54</sup> For example, in South Africa, the social model has been reflected in national policies such as the integrated national disability strategy of 1997.<sup>55</sup> However, the social model of disability has been critiqued by medical sociologists who reject the models' distinction between impairment and disability. Social model theorists have responded to this critique by stating that they do not deny the fact that some forms of illnesses may have disabling consequences nor do they deny the role of medical professionals in treating various ailments, but they point out that medical theorists fail to distinguish between a person's illness and his or her disability.<sup>56</sup> The social model holds that to guarantee the full inclusion and equitable participation of PWDs in the society, there is a need for society to remove the physical, legal, institutional, and attitudinal barriers against PWDs.

Disability is recognised as an evolving concept within the Preamble of the CRPD. This is as a result of the intersection between a disability and the environmental barriers that hinders the equitable and full participation with others.<sup>57</sup> The drafters of the CRPD were clear that disability is a social construct based on the interaction between a person with disability and the environment, meaning disability is not inborn but rather in the individual as the result of some impairment.<sup>58</sup> For example, a PWD may face challenges gaining employment, not because of his or her condition, but because of a lack of disability-friendly infrastructures and equipment.<sup>59</sup>

---

<sup>51</sup> S D 'Alessio, 'Inclusive education in Italy: a critical analysis of the policy of intergrazione scolastica' (2011), 44.

<sup>52</sup> M Oliver 'A new model of the social work role in relation to disability': in J Crampling (ed). *The handicapped person: a new perspective for social workers* (1981), 19-32.

<sup>53</sup> Retiel & Letsosa (n 39 above) 3.

<sup>54</sup> A Giddens, 'Sociology' (2006).

<sup>55</sup> Retiel & Letsosa (n 39 above)4.

<sup>56</sup> As above 6.

<sup>57</sup> Preamble of the CRPD.

<sup>58</sup> United Nations 'From exclusion to equality: realizing the rights of persons with disabilities' (2007) UN Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and Its Optional Protocol.

<sup>59</sup> As above.

According to the Preamble of the CRPD, there exists a human- right model of disability which does not define disability but simply recognises it as an ‘evolving concept’.<sup>60</sup> From the rights-based lens, PWDs are active against the social forces of able-ism where their voices are heard and the slogan “nothing for us, without us” is enforced and strengthened. Areheart argues that according to this dominant understanding of disability, disability is regarded as a product of clinical diagnosis.<sup>61</sup> It is the opinion of this author that the above assertion is however not true in the context of Cameroon as PWDs are perceived from religious-medical-charity-and social models. In my opinion, the rights-based model is still not yet practical in the context of Cameroon due to the absence of holistic disability rights policies and frameworks that can echo the voice of PWDs and their right to access safe and legal abortion services.

In conclusion, I note that no studies have been conducted in Cameroon to empirically assess the experiences of women with disabilities in accessing safe and legal abortion services, and thus invoked the theory of intersectionality to demonstrate how gender and disability intersect to create complex challenges for women with disabilities to access safe and legal abortion services. I agree with Moodley and Graham who posit that intersectionality provides a lens to have a comprehensive understanding of the mutual process of marginalisation and exclusion pertaining to gender and disability.<sup>62</sup> .

## **1.8. Literature review**

### **1.8.1 Sexual and reproductive health and rights and women with disabilities**

According to Addlakha et al, discourses on disability, reproductive rights and sexuality have gained prominence in research and policy developments in high-income regions of the world in recent years.<sup>63</sup> However, Addlakha et al further opine that, such discussions are only now emerging in public discourses in many middle-income regions of the world, including Cameroon.<sup>64</sup> Similarly, Ofuani posits that the definition of disability is a very controversial issue within disability debates.<sup>65</sup> This makes it problematic to proffer an acceptable definition of ‘disability’.<sup>66</sup> Ofuani further submits that while the CRPD acknowledges that ‘disability is an evolving concept’, it does not however provide an explicit definition of the concept but

---

<sup>60</sup> Preamble, para e, CRPD.

<sup>61</sup> BA Areheart ‘Disability trouble’ (2011) 29 *Yale Law and Policy Review* 348-349.

<sup>62</sup> J Moodley & L Graham ‘The importance of intersectionality in disability and gender studies’ (2015) 29 (2) *Agenda* 24-33.

<sup>63</sup> Addlakha et al (n 5 above).

<sup>64</sup> Addlakha et al (n 5 above).

<sup>65</sup> AI Ofuani ‘The right to economic empowerment of persons with disabilities in Nigeria: How enabled?’ (2011) 11 (2) *African Human Rights Law Journal* 227-228.

<sup>66</sup> Ofuani (n 65 above).

simply elucidates who a PWD is.<sup>67</sup> Article 1 of the CRPD states that ‘persons with disabilities include those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’.<sup>68</sup>

While Stein and Lord acknowledge that the CRPD does not construct any set of new rights, they emphasise that PWDs are covered by existing human rights and principles.<sup>69</sup> Schaaf however submits that though the CRPD guarantees and upholds the protection status for PWDs, the drafters of the Convention focused on protection from forced sterilisation and sexual abuse, with little focus on other reproductive health care aspects, including access to legal abortion.<sup>70</sup> According to Kayess and French, the drafters of the CRPD understood that most states did not have comprehensive disability legislation and called on states to draft or revise legislation on disability to recognise and reframe the human rights needs and concerns of PWDs.<sup>71</sup> Similarly, Johnson is of the opinion that, to have a ‘disability’ means having fewer truncated and limited rights and that disability is a form of gendered oppression in Nigeria.<sup>72</sup> Johnson also opined that the inequalities faced by women with disabilities should not be solely perceived as a result of certain factors such as cultural, biological or socio-economic, but rather how these factors intersect with one another and how they influence and shape the experiences of women with disabilities.<sup>73</sup> Kayess and French further submit that PWDs experience different forms of oppression and are often discriminated against by social structures that segregate and exclude them from social engagements and provide no means of inclusiveness for them in their communities.<sup>74</sup> The reasoning of Kayess and French depicts the situation of women with disabilities in the context of Cameroon, who experience multiple forms of discriminatory acts against them, based on social structures and practices. The Lancet and Guttmacher Institute coined an integrated definition of SRHR which states ‘sexual and reproductive health rights is a state is a state of physical, emotional,

---

<sup>67</sup> Ofuani (n 65 above).

<sup>68</sup> CRPD, art 1.

<sup>69</sup> J Lord & M Stein ‘Prospects and practices for CRPD implementation in Africa’ (2013) *African Disability Rights Yearbook* 100.

<sup>70</sup> M Schaaf ‘Negotiating sexuality in the Convention on the Rights of Persons with Disability’ (2011) 8 (14) *SUR International Journal on Human Rights* 114.

<sup>71</sup> Kayess & French (n 36 above).

<sup>72</sup> A Johnson ‘Hush woman! The complex “disabled” woman in Nigeria’s legal and human rights framework: A deconstruction’ (2020) 8 *African Disability Rights Yearbook* 3-30.

<sup>73</sup> See A Johnson ‘The voiceless woman: Countering dominant narratives concerning disabled women in Nigeria’ Unpublished PhD thesis, University of Pretoria (2019).

<sup>74</sup> Kayess & French (n 36 above).

mental, and social wellbeing in relation to all aspects of sexuality and reproduction, and not merely the absence of disease, dysfunction, or infirmity'.<sup>75</sup>

A woman's ability to end an unwanted pregnancy depends on the legal environment in which she finds herself. Globally, and most especially in the developing world, one in every four women lives in countries where abortion is restricted or permitted on circumscribed grounds.<sup>76</sup> Even in countries where laws permit abortion on circumscribed grounds, the laws still impose restrictions on the procedure.<sup>77</sup> This is the case with Cameroon. Rubinfeld and Kallianes, opine that the SRHR of women with disabilities are constrained by assumptions that they are asexual, lack access to reproductive health information, contraceptives, and unable to birth and raise kids as mothers.<sup>78</sup> Sharing the same views, Silvers et al submit that it is a common mistake to assume that having a disability affects a person's competence.<sup>79</sup> They further posit that it is "inaccurate to assume that disabled means having no sexual or reproductive interests or being sexually inactive, celibate, or asexual". Assumptions like this maybe the reason why PWDs receive unfair access to medically indicated reproductive care other than people of similar age and sex.<sup>80</sup>

By upholding the right to reproductive autonomy and decision making, a pregnant woman should have access to accurate information to guide her make informed decisions on whether or not to continue a pregnancy.<sup>81</sup> To this, Ngwena submits that limited grounds for granting abortion do not provide adequate 'enabling power' for women, especially women with disabilities to access safe and legal abortion.<sup>82</sup> Ngwena further argues that the exclusion of social and economic factors as grounds for terminating a pregnancy 'is a denial of admitting that many women opt for termination of pregnancy due to their social and economic status and that women have the legal right to seek safe abortion',<sup>83</sup> this includes women with disabilities. Nabaneh further submits that though the Maputo Protocol does not grant abortion upon request or on socio-economic grounds, the African Commission on Human and Peoples' Rights 'can employ a purposeful interpretation by implicitly reading into article 14(2)(c) for broadly interpreting the right to health' to

---

<sup>75</sup> Starrs et al 'Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher. *Lancet* 2018; 391:2642-92.

<sup>76</sup> The Alan Guttmacher Institute (AGI) 'Sharing responsibility: Women, Society and Abortion Worldwide' (1999)

<sup>77</sup> As above.

<sup>78</sup> P Rubinfeld & V Kallianes 'Disabled women and reproductive rights' (1997) 12 (2) *Disability and Society* 203.

<sup>79</sup> Silvers et al 'Reproductive Rights and Access to Reproductive Services for Women with Disabilities' (2016) 18 (4) *AMA Journal of Ethics* 430-437.

<sup>80</sup> As above.

<sup>81</sup> CEDAW art 16.

<sup>82</sup> CG Ngwena 'Inscribing abortion as human right: Significance of the Protocol on the Rights of Women in Africa'. (2010) 32 (4) *Human Rights Quarterly* 783-864.

<sup>83</sup> C Ngwena. 'Access to legal abortion: Developments in Africa from a reproductive and sexual health rights perspective' (2014) 19 (2) *South African Public Law* 335-338.

provide options for the woman to decide to or not to keep the pregnancy.<sup>84</sup> This implies that a woman can have the ability to make informed choices, and be able to exercise her right to bodily autonomy. As earlier mentioned, Cameroon operates a highly restrictive abortion regime. Article 337 (a)(b) (c) of the Penal Code provides that any woman who has an abortion, or consents to it, maybe punished by imprisonment of 15 days to 5 years and/ or a fine of 5000 CFA Francs to 200.000 CFA Francs, while the medical professional who performs an illegal abortion may be forced to close their practices.<sup>85</sup> The Penal Code grants only abortion on circumscribed grounds, to save the life of the mother, where the pregnancy endangers the woman's physical and mental health or where the pregnancy is a result of rape or incest.<sup>86</sup> Ngwena therefore posits that granting abortion only on circumscribed grounds forces pregnant women to become mothers..<sup>87</sup> As a result, it therefore leaves a gap for the continuous infringement on the reproductive rights of women, including women with disabilities, as it hinders their ability to make reproductive choices.

In Pizzarossa and Durojaye's opinion, the right to procure safe abortion by women, including women with disabilities, is two-fold - first, the state is prohibited from interfering with a woman's decisions to have a safe abortion on therapeutic grounds; and second, the state is obliged to guarantee the full realisation of the reproductive rights of women and girls.<sup>88</sup> Though the Constitution of Cameroon 1972, amended in 2008, does not contain any specific provisions on PWDs,<sup>89</sup> it however promulgated its first law relating to the protection of PWDs on 21 July 1983.<sup>90</sup> By 1990, Decree 90/1516 of 26 November was issued which was binding the modalities of the application of the law of 1983.<sup>91</sup> Cameroon signed the CRPD in October 2008 without ratification. Law 2010/002 of 13 April 2010 was adopted by the government which guaranteed the promotion and protection of the rights of PWDs including women with disabilities.<sup>92</sup> Article 282 of the Penal Code equally provides penal sanctions for violating or mistreating PWDs.

## 1.9. Scope and limitation

---

<sup>84</sup> S Nabaneh 'A purposive interpretation of Article 14(2) (c) of the African Women's Protocol to include abortion on request and for socio-economic reasons' Unpublished LLM mini-dissertation, University of Pretoria (2012) 39.

<sup>85</sup> Penal Code of Cameroon (n 21 above) art 337 (a), (b), (c).

<sup>86</sup> As above, art 339.

<sup>87</sup> Ngwena (n82 above) 849.

<sup>88</sup> LB Pizzarossa & E Durojaye 'International human rights norms and the South African choice on termination of pregnancy act: An argument for vigilance and modernisation' (2019) 35 (1) *South African Journal on Human Rights* 50-69.

<sup>89</sup> Constitution of Cameroon 1972 as amended in 2008.

<sup>90</sup> Law no.83/013 of 21 July 1983 relative to the protection of persons with disabilities.

<sup>91</sup> Decree no. 90/1516 of 26 November 1990 setting the modalities of application of law no. 83/013 relative to the protection of persons with disabilities.

<sup>92</sup> Law 2010/002 of 13 April 2010.

While the study seeks to provide insights into the barriers faced by women with disabilities in accessing safe and legal abortion services, the study has some limitations. One of the most important limitations of this study is that while I draw evidence by analogy that women with disabilities are discriminated against in exercising their SRHR, specifically in accessing safe and legal abortion services, there is no empirical data in the context of Cameroon that clearly distinguishes between the barriers faced by women without disabilities and women with disabilities, in accessing safe and legal abortion services. The second limitation is that, though the discussions in this study will not involve other reproductive health care services apart from abortion, I, however, rely on discussing SRHR and access to reproductive health care services in order to explain abortion and disability.

### **1.10. Chapter outline**

This study is sectioned into five chapters. Chapter one introduces the background of the study, the problem statement, the study objectives, the research questions, the methodology and an overview of the chapters. Chapter two discusses access to safe and legal abortion services for women with disabilities within international and regional human rights frameworks. Chapter three examines Cameroon's legal frameworks that govern abortion and existing disability policies and how compliant they are with international and regional human rights frameworks. Chapter four explains barriers faced by women with disabilities in accessing safe and legal abortion services. Chapter five provides concludes the study and provides recommendations

## CHAPTER TWO

### INTERNATIONAL TREATIES, ABORTION AND DISABILITY

This chapter examines how international and regional human rights instruments guarantee access safe and abortion for women generally and particularly women with disabilities. It will give a brief background on disability and reproductive health rights, with a focus on access to safe and legal abortion and its prominence in the growing human rights discourse.

#### 2.1 Introduction

While PWDs constitute the largest minority groups affected by multiple forms of human rights violations, historically, they were excluded from the UN concept of minority for a long time.<sup>93</sup> However, in the 1970s, issues pertaining to disability rights started began gaining prominence at the global level. In 1971, the Declaration on the Rights of Mentally Retarded Persons was adopted by the United Nations General Assembly (UNGA) as the first soft law on disability rights.<sup>94</sup> Article 1 of this Declaration stipulated that individual with mental illness have the same rights and entitlements equal to non-disabled persons.<sup>95</sup> However, the Declaration was narrow as it did not fully represent other forms of disability. Four years later, by 1975 the UNGA adopted the Declaration on the Rights of Disabled Persons which provided that PWDs could enjoy equal civil and political rights as other human beings.<sup>96</sup> The Declaration enlisted a few economic and social rights that were considered critical to the development and social inclusion of PWDs.<sup>97</sup> The Declaration further guaranteed the right to protection against any form of abusive and degrading treatment against PWDs.<sup>98</sup>

---

<sup>93</sup> Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities, adopted by the General Assembly in its resolution 47/135 of 18 December 1992.

<sup>94</sup> General Assembly resolution 2856 (XXVI) of 20 December 1971.

<sup>95</sup> CEDAW (n 81 above) art1

<sup>96</sup> General Assembly resolution 3447 (XXX) of 9 December 1975.

<sup>97</sup> General Assembly Resolution 3447 para 4.

<sup>98</sup> General Assembly Resolution 3447 para 6.

The UNGA promulgated the year 1981 as the ‘International Year of the Disabled’ with the theme ‘full participation and equality’.<sup>99</sup> It called for equitable access to opportunities, privileges, rehabilitation, and the prevention of disabilities at the national, regional, and international levels. One of the major progress of the International Year of Disabled Persons was the adoption of the World Program of Action which addressed the concerns of disabled persons.<sup>100</sup> The World Program of Action was launched with the main objective to ensure inclusivity and reduce discriminatory practices against PWDs and to ensure their rehabilitation and equalisation of opportunities.<sup>101</sup> The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities were adopted in 1993, with the main goal to ensure the full inclusion of PWDs in all aspects of society.<sup>102</sup> Despite the adoption of these Declarations, they were however not legally binding as they formed part of soft law. However, they set a strong moral ground for governments to be committed to taking action to address the needs of PWDs.

## **2.2. Access to safe and legal abortion services for women with disabilities from an international human rights-based approach**

Access to safe abortion on an equal basis is a human right and guaranteed in international and regional human rights frameworks. These frameworks provide that women, including women with disabilities have the right to decide over matters concerning their reproductive autonomy, which includes access to safe and legal abortion services.

## **2.3. Universal Declaration on Human Rights**

As earlier alluded, the right to SRHR, particularly access to safe and legal abortion services is enshrined in many international human rights frameworks. The UNGA adopted the Universal Declaration of Human on 10 December 1948. It guaranteed the indivisibility, inalienability, interdependence, and universality of human rights.<sup>103</sup> The UDHR was modelled on the principles of the UN Charter which recognised the need to promote and protect specific rights and freedoms.<sup>104</sup> Though the UN did not proclaim the UDHR as a

---

<sup>99</sup> General Assembly Resolution 3/123 <https://www.un.org/esa/socdev/enable/disiydp.htm> (accessed 25 September 2021).

<sup>100</sup> United Nations Department of Economic and Social Affairs <https://www.un.org/development/desa/disabilities/resources/world-programme-of-action-concerning-disabled-persons.html> (accessed 25 September 2021).

<sup>101</sup> General Assembly resolution 37/52 of 3 December 1982, para 1.

<sup>102</sup> A/RES/48/96 of 20 December 1993.

<sup>103</sup> Preamble of the UDHR. Adopted and proclaimed by General Assembly Resolution 217 A (III) of 10 December 1948.

<sup>104</sup> LO Gostin & L Gable ‘The human rights of persons with mental disabilities: A global perspective on the application of human rights principles to mental health’ (2004) 63 *Maryland Law Review* 20.

legally binding document, the core statutory provisions have been accepted and applied in many countries, and the principles progressively attained the status of customary international law.<sup>105</sup> Article 25 of the UDHR affirmed that “everyone has the right to a standard of living adequate for their health and right to security in the event of disability”.<sup>106</sup> Cameroon ratified the UDHR in 1983. Under this Declaration, Cameroon has the obligation of ensuring that everyone, including women with disabilities should have access to reproductive health care services, including access to safe and legal abortion services. Cameroon equally has an obligation to ensure that women with disabilities have access to disability-friendly medical care services. This entails ensuring that both public and private health care facilities are equipped with disability-friendly equipment, and medically trained professionals who can provide medical care to everyone, including women with disabilities. However, Gostin and Gable further submit that though the UDHR established a “common standard” it had a limited application to the rights of persons with mental disabilities.<sup>107</sup> This includes other PWDs.

#### **2.4. International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights**

The adoption of the UDHR set the center stage for the transformation of the UDHR into a legally binding document.<sup>108</sup> This led to the adoption of the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (CESCR) in 1966 which entered into force in 1976. The CESCR is often considered the main legal instrument that explicitly addresses the right to health. Article 12 of the CESCR stipulates that state parties have the obligation of ensuring the rights of everyone to enjoy the highest attainable standards of physical and mental health.<sup>109</sup> Though the CESCR does not refer to PWDs, however, *General Comment 14* of the Committee on Economic, Social and Cultural Rights (Committee on ESCR) provides that the right to health contains four elements; accessibility, availability, acceptability, and quality.<sup>110</sup> Quality and accessible health care services must be economically and physically accessible, particularly for marginalised and vulnerable.<sup>111</sup> This implies to ensure non-discrimination, women with disabilities should have access to quality, affordable, acceptable reproductive

---

<sup>105</sup> H Hurst ‘The status of the Universal Declaration of Human Rights in National and International law’ (1996) 25 *Georgia Journal of International and Comparative Law* 287-397.

<sup>106</sup> Universal Declaration of Human Rights (10 December 1948) art. 25.

<sup>107</sup> Gostin & Gable (n 104 above).

<sup>108</sup> As above.

<sup>109</sup> CESCR art 12.

<sup>110</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

<sup>111</sup> As above para 12(b) & 31.

health services without any form of discrimination. However, the Committee on ESCR noted in its *General Comment No 5* that the lack of disability provisions in the CESCRC is due to the lack of awareness of the importance of tackling disability issues.<sup>112</sup>It, therefore, calls on state parties to address the specific needs of women with disabilities by prioritising the implementation of social, economic, and cultural rights programmes.<sup>113</sup>

Cameroon ratified the CESCRC in 1984. As a state party to the Convention, Cameroon has the responsibility to adopt measures at the state level to ensure that specific individuals such as women with disabilities have access to reproductive health care services, one which includes access to safe abortion for every woman with any form of discrimination. In March 2016, the Committee on ESCR adopted *General Comment 22* on the right to SRHR.<sup>114</sup> The adoption of *General Comment 22* reaffirmed the right to sexual and reproductive health enshrined under article 12 of the CESCRC. *General Comment 20* on non-discrimination highlights the prohibited grounds for discrimination to include sex, race, color, birth or ‘other statuses.’<sup>115</sup> This implies states have an obligation to ensure equal access to reproductive health services without any form of discrimination.

In reference to *General Comment 22*, Cameroon, like all state parties have an obligation to ensure access to reproductive rights and health care services by repealing and reforming laws that prevent women, including women with disabilities from realising their SRHR and accessing safe and legal abortion services. Implicit of this state, parties have an obligation to ensure women, specifically women with disabilities have access to SRHR and to access reproductive healthcare services, such as legal and safe abortion without any form of discrimination.

## **2.5. Convention on the Elimination of All Forms of Discrimination against Women.**

Cameroon ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1994. It addresses the health and discriminatory issues affecting women, including those with disability. Article 12 is central to addressing women’s right to health, reproductive choice to access both

---

<sup>112</sup> UN Committee on Economic, Social and Cultural Rights General Comment 5: Persons with Disabilities, 9 December 1994, E/1995/22, para 5.

<sup>113</sup> UN Committee on Economic, Social and Cultural Rights (CESCRC), General Comment 5: Persons with Disabilities, CRPD/C/GC/5, para 19.

<sup>114</sup> Committee on Economic, Social and Cultural Rights, General Comment. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2 May 2016, E/C. 12/GC/22.

<sup>115</sup> United Nations Commission on Population and Development ‘Framework of actions for the follow-up to the programme of action of the International Conference on Population and Development Beyond’ (2014.)

family planning and abortion.<sup>116</sup> The right to reproductive choice indicates that women, including women with disabilities have the right to choose whether to reproduce, including the right to decide whether or not to carry a pregnancy to full term, and the right to choose their preferred method of family planning and contraception. The right to access sexual information, including information on safe and legal abortion for everyone including women with disabilities is recognised under articles 10(h) and 16(1e) of CEDAW.<sup>117</sup> In line with this provision, state parties, including Cameroon, have an obligation to ensure that through policies and laws, appropriate information on reproductive health is provided with dignity, confidentiality, and respect.

CEDAW obliges state parties to eliminate all forms of discriminatory practices against women, including women with disabilities. Referring to *General Recommendation 24*, the CEDAW Committee states that “it is discriminatory for a state to refuse to provide legally for the performance of certain health services for women”.<sup>118</sup> *General Recommendation 24* further recognises that states must take all judicial, administrative, and legislative measures to guarantee the realisation of women’s right to health, including women with disabilities.<sup>119</sup> It is imperative to call to mind *General Recommendation 19 and 35* of CEDAW as it applies to violence against women. *General Recommendation 19* on violence against women highlights that violence against women constitutes a form of discrimination and has a negative impact on women globally.<sup>120</sup> This includes women with disabilities. It further posits that the lack of access to reproductive healthcare services including access to safe and legal abortion is due to the multiple forms of discriminatory practices against women, particularly women with disabilities.

In line with *General Recommendation 35*, state parties including Cameroon is obligated to take all applicable measures and relevant measures and adopt policies aimed at eliminating discriminatory practices against women. This includes discriminatory practices that prevent women’s access to enjoy their SRHR and access reproductive health services including access to safe and legal abortion services. However, Montez notes that despite CEDAW being recognised as the major human rights convention for gender equality, it has been heavily criticised on two grounds.<sup>121</sup> First, Montez highlights that CEDAW lacks the

---

<sup>116</sup> CEDAW (n 81 above) art.12.

<sup>117</sup> CEDAW (n 81 above), arts 10(h) & 16(1e).

<sup>118</sup> UN Committee on Elimination of Discrimination Against Women (CEDAW), (Women and health), 1999 UN Doc A/54/38/Rev.1 chap 1 para 7.

<sup>119</sup> As above.

<sup>120</sup> The Observatory on the Universality of Rights <https://www.oursplatform.org/wp-content/uploads/CEDAW-Committee-General-Recommendation-19-Violence-against-Women.pdf> (accessed 28 September 2021).

<sup>121</sup> P Montez ‘Women’s rights are human rights: CEDAW’s limits and opportunities’ (2021) *Berkeley Journal of International Law*.

specific provisions that address the intersectional identities of women.<sup>122</sup> This gap depicts that women only face discrimination based on their gender, as opposed to other forms of discrimination they experience based on their disability. Second, Montez highlights that CEDAW has been criticised for its extensive reservations, which allows states parties to ratify the Convention but only enforce the provisions which they want to comply with.<sup>123</sup> However, though CEDAW has been criticised for its extensive reservations, article 28(2) of the Convention adopted the impermissibility principle,<sup>124</sup> in line with articles 19 and 20<sup>125</sup> of the Vienna Convention on the Law of Treaties which regulates the use of reservations.<sup>126</sup> Article 28(2) of CEDAW prohibits the entering into reservations that are incompatible with the objective and purpose of the Convention. Montez, therefore, opines that the inconsistent approach to intersectionality and the ability of states parties to make reservations permits discriminatory practices against women, including women with disabilities.<sup>127</sup>

## 2.6. Convention on the rights of persons with disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) was adopted in December 2006 by the UNGA and is recognised as the principal international legal instrument that guarantees the rights of PWDs.<sup>128</sup> The main objective of the CRPD is to guarantee the rights and inherent dignity of PWDs based on existing human rights principles. It is the main human rights framework that explicitly enumerates the civil and political rights of PWDs.<sup>129</sup> Article 1 of the CRPD states that ‘persons with disabilities include those who have long term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’.<sup>130</sup>

The CRPD acknowledges that women with disabilities experience multiple and conflicting forms of gender and disability-based violence.<sup>131</sup> It obliges state parties to take concrete measures to ensure the advancement,

---

<sup>122</sup> As above.

<sup>123</sup> As above.

<sup>124</sup> CEDAW (n 81 above) art 28(2).

<sup>125</sup> Vienna Convention on the Law of Treaties (1969), entered into force 27 January 1980, arts. 18 and 19.

<sup>126</sup> UN Women ‘Convention on the Elimination of All Forms of Discrimination Against Women, reservations to CEDAW’ <https://www.un.org/womenwatch/daw/cedaw/reservations.htm> (accessed 13 March 2022).

<sup>127</sup> As above.

<sup>128</sup> Y Basson “State obligations in international law related to the right to an adequate standard of living for person with disabilities” (2017) 21 *Law, Democracy and Development* 68-83.

<sup>129</sup> United Nations (UN) 2007, Convention on the Rights of Persons with Disabilities GA Res 61/106 UN Doc A/RES/61/106 (24 January 2017).

<sup>130</sup> CRPD, art 1.

<sup>131</sup> CRPD (n 130 above) art 6

and empowerment of women and girls with disabilities.<sup>132</sup> Article 25 guarantees the right to health.<sup>133</sup> It calls on state parties, including Cameroon to prevent and eliminate all forms of discriminatory practices that prevent PWDs from accessing health care services, including SRHR.

*General Comment 3* of the CRPD on women and girls with disabilities, therefore, calls on state parties to adopt measures that prioritise access to health care services for PWDs.<sup>134</sup> This includes access to reproductive health services, and including access to safe and legal abortion services. In its *General Comment 6*, state parties have the duty to protect, respect and fulfil the rights of all PWDs to non-discrimination and equality.<sup>135</sup> Thus, this suggests that state parties must refrain from actions that discriminate against PWDs, particularly women with disabilities and to ensure equal access to reproductive health services. Cameroon signed the CRPD in 2008 but has not ratified the convention.<sup>136</sup> The delay in ratification creates a continuous pattern of discrimination against PWDs, including women with disabilities.

## **2.7. Access to safe and legal abortion services by women with disabilities from the African regional human rights-based approach**

Within the African human rights system, there exists a number of legal frameworks that affirm women's right to procure safe abortion, particularly for women with disabilities. The African Charter on Human and Peoples' Rights (ACHPR) is the foundation of the regional human rights system. It was adopted in 1981 and entered into force in 1986.<sup>137</sup> The African Charter is defined as an application of the UDHR to the African perspective.<sup>138</sup> It is an embodiment of the social, economic, cultural, and political rights to be enjoyed by all, including PWDs. The right to non-discrimination for PWDs is affirmed in the preamble of the African Charter. Article 16 of the African Charter affirms the right to the highest attainable standard of physical and mental health for everyone.<sup>139</sup> This includes PWD particularly women with disabilities. The right to health as affirmed under article 16 was illustrated in the case of *Purohit and Moore V: The*

---

<sup>132</sup> As above.

<sup>133</sup> CRPD (n 130 above) art 25.

<sup>134</sup> UN Committee on the Rights of Persons with Disabilities (CRPD), *General comment. 3 (2016), Article 6: Women and girls with disabilities*, 2 September 2016. CRPD/C/GC/3.

<sup>135</sup> UN Committee on the Rights of Persons with Disabilities (CRPD), *General comment No.6 (2018), on equality and non-discrimination*, 26 April 2018, CRPD/C/GC/6.

<sup>136</sup> International Disability Alliance, Suggestions for disability-relevant recommendations to be included in the Concluding Observations of the Committee against Torture 47<sup>th</sup> Session [https://tbinternet.ohchr.org/Treaties/CESCR/Shared%20Documents/CMR/INT\\_CESCR\\_NGO\\_CMR\\_47\\_8396\\_E.doc](https://tbinternet.ohchr.org/Treaties/CESCR/Shared%20Documents/CMR/INT_CESCR_NGO_CMR_47_8396_E.doc) (accessed 20 January 2022).

<sup>137</sup> OAU Doc.CAB/LEG/67/3 rev.5, 21 I.L.M 58 (1982) entered into force 21 October 1986).

<sup>138</sup> MN N'Sengha 'The African Charter on Human and Peoples' Rights: An African contribution to the project of global ethic (2010).

<sup>139</sup> ACHPR, art 16.

*Gambia*.<sup>140</sup> In the *Purohit case*, the Commission held that The Gambia had failed to satisfy the requirements of articles 16 and 18(4). The Commission stated that the enjoyment of the right to health is critical to the realisation of other human rights including the right to access health care facilities, goods, and services without any form of discrimination. It is the opinion of this author that the Purohit decision is an important development in that it guaranteed disability rights within the African human rights system.

Article 18(4) is the only article in the African Charter that makes direct reference to PWDs and affirms their right to the special protection of their moral or physical needs.<sup>141</sup> Cameroon ratified the African Charter in 1989. Cameroon, therefore, has the duty to create measures that can guarantee the mental and physical health of women with disabilities and ensure their moral and physical needs are met.

## **2.8. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa**

The African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) serves as a cornerstone legal instrument that guarantees the rights of women in Africa. It entered into force in 2005. According to its Preamble, it responds to the inefficient protection of women's rights in Africa.<sup>142</sup> Generally, the Maputo Protocol prohibits all forms of discrimination against women, particularly on the ground of disability.<sup>143</sup> Durojaye posits that the Maputo Protocol contains comprehensive and progressive provisions relating to women's rights, which provides the African Union Commission an opportunity to address the human rights violations faced by women.<sup>144</sup> Durojaye further posits that under international human rights law, the Maputo Protocol contains one of the most exhaustive provisions affirming the right to sexual and reproductive health.<sup>145</sup> Ngwena and Durojaye further submit that the Maputo Protocol advances the substantive understanding of sexual and reproductive health, as a human right.<sup>146</sup>

Article 14 of the Maputo Protocol places responsibilities on state parties to guarantee women's right to health, including SRHR is respected and promoted.<sup>147</sup> This includes the right to reproductive autonomy, access to contraceptives and important information on contraceptives and the ability to procure safe and legal abortion services. Article 14(2) further affirms women's reproductive rights by permitting medical

---

<sup>140</sup> *Purohit & Moore v The Gambia*, Communication No.24/2001 (2003).

<sup>141</sup> ACHPR (n 139 above) art 18(4).

<sup>142</sup> Maputo Protocol, para 11.

<sup>143</sup> Maputo Protocol (n 142 above) arts 2 & 23(b).

<sup>144</sup> E Durojaye 'The approaches of the African Commission to the right to health under the African Charter' (2013) 17, *Law, Democracy and Development* 393-394.

<sup>145</sup> As above.

<sup>146</sup> See C Ngwena & E Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014).

<sup>147</sup> Maputo Protocol (n 142above), art 14.

abortion on circumscribed grounds such as in cases of rape, incest, sexual assault and where the continuous pregnancy poses a threat to the mental and physical health of the mother, or to the life of the mother and foetus.<sup>148</sup> Cameron ratified the Maputo Protocol in 2012 and has an obligation to provide an enabling environment whereby women, specifically women with disabilities can access safe and legal abortion services. According to Ngwena, the Maputo Protocol has been acclaimed as the only international human rights framework that allows for medical abortion, and the first-time abortion was expressly recognised as a human right in a human rights treaty.<sup>149</sup> Article 23(a) places responsibility on state parties to ensure women with disabilities are protected and the state should take all appropriate measures to ensure their access to employment, vocational training and decision making in line with their social, physical and economic needs.<sup>150</sup>

Viljoen is of the opinion that the Maputo Protocol broadens the protective capacity of the rights of women by addressing issues concerning African women which were not included in CEDAW.<sup>151</sup> This includes addressing the multiple forms of discrimination and oppression experienced by women with disabilities on the intersectional grounds of gender and disability. While article 23 of the Maputo Protocol serves as a stand-alone provision addressing the needs of women with disabilities, Kamga however argues that a single provision cannot address the multiple challenges faced by women with disabilities who suffer double discrimination, on the basis of gender and disability.<sup>152</sup> *General Comment 2* was adopted in May 2014 and calls on states parties to ensure the domestication of article 14(2) (c) to recognise the legality of abortion.<sup>153</sup> It equally calls for the elimination of restrictive laws, policies, practices, and procedures that impede access to safe and legal abortion. Both *General Comment 2*<sup>154</sup> and *General Comment 22* of the Committee on ESCR lay emphasis on the SRHR for women, including women with disabilities.<sup>155</sup> Both General Comments affirm the right of women with disabilities to make meaningful and autonomous decisions about their reproductive health.

---

<sup>148</sup> ACHPR (n 139 above) art 14 (2).

<sup>149</sup> Ngwena (n 83 above) 783-864.

<sup>150</sup> ACHPR (n 139 above) art 23.

<sup>151</sup> F Viljoen 'An introduction to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2009) 16 (1) *Washington and Lee Journal of Civil Rights and Social Justice* 19.

<sup>152</sup> SAD Kamga 'The rights of women with disabilities in Africa: Does the Protocol on the Rights of Women in Africa offer any hope?' (2011) *Centre for Women Policy Studies*.

<sup>153</sup> African Commission on Human and Peoples' Rights, General Comment 2 (2014) on art14.1 (a), (b), (c) and (f) and art14.2 (a) and (c), to the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa, paras 22, 24, 27 (2014).

<sup>154</sup> ACHPR (n 139 above) art 14.

<sup>155</sup> General Comment 22 (2016) on the right to sexual and reproductive health, paras 29, 35 and 48.

## 2.9. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disability in Africa

The African Decade of Persons with Disabilities (1999-2009) was adopted at the 35<sup>th</sup> session of the Organisation of African Unity Assembly of States and Governments in July 1999. The main objective of the African Decade of PWDs was to ensure full participation, empowerment, and equality for PWDs.<sup>156</sup> The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disability in Africa (African Disability Rights Protocol) was adopted in 2018 and would come into effect only after ratification by 15 African Union member states. The Protocol has so far registered 11 signatures, including Cameroon and ratification by three countries.<sup>157</sup> The Protocol complements the CRPD from an African perspective.

Durojaye and Nabaneh maintain that the African Disability Rights Protocol is a legally binding document which protects the rights of PWDs and takes cognisance of their lived realities and upholds the core values and principles as set out in the CRPD.<sup>158</sup> As provided for in article 2 of the Protocol, the purpose of the Protocol is to ensure that the rights of PWDs are promoted, respected and their inherent dignity respected.<sup>159</sup> Article 17 guarantees the right of health for PWDs, including women with disability. However, the right to health does not explicitly mention SRHR of women with disabilities. Cameroon has signed the African Disability Rights Protocol though the Protocol has not yet entered into force. This suggests that PWDs including women with disabilities cannot rely on the Protocol on Disability Rights for the advancement of their reproductive health and rights, particularly to access safe and legal abortion.

The Protocol recognises the intersectional forms of discrimination against PWDs and provides that PWDs should have access to quality, free, affordable, and accessible health services on an equal basis with others.<sup>160</sup> It specifically provides that health campaigns and the training of health care providers should include disability specific issues and should not stigmatize PWDs.<sup>161</sup> The protective capacity of the Protocol on disability is limited, given that it has not yet come into force.

---

<sup>156</sup> Continental Plan of Action for the African Decade of Persons with Disabilities (CPOA), African Union, January 2013.

<sup>157</sup> African Union Commission [https://au.int/sites/default/files/treaties/36440-sl-PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLESaEUtm RIGHTS ON THE RI...pdf](https://au.int/sites/default/files/treaties/36440-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLES%20RIGHTS%20ON%20THE%20RI...pdf) (accessed 11 January 2022).

<sup>158</sup> S Nabaneh & E Durojaye 'Human rights and access to health care for persons with albinism in Africa' (2019)7 *African Disability Rights Yearbook*, 40.

<sup>159</sup> The Protocol on Disability, art 2.

<sup>160</sup> The Protocol on Disability, art 16.

<sup>161</sup> ACHPR (n 141 above) arts. 16(h) and (i).

## CHAPTER THREE

### NATIONAL FRAMEWORK

#### 3.1. Background

At the start of the twentieth century, abortion was illegal in almost every country of the world.<sup>162</sup> In 1803, the Lord Ellenborough's Act was passed, which made abortion a common law misdemeanor. By the 1803 Act, abortion became a felony punishable by death-post "quickening" abortion. Abortion prior to "quickening" was reserved "lesser" penalties including fines, imprisonment, whipping or transportation for up to fourteen years.<sup>163</sup> Lord Lansdowne's Act of 1828 repealed the 1803 Act with no material change other than a minor relaxation of the penalties.<sup>164</sup> The 1837 Offences Against the Persons Act (OAPA) was amended in 1861, which incorporated abortion as an offence applicable to the woman procuring abortion and the abortionist.<sup>165</sup> To this, Sheldon opines that, sections 58 and 59 of the OAPA 1861 underpins abortion law in the United Kingdom.<sup>166</sup> In 1861, abortion was considered a challenging and dangerous medical procedure which was only authorised on medical grounds in compelling cases.<sup>167</sup> Berer submits that the practice of abortion was criminalised in criminal or penal codes which formed part of the criminal statutes.<sup>168</sup> Drawing on the colonial historical background of abortion, there have been three major reasons advanced for the existence of restrictive laws on abortion. First, there was the need to protect women from life-threatening abortions as they were considered killed by those who carried out the act.<sup>169</sup> Second, abortion

---

<sup>162</sup> MF Fathalla 'Abortion and public health ethics' in AC Mastroianni et al *The Oxford Handbook of Public Health Ethics* (2019)403-414.

<sup>163</sup> D Green 'The Abortion Act 1967' (1968) 8 (1). *The British Journal of Criminology* 82-86.

<sup>164</sup> As above

<sup>165</sup> C De Costa 'Abortion law, abortion realities' (2008) Delivered at the James University Townsville Campus.

<sup>166</sup> S Sheldon 'The decriminalisation of abortion: An argument for modernisation' (2016) 36 (2) *Oxford Journal of Legal Studies* 334-365.

<sup>167</sup> M Potts et al 'Book reviews: Abortion' (1978) 98 (3) *Royal Society of Health Journal* 135.

<sup>168</sup> M Berer 'Abortion law and policy around the world: In search of decriminalisation' (2017) 19 (1) *Health Human Rights* 13-27

<sup>169</sup> As above.

was also considered a sin or a form of transgression of morality.<sup>170</sup> The third reason advanced for restrictive abortion law was to protect the life of the foetus in some or all stages of the pregnancy.<sup>171</sup>

In line with section 58 of the OAPA of 1861, Cook and Dicken opined that this remained the foundation of the prohibition of abortion in most common law jurisdictions globally, including Cameroon.<sup>172</sup> However, despite the criminalisation of abortion law in England, there were exceptional circumstances under which abortion could be procured. The case of *R v Bourne* established the legality of abortion, not only to preserve the woman's life but also her physical and mental health.<sup>173</sup> In the Bourne case, the court ruled in favour of Dr Bourne for terminating the pregnancy of a 15-year-old rape victim, whose pregnancy if continued, she would have become a 'mental wreck'.<sup>174</sup> In addition to stating the circumscribed grounds for procuring abortion, the Bourne case equally held that an abortion procedure had to be performed by a physician.<sup>175</sup> In the French civil law system, the first widely accepted statute concerning induced abortion appeared in the Napoleonic code, which was enacted during the same period as the first legislation on abortion in England and was similarly influenced by Canon law.<sup>176</sup> The abortion policy of a country is a product of the social, political, economic, and religious context it is embedded in, and most significantly, the nature of abortion laws depends upon their legal heritage.<sup>177</sup> As earlier alluded, Cameroon's bi-jural system of law is a relic of both the English Common law and the French Civil law systems. Thus, one could state that both legal systems' penal laws contributed to shaping Cameroon's penal law, with regards to the restrictive regime on abortion.

Cameroon has a unique and complex political and legal evolution on account of being a former protectorate to three different countries. Between 1884 and 1961, Cameroon was ruled by the Germans, the British, and the French, each having its own legal system.<sup>178</sup> The Germans ruled Cameroon from 1884 - 1915, and later

---

<sup>170</sup> As above.

<sup>171</sup> As above.

<sup>172</sup> R Cook & B Dickens 'Abortion laws in African Commonwealth countries' (1981) 25 (2) *Journal of African Law* 60-79.

<sup>173</sup> *R v Bourne* [1939] 1 KB 687 3 All E.R 615 (1938).

<sup>174</sup> B Dickens & R Cook 'Development of commonwealth abortion laws' (1979) 28 (3). *The International and Comparative Quarterly* 424-427.

<sup>175</sup> Cook & Dickens (n172above) 60-79.

<sup>176</sup> United Nations, 'Abortion Policies around the world'. [https://www.un.org/en/development/desa/population/theme/policy/AbortionPoliciesAGlobalReview1995\\_Vol3.PDF](https://www.un.org/en/development/desa/population/theme/policy/AbortionPoliciesAGlobalReview1995_Vol3.PDF) (accessed 18 January 2022).

<sup>177</sup> United Nations 'Abortion Policies: A Global Review' (3). [https://www.un.org/en/development/desa/population/theme/policy/AbortionPoliciesAGlobalReview1995\\_Vol3.PDF](https://www.un.org/en/development/desa/population/theme/policy/AbortionPoliciesAGlobalReview1995_Vol3.PDF) (accessed 26 January 2022).

<sup>178</sup> VJ Ngoh 'The Political Evolution of Cameroon, 1884-1961' Unpublished MA Dissertation, Portland State University 1979 at 4-5

divided between France and Britain after the Germans were ousted in 1916.<sup>179</sup> Between 1919-1945, France and Britain ruled their respective portions of Cameroon as mandated territories under the League of Nations.<sup>180</sup> In 1960, French Cameroon gained independence from France, while the ‘British Southern Cameroon’ gained independence from Britain in 1961.<sup>181</sup> In 1961, while the Northern part of British Cameroon voted to join Northern Nigeria, the ‘British Southern Cameroon’ voted to unite with French Cameroon. In 1961, the two Cameroons united to form the Federal Republic of Cameroon, and in 1972, it became the United Republic of Cameroon.<sup>182</sup>

### 3.2. The Constitution of Cameroon

The 1972 Constitution of Cameroon, amended in 2008, represents the highest source of domestic laws in Cameroon, which provides a set of fundamental rights that are binding on every citizen, including how government and law-making institutions are structured.<sup>183</sup> Article 45 of the Constitution of Cameroon provides that duly ratified and approved international agreements abrogate national laws.<sup>184</sup> The Preamble is an integral part of the Constitution. Despite the right to health not expressly guaranteed in the Constitution, it is, however, interwoven with other rights including the right to equality, which is guaranteed in the Constitution. As noted above, Cameroon has ratified several international and regional human rights instruments which guarantees the right to health. As stipulated by the Constitution; internationally ratified treaties became an integral part of national law. This therefore obliges Cameroon to take every measure to ensure equal access to health care services for women, including women with disabilities. This will include equal access to SRHR, particularly access to safe and legal abortion services. Article 12 of the Constitution guarantees the right to life, physical and moral integrity. The rights to physical and moral integrity could mean that everyone has the right to be treated with dignity.

The Constitution does not provide any specific provision addressing discrimination. The Preamble of the Constitution only states that every Cameroonian shall enjoy the right to development from the proceeds of the country’s natural resources without any form of discrimination. Though the definition of discrimination is narrow, this section of the Constitution further provides that public-funded health care facilities ought to

---

<sup>179</sup> As above.

<sup>180</sup> As above.

<sup>181</sup> CM Ade ‘The legal status of juveniles in Cameroon’ (2001) 25 (2) *International Journal of Comparative and Applied Criminal Justice*, 149-165.

<sup>182</sup> Ngoh (n 178 above)

<sup>183</sup> Constitution of the Republic of Cameroon, Preamble, 1972 and amended 2008.

<sup>184</sup> As above.

provide health care services to everyone without any form of discrimination.<sup>185</sup> This, therefore, implies that women with disabilities should access reproductive health care services without any form of discrimination. However, while some countries such as Ghana and Rwanda have been influenced by international human rights frameworks with specific provisions that guarantee the rights of PWDs, this is not the case with Cameroon. For example, article 16 of the Constitution of Rwanda of 2003 stipulates that all Rwandans are born and remain equal in rights and freedoms. Discrimination on the basis of physical or mental disability of any form or any other form of discrimination is prohibited and punishable by law.<sup>186</sup> The rights of PWDs is guaranteed under article 29(1) of the Constitution of Ghana of 1971.<sup>187</sup> The Constitution of Ghana further provides that PWDs shall not be subject to any form of exploitation or treatment which appear to be discriminatory, abusive, or degrading in nature.<sup>188</sup> Thus, in the context of Cameroon, the narrow definition of non-discrimination in the Constitution does not sufficiently protect the rights of PWDs, including women with disabilities.

Despite the right to information not recognised in the Constitution, it however recognises the right to education.<sup>189</sup> This could be used as grounds to access information, including SRHR information, which is pivotal to guide women, particularly women with disabilities to make informed decisions and choices regarding their reproductive autonomy, including information on procuring safe and legal abortion. Article 9 of the African Charter further accords everyone the right to receive information.<sup>190</sup> The right to information is imperative, as posited by Ngwena et al, even where abortion maybe legal, many women do not have access to information due to cumbersome administrative requirements or ignorance of the law by both women and health care providers.<sup>191</sup> This, therefore, implies that in health care facilities, when women with disabilities seek information about their reproductive health, such information should be conveyed in a respectful and confidential way, and information displayed or conveyed in disability-friendly materials such as the use of braille materials for visually impaired women, or sign language for those with sensory impairment.

---

<sup>185</sup> Constitution of Cameroon (n 183 above), art 22 of the Preamble.

<sup>186</sup> Constitution of Rwanda, 2003 art 16.

<sup>187</sup> Constitution of Ghana 1992, art 29(1).

<sup>188</sup> As above, art 29 (2-8)

<sup>189</sup> Constitution of Cameroon (n 183 above) art 18 of the Preamble.

<sup>190</sup> ACHPR (n 139 above) art 9.

<sup>191</sup> CG Ngwena et al 'Human rights advances in women's reproductive health in Africa' (2005) 129 (2) *International Journal of Gynaecology and Obstetrics* 184-187.

Though article 45 of the Constitution provides that Cameroon should align with all duly ratified international regional and sub-regional conventions, this is not always the case.<sup>192</sup> In the author's opinion, despite the many international and regional human rights treaties ratified by Cameroon, the state is obliged to take legislative measures to repeal national laws that conflict with international and regional human rights standards. The failure to do contributes to the continuous cycle of discrimination against women with disabilities.

### 3.3. Penal Code

Reed and Katzive argue that despite abortion being a medical procedure, its legal status is contained in penal codes, which historically have criminalised abortion.<sup>193</sup> Even with a restrictive law on abortion in Cameroon, article 339 of the Penal Code of 1967 authorises abortion on circumscribed grounds.<sup>194</sup> The Penal Code further provides in article 337(a) a woman who has an abortion or consents to it may be punished by imprisonment of 15 days to one year and/or a fine of 5000 CFA Francs (USD 7.96) to 200 000 CFA Francs (USD 318.38)<sup>195</sup> (b) anyone who procures an abortion for a year, even with her consent, may be punished by imprisonment of one to five years and a fine of 100 000 CFA Francs (USD 159.19) to 200 000 CFA Francs (USD 318.38)<sup>196</sup> (c) these penalties are doubled for any person who regularly performs illegal abortions and for persons who practices a medical profession or related profession<sup>197</sup> and lastly medical professionals may be forced to close their practices and cease to work in the field of medicine.<sup>198</sup>

As posited in the Bourne case, the abortion must be conducted by a physician, which is the same position in the Penal Code of Cameroon. The law provides that:<sup>199</sup>

The doctor shall obtain the opinion of two experts each chosen respectively from legal experts and members of the National Council of Medical Practitioners. The latter shall testify in writing that the life of the mother can only be safeguarded by means of intervention. The protocol of consultation shall be made in 3 copies one of which shall be handed to the patient and the other two to the consultant physician and legal expert. Besides, a protocol of the decision taken shall be sent by registered mail to the Chairperson of the National Council of Medical Practitioners.

---

<sup>192</sup> Constitution of Cameroon (n 183 above) art 45.

<sup>193</sup> B Reed & L Katzive 'Developments in laws on induced Abortion: 1998-2007 (2008) 34 (3) *International Perspectives on Sexual and Reproductive Health* 110-120.

<sup>194</sup> Penal Code of Cameroon (n 21 above) art 339.

<sup>195</sup> Penal Code of Cameroon (n 21 above) art 337 (1).

<sup>196</sup> As above, art 337 (2).

<sup>197</sup> As above, art 337 (3).

<sup>198</sup> As above, art 337 (4).

<sup>199</sup> C Cheka Legal aspects of family planning within the context of the reorientation of PHC in Cameroon. Part one: Contraception and Abortion. GTZ report 1996 (Unpublished).

This provision of the law is problematic on three fronts. First, in establishing the legally recommended team, second, women eligible for legal abortion might be ignorant of the law and lastly, the issue of third-party authorisation. Leke opines that obtaining legal abortion remains cumbersome.<sup>200</sup> Unfortunately, administrative bodies like the Society of Gynecologists and Obstetricians of Cameroon (SOGOC), the National Bar Association and the Cameroon Medical Council have been relatively silent towards pushing for a more liberal abortion law and policies. Ethiopia carried out a reform of its penal code in 2005 which liberalised its law on abortion.<sup>201</sup> This reform by the government was publicly supported by the Ethiopian Society of Obstetricians-Gynecologists (ESOG).<sup>202</sup> The issue of third-party authorisation is problematic and have been condemned by treaty bodies. General Comment 22 obliges states parties to repeal laws that hinder access to reproductive health services, including third-party authorisation for accessing abortion care.<sup>203</sup> The Committee on ESCR also noted that states must prevent private actors from establishing third-party authorisation requirements.<sup>204</sup> Third-party authorisation equally constitutes a violation of the right to privacy.

In the case of *L.M.R V Argentina*, the Human Rights Committee held that judicial authorisation for abortion services constituted a human rights violation, particularly the right to privacy of the victim.<sup>205</sup> *General Comment 22* provides that the abolition of the third-party authorisation requirement is not only limited to public health facilities but includes private medical facilities too.<sup>206</sup> While some countries such as Bolivia and Rwanda have taken steps to strike off the third-party authorisation when seeking safe abortion services, it is of the author's opinion that Cameroon has remained indifferent. In 2019, Rwanda struck off the judicial authorisation requirement for abortion, which permitted women, including women with disabilities over the age of 18 to access safe and legal abortion services without judicial authorisation.<sup>207</sup>

However, restricting access to abortion does not entirely prevent it from occurring, it rather leads to many women resorting to illegal abortion services when faced with unwanted pregnancies. Moreso, liberalising abortion laws and providing an enabling environment reduces the number of maternal mortalities. As

---

<sup>200</sup> RJI Leke 'Reducing maternal mortality through the prevention of unsafe abortion and their complication in Cameroon'. (2018) 8 *Gynecology and obstetrics* 60.

<sup>201</sup> SJ Holcombe 'Medical society engagement in contentious policy reform: the Ethiopian Society for Obstetricians and Gynecologists (ESOG) and Ethiopia's 2005 reform of its Penal Code on abortion' (2018) 3 *Health Policy* 583-591.

<sup>202</sup> Holcombe (n 201 above).

<sup>203</sup> CESCR General Comment 22 (n 155 above) para 41.

<sup>204</sup> As above.

<sup>205</sup> *L.M.R v. Argentina*, Human Rights Committee, Communication No.1608/2007, para 9.3, U.N. Doc. CCPR/C/101/D/1608/2007 (2011).

<sup>206</sup> CESCR, General Comment 22 (n 155 above) para 43.

<sup>207</sup> Ministerial Order of Rwanda, 2019, art 8.

posited by Jewkes et al, with the liberalisation of abortion laws in 1997, the number of women who died from abortion complications declined by 90 per cent over a 7-year period.<sup>208</sup> It is, therefore, clear that, there is a need to repeal Cameroon's Penal Code due to its lack of compliance with international jurisprudence. Cameroon's Penal Code still criminalises abortion in an era where many countries are decriminalising and liberalising their abortion laws. It further places third-party requirements, which makes it an entirely cumbersome process even when there is a legitimate reason to procure abortion services.

### 3.4. National health policies

Law No 90/03 of 4 January 1996 governs the law on health in Cameroon and article 2 provides that every citizen should have access to integrated and quality health care services.<sup>209</sup> This would include access to reproductive health care services, including access to safe and legal abortion services for everyone including women with disabilities. It should be noted that there are no official government statistics on the prevalence of unsafe abortion in Cameroon. Information on the prevalence of unsafe abortion is based on studies conducted by different academic scholars. In a 2015 study conducted by Ngowa et al in urban and rural areas of Cameroon, it was evident that out of the 134 of the 509 respondents (26.3 per cent) admitted to having had a voluntary induced abortion.<sup>210</sup> The study further revealed that 65 of the respondents (25.6 percent) in the urban setting and 69 (27.1 per cent) in the rural settings had had an induced abortion.<sup>211</sup> The study equally showed that among the respondents, 38 (29.3 per cent) had undertaken more than 01 induced abortion.<sup>212</sup> The study further revealed that the age group most represented were young women between the ages of 20-29 (55.2 per cent).<sup>213</sup> Ngowa et al further maintained that the results of the study depict that in spite of the restrictive nature of the abortion regime in Cameroon, a large number of Cameroonian women terminate unwanted pregnancies.<sup>214</sup> Tebeu et al asserted that 25 per cent of induced abortion often resulted in maternal mortality due to complications from unsafe abortion.<sup>215</sup> Given that access to contraception is equally restricted, the study analysed how the restrictions on access to modern contraception leads to high prevalence of unintended pregnancies, and most women resorting to procuring unsafe abortion services. Despite the clarion call and state obligations under international and regional

---

<sup>208</sup> Jewkes et al 'The Impact of age on epidemiology of incomplete abortion in South Africa after legislative Change' (2005) 112 *British Journal of Obstetrics and Gynaecology* 355.

<sup>209</sup> Republic of Cameroon Domain of Health Law of 4 January 1996 (96/03).

<sup>210</sup> Ngowa et al (n 9 above) 475-480.

<sup>211</sup> As above, 475-480.

<sup>212</sup> As above, 475-480.

<sup>213</sup> As above, 475-480

<sup>214</sup> As above, 475-480

<sup>215</sup> Tebeu et al, 'Maternal Mortality in Cameroon: a university teaching hospital report' (2015) 21 *Pan African Medical Journal*, 16.

human rights laws for women including women with disabilities to access modern contraception, this is not the case in Cameroon. Act No 90/035 authorises only pharmacists to sell contraceptives, unlike condoms which can be bought from non-pharmacists.<sup>216</sup>

Act No 90/035 on the Practice of the Profession of Pharmacists prohibits pharmacists from advertising birth control products or drugs that might lead to an abortion. Act No 90/035 also stipulates partner authorisation for married women seeking to access contraception. The question that arises from such provision is, what happens to unmarried women with disabilities? It is argued that this policy violates women's right to non-discrimination and equality against unmarried women who do not desire to have children and want to avoid unintended pregnancy. More so, the issue of partner authorisation equally violates women's rights to privacy and infringes on their right to reproductive autonomy to decide when to have children and the spacing of children.

Access to contraception is a critical aspect of the right to health.<sup>217</sup> Cameroon ratified CEDAW in 1984, which provides in articles 10 and 16 that women have the right to make decisions on the number and spacing of children.<sup>218</sup> *General Comment 36* provides that states parties should ensure women, men, boys and girls have equal access to quality information and education about SRHR, information on contraceptive methods and to prevent the stigmatisation of women and girls procuring abortion..<sup>219</sup> This includes that women with disabilities should have equal access to information on SRHR and should not be discriminated against on the basis of their gender and disability when seeking abortion services. This, further implies, that at health care facilities, information should be communicated in a manner that women whether suffering from hearing or a visual impairment, sensory or physical disabilities should be able to access educational information on contraceptives. Through the ratification of CEDAW, Cameroon is obligated to ensure that women with disabilities should have access to contraceptive services without any form of discrimination, and as a means of preventing an unwanted pregnancy. It also suggests that women with disabilities should have access to accurate educational information on the different contraceptive methods.

Cameroon lastly organised a national demographic and health survey in 2011 during which it was recorded that 94.4 per cent of women knew about contraceptive methods.<sup>220</sup> The report further stated that among

---

<sup>216</sup> Act No 90/035 on the Practice of the Profession of Pharmacists.

<sup>217</sup> Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/66/254 (2011), paras.44, 48. See also ICESCR, Art 12.

<sup>218</sup> CEDAW (n 81 above) arts10 & 16.

<sup>219</sup> General Comment 36 (2018) on art. 6 of the ICCPR, on the right to life, U.N. Doc., CCPR/C/GC/36 (2018), para.8

<sup>220</sup> Institute National de la Statistique (INS) et ICF International Enquete Demographique et de la Sante a l'indicateurs Multiplies du Cameroun (2011).

women, the usage of all contraception methods was 23.7 per cent, 16.1 per cent for modern methods, and 7.6 per cent for traditional methods.<sup>221</sup> In another study conducted by the Guttmacher Institute on Cameroon, it was recorded that in 2013, approximately 2.3 million sexually active Cameroonian women wanted to delay having a child (72 per cent) or wanted no child (28 per cent). However, the study found out that just 37 per cent of these women were using a modern contraceptive method, 18 per cent relied on traditional method and 45 per cent of women used no contraceptive method at all. The study concluded that the low level of contraceptive use results in the upsurge of unwanted pregnancies and increases the country's high prevalence of maternal mortality and illness.<sup>222</sup> Although the WHO discourages the use of abortion as a family planning method, family planning programs should however prioritise the prevention of unsafe and illegal abortion as a human rights and public health concern.<sup>223</sup> In recognition of the above, Vlassoff and Jerman opine that the use of modern birth control methods is fundamental to the prevention of maternal and child mortality, as it reduces the need for abortion, particularly illegal and unsafe abortion.<sup>224</sup> According to Njotang et al, since 2011, despite the use and access to modern contraceptives to fight against infant and maternal mortality, the prevalent use of modern contraception has shown only a slow increase, with a constant rise in maternal mortality.<sup>225</sup>

### 3.5. National laws on disability rights

The Constitution of Cameroon does not contain any specific provisions on PWD. However, Cameroon promulgated its first law relating to the protection of PWDs on 21 July 1983.<sup>226</sup> By 1990, Decree 90/1516 of 26 November was issued which was binding the modalities of the application of the law of 1983.<sup>227</sup> The medical and social models of disability are quite applicable in the context of Cameroon. By the law of 1983, the government issued special national identification cards to PWDs. PWDs could therefore use the identification cards to access financial, medical, and material assistance from the government. However, a study conducted on the rights of PWDs in Cameroon reveals that PWDs do not always benefit from this

---

<sup>221</sup> As above.

<sup>222</sup> Guttmacher Institute, 2016 <https://www.guttmacher.org/report/benefits-meeting-contraceptive-needs-cameroonian-women> (accessed 28 September 2021).

<sup>223</sup> D Shaw 'The ABCs of Family Planning' (2010). *The Partnership for Maternal, Newborn and Child Health*.

<sup>224</sup> J Jerman et al 'Benefits of meeting the contraceptive needs of Cameroonian women' (2014) Guttmacher Institute 1-18.

<sup>225</sup> PN Njotang et al 'Determinants of modern contraceptive practice in Yaoundé-Cameroon: A community based cross sectional study' (2017) 10 (1) *BMC Research Notes*, 219.

<sup>226</sup> Law no. 83/013 of 21 July 1983 relative to the protection of persons with disabilities.

<sup>227</sup> Decree no. 90/1516 of 26 November 1990 setting the modalities of application of law no 83/013 relative to the protection of persons with disabilities.

assistance as provided for in the 1983 law.<sup>228</sup>The focus on the social and medical models is an indication that the government has not taken cognisance of the human rights model of disability. This leaves gaps for continuous discrimination based on stereotypes that PWDs are not rights holders.

Although, Cameroon signed the CRPD in October 2008 without ratification. Law 2010/002 of 13 April 2010 was adopted by the government, which affirmed the promotion and protection of the rights of PWDs including women with disabilities.<sup>229</sup> Furthermore, article 282 of the Penal Code equally provides penal sanctions for violating or mistreating PWDs. Though the laws looked promising to guarantee the rights of PWDs, the national disability laws and policies have nonetheless been silent about the SRHR of women with disabilities. It is therefore no doubt that Cameroon is not compliant with its obligations under international and regional human rights standards.

---

<sup>228</sup> Meyer et al ‘Study on the Rights of Persons with Disabilities in Cameroon’ Report commissioned by the African Union of the Blind (AFUB) and the Cameroon National Association for the Blind (CNAB) in partnership with Disabilities Rights Promotion International (2007) 36 <http://www.yorku.ca/drpi/files/DRPICameroonRepEn.pdf> (accessed 12 July 2021).

<sup>229</sup> Law 2010/002 of 13 April 2010.

## CHAPTER FOUR

### **BARRIERS FACED BY WOMEN WITH DISABILITIES IN ACCESSING SAFE AND LEGAL ABORTION SERVICES IN CAMEROON**

This chapter will focus on examining the barriers faced by women with disabilities in accessing legal and safe abortion services in Cameroon. By examining such, the study would show how several factors intersect with disability to prevent women with disabilities from accessing safe and legal abortion services when they need to.

#### **4.1. Introduction**

Historically, disability has been used to justify the inequalities experienced by disabled people.<sup>230</sup> Johnson posits that the inequalities suffered by disabled women cannot solely be understood as a result of biological, cultural or socio-economic factors, but as an intersection of these factors.<sup>231</sup> Women and young girls with disabilities have the same right to reproductive and sexual health as persons without disabilities, but they are however often excluded from services needed to achieve their SRHR due to multiple factors.<sup>232</sup> The barriers that girls and young women with disabilities face to fulfil their SRHR are compounded by the variety and intensity of their disabilities<sup>233</sup> Whether suffering from cognitive deficiency, physical

---

<sup>230</sup> DC Baynton 'Disability and the justification of inequality in American history: In PK Longmore & L Usmank (eds) *The new disability history: American perspective* (2001).

<sup>231</sup> Johnson (n73 above).

<sup>232</sup> *Women and Young Persons with Disabilities: Guidelines for providing rights-based and gender-responsive services to addressing gender-based violence and sexual and reproductive health and rights 2018 publication Factsheets and briefing notes.*

<sup>233</sup> *Let me decide and thrive - Global discrimination and exclusion of girls and young women with disabilities.* Plan International 2017. [https://plan-international.org/uploads/2022/01/srhr\\_report\\_eng\\_web.pdf](https://plan-international.org/uploads/2022/01/srhr_report_eng_web.pdf) (accessed 30 January 2022).

immobility, or intellectual disability, PWDs and women with disabilities in particular face almost the same form of discrimination. PWDs, including women with disabilities encounter almost similar barriers to accessing safe and legal abortion services. Durojaye and Nabaneh equally posit that the concept of disability recognises multiple forms of discrimination.<sup>234</sup> The principle of non-discrimination is underpinned in the majority of human rights treaties<sup>235</sup> as well as under regional human rights frameworks.<sup>236</sup> The Committee on the CRPD notes that;<sup>237</sup>

The concept of intersectional discrimination recognises that individuals do not experience discrimination as members of a homogenous group, but, rather as individuals with multidimensional layers of identities, statuses, and life circumstances. It acknowledges the lived realities and experiences of heightened disadvantage of individuals caused by multiple and intersecting forms of discrimination, which requires targeted measures to be taken with respect to disaggregated data collection, constitution, policymaking, the enforceability of non-discrimination policies and the provision of effective remedies.

As reported by the International Federation of Gynecologists and Obstetrics (FIGO) countries around the world have committed to ensuring that women and girls have the right to make decisions about their health, bodies, and lives.<sup>238</sup> However, the right to make these decisions continue to be hindered by policy, legal, socio-cultural, and systematic barriers.<sup>239</sup>

#### 4.2. Policy-Level Barriers

Cameroon operates a restrictive abortion regime, where abortion is granted on circumscribed grounds. This restrictive abortion law affects women generally but becomes more complex for women with disabilities. Global data provides that restrictive laws on access to safe abortion do not necessarily reduce the incidents of abortion but lead to an upsurge in unsafe and illegal abortions.<sup>240</sup> Even when abortion can be sought on therapeutic grounds, the process to obtain such becomes very cumbersome, especially with regards to third party authorisation requirements. The third-party authorisation requirement compels an individual to obtain the consent of third parties beyond healthcare providers such as a parent, spouse, judge, or medical

---

<sup>234</sup> Durojaye & Nabaneh (n 158 above) 40.

<sup>235</sup> Art 2 ICCPR, art2 ICESCR.

<sup>236</sup> Art 2 ACHPR; art 2 Maputo Protocol.

<sup>237</sup> CRPD General Comment 3: Article 6: Women and girls with disabilities (2016) UN Doc CRPD/C/GC/3 dated 2 September 2016 <https://www.refworld.org/docid/57c977344.html> (accessed 21 January 2022).

<sup>238</sup> FIGO statement ‘Conscientious objection: a barrier to care’ (2021) The Global Voice for Women’s Health.

<sup>239</sup> As above.

<sup>240</sup> WHO & Guttmacher Institute , Worldwide, an Estimated 25 Million Unsafe Abortions Occur Each Year, <https://www.who.int/news/item/28-09-2017-worldwide-an-estimated-25-million-unsafe-abortions-occur-each-year> (accessed 28 January 2022).

committee, before they can access legal abortion services.<sup>241</sup> The effect of third-party authorisation requirements is exacerbated for women with disabilities. This is because they are more likely to be deprived of their legal capacity to make reproductive choices, thereby stripping them of their decision-making capacity.<sup>242</sup> However, the national disability policies have been silent on the SRHR of women with disabilities, including access to reproductive health care services and safe and legal abortion services. There are no specific provisions in any of the above-cited disability policies addressing the SRHR of women with disabilities.

Furthermore, Cameroon lacks a national comprehensive law or policies on disability rights to guarantee the SRHR of women with disabilities. Although Cameroon has promulgated national laws and decrees relative to the protection of PWDs, including women with disabilities, the laws and decrees have been silent on addressing the SRHR of women with disabilities. The lack of a comprehensive framework advocating for their SRHR, makes it difficult for women with disabilities to access safe and legal abortion services. Also, Cameroon has not ratified the CRPD, this therefore sets limitations for women with disabilities to fully exercise their SRHR including the right not to be discriminated against when seeking to procure safe abortion.

### **4.3. Service delivery barriers and financial implications for procuring abortion**

Women with disabilities may face barriers in accessing reproductive health services such as access to safe and legal abortion due to the physical inaccessibility of health services. This challenge of accessibility is not only limited to infrastructure but equally to equipment.<sup>243</sup> Many public primary healthcare systems are under resourced, with limited medical supplies, infrastructures, personnel, and disability friendly medical equipment. According to Wonkam et al, Cameroon's population is served by a total of 1500 physicians who practice mostly in public hospitals.<sup>244</sup> Moreover, while nurses and midwives are allowed to undertake Manual Vacuum Aspiration (MVA) in Cameroon, access to MVA is limited due to lack of training and MVA kits.<sup>245</sup> The lack of the MVA training for health care practitioners to operate such kits restricts their

---

<sup>241</sup> Center for Reproductive Health & Women Enabled Inc. available at <https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-third-party-authorization/> (accessed 29 January 2022).

<sup>242</sup> World Health Organization and UNFPA, Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note 6-7 (2009) [https://www.unfpa.org/sites/default/files/pub-pdf/srh\\_for\\_disabilities.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/srh_for_disabilities.pdf). (Accessed 29 January 2022).

<sup>243</sup> Center for Reproductive Health & Women Enabled Inc (n 241 above).

<sup>244</sup> A Wonkan et al, 'Knowledge and attitudes concerning medical genetics amongst physicians and medical students in Cameroon (sub-Saharan Africa) (2006) 8 *Genetics in Medicine* 331-38.

<sup>245</sup> F Tumasang et al 'Expanding the use of manual vacuum aspiration for incomplete abortion in selected health institutions in Yaounde, Cameroon' (2014) 126 (1) *International Journal of Gynaecology and Obstetrics* 28-30.

abilities to provide abortion services when the need arises. Women with visual impairment most often find it difficult to navigate around health care facilities and most times often accompanied by family relations and friends who serve as their guide. It, therefore, means that medical personnel are not adequately trained or prepared to deal with women with disabilities who seek reproductive health care services.

Due to economic factors arising from the high cost of procuring abortion services in public and private institutions, most women, particularly women with disabilities often resort to clandestine abortion services which are often less costly. This is because of the intersection of poverty and disability. In a recent study conducted by Mbuwir and Abanem on Cameroon, the average cost of procuring an abortion was 29 000 CFA Francs (USD 48), the minimum cost was 20 000 CFA Francs (USD33), and the maximum cost was 40 000 CFA Francs (USD67).<sup>246</sup> The study further revealed that this was possibly one of the reasons that women, including women with disabilities resort to procure cheaper abortion services, which are often offered clandestinely in the community. The study notes that even though the Penal Code of Cameroon provides grounds on which abortion can be procured, it however does not state that such services will be provided free of charge in public or private institutions. Therefore, even when there is a legitimate need to procure an abortion, the high financial cost, discrimination, and poverty intersect with disability and pushes women with disability to seek less costly, clandestine, and unsafe abortion services. As earlier alluded in preceding chapters, unfortunately, the medical administrative bodies like the SOGOC, the Cameroon Medical Council and the National Bar Association have been relatively silent towards pushing for improved access to SRH services and legislative reforms on penal laws governing access to abortion. Furthermore, the African human rights bodies have not made any comments about ensuring consensual access to modern contraceptives for PWDs on an equal basis with others. This therefore signifies an unmet need for the contraceptives for PWDs, particularly for women with disabilities.<sup>247</sup>

#### **4.4. Conscientious Objection**

Historically, the practice of conscientious objection were mostly common in the opposition to join to military service, based on ethical or religious grounds.<sup>248</sup> However, Cooks et al posit that the concept is progressively being used in certain medical procedures, particularly in the context of sexual and

---

<sup>246</sup> CB Mbuwir & EEB Abanem, “Abortion practices among women in Buea: a socio-legal investigation” (2019) 32 (146) *Pan African Medical Journal* 1-9.

<sup>247</sup> Women Enabled International: African regional human rights systems: Legal standards on the rights of women and girls with disabilities ‘(2021) 27.

<sup>248</sup> U Schuklenk ‘Conscientious objection in medicine: accommodation versus professionalism and the public good’ (2008) 126 (1) *British Medical Bulletin* 47-56.

reproductive health.<sup>249</sup> Conscientious objection refers to a physician's legitimate right not to provide medical services that infringe on their ethical or moral principles.<sup>250</sup> Many countries have adopted the concept as justification for the refusal of provision of abortion services for women, even when women have a legitimate reason to terminate a pregnancy.<sup>251</sup> Furthermore, conscientious objection in the context of abortion care refers to when an institution or healthcare provider refuses to provide abortion services or information based on his religious beliefs or conscience.<sup>252</sup>

Zampas and Ibanez opine that globally, several countries have incorporated conscientious objection provisions in statutes, including medical ethical standards applicable to reproductive care services.<sup>253</sup> The scope of conscientious objection clauses and the legal rights and obligations of patients and providers vary from country to country.<sup>254</sup> Bain et al argue that the right to seek abortion is dangerous in settings where conscientious objection for health care providers is not regulated by the law.<sup>255</sup> In the context of Cameroon, the government does not explicitly prohibit the practice of conscientious objection, implicit of this is that there is no ethical guidance regulating the applicability of the practice by health care providers and institutions. This therefore implies that, even in cases where abortion is authorised on circumscribed grounds, a health care provider or institution may decide to invoke his or her conscience and fail to exercise their duty of care. Nabaneh states that 'the absence of clear laws or guidelines regulating conscientious objection provides a conducive environment wherein health care providers can act within their 'own' interpretation of the law.'<sup>256</sup> This can therefore lead to the systematic abuse and misinterpretation of what the right entails.<sup>257</sup>

While Cameroon's health care system is governed by the ministry of public health, health services are provided for by public, private and traditional health care providers.<sup>258</sup> Wodon and Jill state that about 40

---

<sup>249</sup> R Cooks et al 'Reproductive health and human rights: Integrating medicine, ethics and law' (2003)

<sup>250</sup> A Faundes et al 'Conscientious objection or fear of social stigma and unawareness of ethical obligations' (2013) 123, *International Journal of Gynaecology and Obstetrics* 557-559.

<sup>251</sup> As above.

<sup>252</sup> 'Law and Policy Guide: conscientious objection' Centre for Reproductive Rights available at <https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-conscientious-objection/> (accessed on 22 July 2022).

<sup>253</sup> C Zampas & A Ibanez 'Conscientious objection to sexual and reproductive health services: International Human Rights Standards and European Law and Practice' (2012) *European Journal of Health Law* 231-256.

<sup>254</sup> As above.

<sup>255</sup> L Bain et al 'Mandatory pre-abortion counselling is a barrier to accessing safe abortion services' (2020) 35 (80) *Pan African Medical Journal* 220-243.

<sup>256</sup> Nabaneh (n 85 above) 6.

<sup>257</sup> R Kane 'Conscientious objection to termination of pregnancy: The competing rights of patients and nurses' (2009) 17 *Journal of Nursing Management* 907. (As cited in Nabaneh, see n85 above) 6.

<sup>258</sup> TE Tandi et al 'Cameroon public health sector: shortage and inequalities in geographical distribution of health personnel' (2015) 14 (43) *International Journal for Equity in Health*.

per cent of health care services is provided by private sector which comprises of non-governmental organisations, faith-based and private institutions.<sup>259</sup> Cameroon has a fragile health care system and challenges to access safe and legal abortion become more exacerbated by the lack of regulatory frameworks for conscientious objection, specifically where faith-based and private health care providers object to provide abortion services and other contraceptives based on their religious, moral, and conscientious beliefs.<sup>260</sup> Awasom-Fru et al opine that while the catholic church as a faith-based institution remains one of the largest health care providers in Cameroon, their role in providing sexual and reproductive healthcare services such as safe and legal abortion services is restricted by religious norms and morals.<sup>261</sup>

In May 2022, Awasom-Fru et al conducted a study in catholic health care facilities in the conflict-prone North-West region of Cameroon, focusing on access to sexual and reproductive health care services for women generally. The study provided that doctors employed in these catholic health facilities were expected to abide by the norms of the Catholic Church, which includes a ban on advising, performing, or prescribing any form of modern family planning and a ban on the prescription of emergency contraceptives in the event of rape or incest.<sup>262</sup> The study further provided that faced with an increasing demand for emergency contraceptives, the situation remained a dilemma for health care providers who tried to find a balance between the hospital's conscientious objection and their moral duties to the patients.<sup>263</sup> To overcome this challenge, the study provided that doctors often sought ways to navigate the challenge of conscientious objection by referring patients to other health care facilities, though catholic hospitals are against referrals.<sup>264</sup> To this, Agejo posits that lack of regulatory frameworks, the inability to make referrals and advise on family planning increased the surge on backstreet abortions.<sup>265</sup> As posited by Faila and Arthur, the lack of regulation of conscientious objection has negative consequences in a country with lots of objectors.<sup>266</sup>

According to Freeman and Coast, in countries where the practice of conscientious objection reduces the number of health care providers, it is likely that women, including women with disabilities seeking abortion

---

<sup>259</sup> O Jill & Q Wodon 'playing broken telephone: assessing faith-inspired health care provision in Africa' (2012) 22 (5-6) *Development in Practice* 819-834.

<sup>260</sup> Awasom-Fru et al 'Doctors' experiences providing sexual and reproductive health care at catholic hospitals in the conflict-affected North-West region of Cameroon: a qualitative study' (2022) 19 (1) *Reproductive Health*, 126.

<sup>261</sup> Faundes et al (n 250 above).

<sup>262</sup> As above.

<sup>263</sup> As above.

<sup>264</sup> As above.

<sup>265</sup> PA Agejo 'Legal framework to gender-based violence, sexual and reproductive health rights of indigenous women in Cameroon' (2019) 11 (4) *African Journal of Legal Studies* 371-387.

<sup>266</sup> Fiala & Arthur 'There is no defense for conscientious objection in reproductive health' (2017) 216 *European Journal*

services, will either face challenges in obtaining safe abortion services, resort to illegal abortion or continue their unwanted pregnancy.<sup>267</sup>

The right to freedom of religion, conscience and thought is guaranteed and regulated in a majority of international and regional human rights legal instruments. This is guaranteed in article 18 of the UDHR<sup>268</sup> and article 18 of the ICCPR.<sup>269</sup> At the regional level, the freedom of conscience is guaranteed in article 8 of the African Charter.<sup>270</sup> However, despite the right of a practitioner to exercise the right to freedom of religion, conscience and thought, the Committee on ESCR emphasised in its *General Comment 22* on the right to sexual and reproductive health, that the exercise of conscientious objection must not be a barrier to access reproductive health services.

FIGO also recognises that while health care providers should not be discriminated against or disrespected for invoking the conscientious clause, in the event where they invoke such and are unable to provide abortion services, they must ensure the provision of appropriate and prompt referrals for women seeking abortion services.<sup>271</sup> The obligation to ensure referrals by health care providers who invoke conscientious objection has also been reiterated by human rights treaty bodies. In *General Recommendation No 24*,<sup>272</sup> the Committee on the Elimination of All Forms of Discrimination against women has reaffirmed that in circumstances where the health care provider invokes conscientious objection, women, including women with disabilities must be referred to alternative health care providers. Referring to *General Comment 2* on interpreting the provisions of article 14 of the Maputo Protocol, states have the obligation to ensure that health providers must refer women, including women with disabilities when they invoke conscientious objection and should equally ensure that women are adequately informed of such decision.<sup>273</sup> It further provides in para 48<sup>274</sup> that states have the obligation to create an enabling political framework in which health care providers do not deny women access to safe abortion information and services.

#### **4.5. Lack of access to education and information on reproductive rights**

---

<sup>267</sup> E Freeman & E Coast 'Conscientious objection to abortion: Zambian health care practitioners' beliefs and practices' (2019) 221 *Social Sciences and Medicine* 106-114.

<sup>268</sup> UDHR (n 106 above) art 18.

<sup>269</sup> ICCPR art 18.

<sup>270</sup> ACHPR (n 139 above) art 8.

<sup>271</sup> FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health 'Ethical Guidelines on conscientious objection' (2006) 14 (27) *Reproductive Health Matters* 148-149.

<sup>272</sup> Committee on CEDAW General Recommendation 24: art 12 of the Convention (Women and Health) (1999): A54/38/rev 1, chap 1.

<sup>273</sup> African Commission General Comment no.2 (n 114 above) para 26.

<sup>274</sup> As above, para 48.

Accurate and timely information is essential to exercise reproductive health rights and when making an informed choice to seek medical intervention such as abortion services.<sup>275</sup> The lack of information and education on SRHR and reproductive health services acts as a barrier in accessing safe and legal abortion services, especially when there is a legitimate need for it. Though this restriction on access to information affects women generally, it is more compounding for women with disabilities who often face challenges in accessing these information due to the different forms of disabilities. As posited by Frohmader and Ortoleva, there is an insufficiency of accessible and relevant information for women with disabilities on issues pertaining to sexual and reproductive rights.<sup>276</sup> *General Comment 22* provides that health facilities, goods, information and services related to sexual and reproductive health care should be accessible to all individuals and groups without discrimination and free from barriers.<sup>277</sup> Health care facilities should be able to provide relevant information, in ways suitable for access by women with disabilities.

As posited by Moazzam and Nguyen, quality information on birth control methods contraceptive and services provides the freedom for people to decide the number and spacing of their children, which improves maternal and child health.<sup>278</sup> This implies that access to quality information on contraceptive use helps women generally, and specifically women with disabilities to determine whether and when to have children to prevent unwanted pregnancies. Similarly, Roberts opines that information on SHRH, and reproductive health care services are often obtained in formal educational setting, health institutions, and from parents.<sup>279</sup>

As earlier alluded, though the Constitution of Cameroon does not explicitly guarantee the right to information, it, however, guarantees the right to education. Law No 2010/002 addresses special education for PWDS which provides that children and adolescents with disabilities shall have access to education.<sup>280</sup> This implies PWDS, specifically women with disabilities should have the right to obtain relevant information on SRHR including information on birth control methods, how to access safe and legal abortion, and other reproductive health information. Furthermore, the Education Framework Act No. 98/004 of 14 April 1998 provides that the government should ensure equal educational opportunities for everyone without any form of discrimination on the grounds of disability, sex, political, social, linguistic, philosophical, or

---

<sup>275</sup> Center for Reproductive Rights & Women International Inc. 98.

<sup>276</sup> C Frohmader & S Ortoleva 'The sexual and reproductive rights of women and girls with disabilities' (2013) 3 Issue Papers International Conference on Human Rights 4-5.

<sup>277</sup> General Comment 22 of the CESCR (n 114 above) para 15.

<sup>278</sup> A Moazzam & TT Nguyen 'Defining counselling in contraceptive information and services: outcomes from an expert think tank' (2022) 48 (2) *BMJ Sexual and Reproductive Health* 1.

<sup>279</sup> GS Roberts 'Sexuality and HIV/AIDS education among deaf and hard of hearing students' (2006) 22 (1) *Deaf Worlds* 111-139.

<sup>280</sup> Law No 2010/008 of 2020, sec.3.

religious views.<sup>281</sup> However, despite the right to education and implicitly the right to obtain information, the government still operates a restrictive law to access information on SRHR and other reproductive health services such as safe and legal abortion and the use of contraceptives. Act 80/10 of 14 July 1980 prohibits the display, distribution, and making of speeches in public places or meetings, or the distribution of books, scripts, printed advertisement, posters, pictures, and drawings of symbols that can provoke or facilitate abortion.<sup>282</sup> I opine that the intersectionality of inequality and disability prevents PWDs, including women with disabilities to access educational opportunities which limits their ability to obtain relevant information. Assifi et al, are of the opinion that with the lack of knowledge and information on the national laws regulating abortion, even when women, including women with disabilities meet the conditions for a legal abortion, they may not be aware of such rights.<sup>283</sup> The inability of women with disabilities to access relevant information on SRHR and services in accessible formats increases their vulnerability to carry unwanted pregnancies.<sup>284</sup> This implies lack of access to relevant information forces women with disabilities to carry unwanted pregnancies or resort to unsafe and clandestine abortion services, which in turn violates their right to reproductive autonomy.

Already faced with a disability, disinformation about the safety of abortion may prevent women, especially women with disabilities from seeking safe abortion services for fear of further disability-related complications. Misconceptions and misinformation about abortion intersect with disability and cause women with disabilities to carry a pregnancy to full term against their wish. In the Mexican case of *Ramirez Jacinto V Mexico*,<sup>285</sup> a minor who had sought a lawful abortion on the grounds of rape got misinformed by the doctor treating her, who exaggerated the risk of abortion. The doctor further claimed that the mother of the minor would solely bear the responsibility if the minor were to die.<sup>286</sup> This deterred the minor from procuring the planned legal abortion. *General Comment 22* of the Committee on ESCR reiterated that access to information includes the right to seek, receive and disseminate information and ideas concerning sexual and reproductive health issues generally and for individuals to receive specific information on their particular health status.<sup>287</sup> In Cameroon, this means women with disabilities owing to their different forms of disabilities should be able to access sexual and reproductive health information in disability material

---

<sup>281</sup> Education Framework Act No. 98/004 of 14 April 1998.

<sup>282</sup> Law No 80-10 of 14 July 1980.

<sup>283</sup> Assifi et al 'Women's awareness and knowledge of abortion Laws: A Systematic Review (2016) 11 (13) *PLOS ONE*.

<sup>284</sup> TE Tandi et al (n 258 above).

<sup>285</sup> *Ramirez Jacinto V Mexico*, Case 161/102/ Inter-American Committee on Human Rights, Report No. 21/07, OEA/Ser.L/V/II.130, doc. 22, rev. 1 (2007).

<sup>286</sup> As above.

<sup>287</sup> General Comment No. 22, Committee on ESCR (n 114 above).

materials such as in braille and sign language. Women with disabilities should have access to unbiased, non-discriminatory, and evidence-based information during pregnancy.

In addition to the challenges faced in obtaining information, Cameroon lacks a national training framework for educators and health professionals in the education and sharing of information with PWDS.<sup>288</sup> Most health professionals are not trained to deal with PWDs, hence the challenge for women with disabilities to freely share confidential information or obtain confidential reproductive health services such as safe abortion, use of contraceptives and other birth control methods. When women with disabilities experience the above range of barriers in accessing essential information on reproductive health care service such as safe and legal abortion services, and are forced to carry unwanted pregnancies, this violates their right to reproductive autonomy and the enjoyment of SRHR.

#### **4.6. Religious and social stigmatisation**

Women with disabilities live at the intersection of two movements, which include protecting their reproductive autonomy, reproductive health rights, including access to safe and legal abortion, and dismantling harmful disability related stigma.<sup>289</sup> According to Adamczyk, research has shown that there exists a strong interconnectedness between individual religiousism and negative attitudes toward abortion.<sup>290</sup> Similarly, Haffner is of the opinion that, religious leaders are important in their faith communities. Haffner further establishes that these religious leaders may influence attitudes toward sexual and reproductive rights, norms, and behaviour at different levels including at the family, community, or individual levels.<sup>291</sup> Haffner also posits that previous research found links between religiosity and experiences of abortion and it is “often the religious voices that oppose sexual and reproductive rights”.<sup>292</sup> In Cameroon, induced abortion is highly contentious and illegal. The Roman Catholic church to which 37 per cent of Cameroonians belong to, considers seeking a safe abortion immoral and consider it an ‘artificial’ form of birth control.<sup>293</sup> With the high levels of religiosity of the Cameroon population, the religious

---

<sup>288</sup> UNESCO, Inclusion in Education, <https://www.unesco.org/en/education/inclusion> (accessed 20 July 2022).

<sup>289</sup> Women Enabled International ‘Abortion and disability: Towards an intersectional human rights-based approach’ (2020).

<sup>290</sup> A Adamczyk ‘The effect of personal religiosity on attitudes toward abortion, divorce, and gender equality - Does cultural context make a difference?’ (2013) 43(1) *EurAmerica* 213-53.

<sup>291</sup> DW Haffner *A time to embrace why the sexual and reproductive justice movement needs religion* (2015).

<sup>292</sup> As above.

<sup>293</sup> S Schuster ‘Abortion in the moral world of the Cameroon Grassfields’ (2005) 13 (26) *Reproductive Health Matters* 130-138.

disapproval of abortion has implications for women, including women with disabilities seeking safe abortion.

Global health literature characterises social norms as peoples' beliefs about what others in a group do, what is approved of or disapproved of. These social norms determine the type of sanction or rewards that should be meted to people who engage in certain behaviour.<sup>294</sup> One of such sanction is social stigma. Makleff et al opine that while abortion is a core element in sexual and reproductive health care, yet social norms and stigma prevent women from seeking legal and safe abortion services.<sup>295</sup> This becomes more exacerbated for women with disabilities who already experience multiple forms of social stigma due to their disability. Manifestations of abortion stigma may influence women's ability to exercise their reproductive autonomy.<sup>296</sup>

---

<sup>294</sup> 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.

<sup>295</sup> As above.

<sup>296</sup> AM Sorhaindo et al 'Qualitative evidence on abortion stigma from Mexico City and five states in Mexico' (2014) 54 (7) *Women Health* 622-40.

## CHAPTER FIVE

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1. Introduction

In this study, I analysed the right to access safe and legal abortion services for women with disabilities in Cameroon using a human- right based and intersectionality approach. I discussed that while women have a right to access safe and legal abortion services, it is usually more challenging for women with disabilities due to the intersection of disability and other factors. The study examined how Cameroon’s restrictive law on abortion, third party authorisation, poverty, religion and social stigma, high cost of procuring abortion and lack of access to SRHR information intersect with disability and hinder women with disabilities from accessing safe and legal abortion services. The study acknowledges that UN Treaty Monitoring Bodies have issued general comments, general recommendations and concluding observations have provided clear guidance on how governments can enact laws to ensure the fulfillment of the SRHR of women with disabilities especially in the context of Cameroon. The study also points to the fact that Cameroon has ratified many international and regional human rights that guarantee women’s right to abortion, including women with disabilities. However, its national laws, health policies, and social structures are not fully compliant with the obligations provided in the various human rights instruments. International and regional human rights laws require states to take measures to address the underlying causes of inequality for PWDs. This includes women with disabilities, by ensuring they have access to essential services and support needed to enjoy SRHR and access reproductive health services on an equal basis, including the ability to procure safe and legal abortion services.

Generally, the study acknowledges that PWDs, including women with disabilities and access to safe and legal abortion services are normatively protected by international and regional human rights frameworks. However, in the context of Cameroon, multiple identities intersect with disability which prevents women with disabilities from accessing safe and legal abortion. While one can assume that the restrictive abortion law aims at ensuring the protection of the right to life, the criminalisation of abortion violates women’s right to reproductive autonomy. While countries such as Ethiopia, South Africa have decriminalised abortion by

allowing those faced with unwanted pregnancies to seek legal and safe abortion without risking their lives through unsafe and clandestine abortion. The findings of this study have shown the high prevalence of maternal mortality in Cameroon as a result of unsafe abortion due to multiple barriers which prevent women with disabilities from accessing safe and legal abortion, it is therefore imperative for Cameroon to decriminalise abortion.

## **5.2. Recommendations**

### **5.2.1 Policy level change**

As mentioned above, human rights treaty bodies have urged that state parties to fulfill their obligations towards guaranteeing the SRHR and access to reproductive health care services for women with disabilities. This can only be achieved when the state party in question has ratified the human rights instrument. Cameroon has signed but not ratified the CRPD. The CRPD stands as the most comprehensive legal document that protects the rights of PWDs, including women with disabilities. In order for women with disabilities to fully exercise their SRHR, access safe and legal abortion services and other reproductive health services, this study recommends that the government should ratify the CRPD as a first and important step towards fulfilling its obligations to protect and promote the rights of PWDs. This study also urges that the government to take steps towards signing the African Disability Rights Protocol.

The government should carry out penal reforms by decriminalising abortion and expanding the grounds on which abortion can be procured. This would imply that professional bodies such as the Cameroon Medical Council, and the National Bar Association, should act in synergy and advocate for legal reforms decriminalising abortion and expanding the grounds for abortion, as done in Ethiopia. The study identified huge financial cost as one of the economic factors that prevents women with disabilities from accessing safe and legal abortion services. Though the penal code provides grounds on which abortion can be procured, it, however, fails to provide that such services should be provided free in public institutions. This study recommends that abortion should be decriminalised, and the services provided for free in health institutions. This will deter women, particularly women with disabilities from resorting to illegal and unsafe abortion service providers.

The government should establish comprehensive disability rights policies that incorporate the reproductive health rights needs of women with disabilities. As earlier mentioned, though Cameroon has issued decrees and laws protecting the rights of persons with disabilities, these laws have been silent on the SRHR needs of women with disabilities. This study therefore recommends that the government should draft and establish

a comprehensive disability right framework that will include the language of SRHR, access to reproductive health care services, including the right to seek abortion.

There is need for the government to eliminate third-party authorisation requirements and the cumbersome process for procuring abortion. In Cameroon, abortion can only be legally procured when authorised by two medical doctors, and in some cases, spousal consent is needed. These third-party authorisation shifts a woman's right over her reproductive autonomy to a third-party. More so, the cumbersome process of getting authorisation pushes women generally, and women with disabilities to seek the faster, illegal, and unsafe means.

The government should create an enabling environment wherein women in general and particularly women with disabilities can procure abortion. As posited by Hessini *et al*, destigmatisation of abortion and a positive attitude towards women seeking to procure abortion is fundamental to the development of a conducive environment.<sup>297</sup> This implies having ready access to health care facilities, nurses and doctors are trained to deal with women with disabilities and ensure the fulfillment of their SRHR. The government should ensure health care facilities have a disability - friendly equipment, and services such as braille materials, disability friendly equipment, and transportation service. Manual Vacuum Aspirators should be provided in health care facilities and personnel trained on how to use this equipment, to provide timely and efficient services.

### **5.2.2 Addressing conscientious objection through regulatory frameworks.**

According to Brooke *et al*, invoking conscientious objection hinders the provision of abortion services, which in turn creates a risk to women's health and the enjoyment of their sexual and reproductive rights.<sup>298</sup> Brooke *et al* further posit that to eliminate the barrier of conscientious objection, States should implement regulations for health care providers on how to invoke conscientious objection without jeopardising women's access to legal abortion services.<sup>299</sup> This is quite important in the context of Cameroon. As earlier alluded to the preceding chapter, conscientious objection in health care is not mentioned in any legal document. This, therefore, creates a fluid interpretation of the concept by healthcare providers, who may narrowly interpret the meaning and fail to uphold their duty to care. Therefore, the government should put

---

<sup>297</sup> L Hessini *et al* "Global policy change and women's access to safe abortion: The impact of the World Health Organization's Guidance in Africa" (2006) 10 (3) *African Journal of Reproductive Health* 14-27.

<sup>298</sup> BR Brooke *et al* 'Conscientious objection to provision of legal abortion care' (2013) 123 (3) *International Journal of Gynaecology and Obstetrics* 2.

<sup>299</sup> As above, 22.

in place regulatory frameworks to govern conscientious objection in line with FIGO guidelines. This will enable women seeking abortion services to have timely referrals.

### **5.2.3 Repeal laws and policies that discriminate against women with disabilities.**

Women with disabilities are discriminated against in all facets of society. These discriminatory practices range from stereotypes about their sexuality, to exercise their reproductive autonomy, access to information and education on SRHR amongst others. Several human rights treaty bodies have called on state parties to take all necessary measures to repeal laws and policies that discriminate against women with disabilities and prevent them from accessing safe and legal abortion services. The CEDAW Committee in its Concluding Observation on Cameroon has urged the government to take concrete steps towards law reforms that are discriminatory against women to ensure compliance with the different human rights treaties ratified by Cameroon.<sup>300</sup> Furthermore, the ESCR Committee in its 25 March 2019 Concluding Observation on Cameroon called on the government to adopt anti-discrimination laws in accordance with article 2(2) of the Covenant.<sup>301</sup> Referring to *General Comment 20* on non-discrimination, the Committee on ESCR considers that the denial or unequal access to reproductive health services, including access to safe and legal abortion services is discriminatory.<sup>302</sup> In this regard, this study recommends that the repeal of discriminatory laws and policies will eliminate the barriers that prevent women with disabilities from accessing safe and legal abortion services.

### **5.2.4 Access to information and education on SRHR including access to safe and legal abortion services**

Though the right to information is not expressly guaranteed in the Constitution of Cameroon, the Constitution however guarantees their right to education.<sup>303</sup> The right to education could be used as grounds to access information, including sexual and reproductive health and rights education. Information and education on sexual and reproductive health and rights will guide women, particularly women with disabilities to make informed choices over their reproductive autonomy, to be aware of their right to seek abortion services when required, their right to decide whether or not to keep a pregnancy. The African Commission in General Comments 1 and 2 calls on states to ensure education and information on sexual

---

<sup>300</sup> Concluding Observation on the Combined fourth and fifth periodic reports of Cameroon, CEDAW Committee (28 February 2014), UN Doc. CEDAW/C/CMR/CO/4-5.

<sup>301</sup> Concluding Observation on the fourth periodic report of Cameroon, ESCR Committee (25 March 2019) UN Doc E/C. 12/CMR/CO/4.

<sup>302</sup> General Comment No 20 ESCR Committee (n 13 above).

<sup>303</sup> Constitution of Cameroon (n 184 above) art 18 of the Preamble.

and reproductive health and rights issues are accessible by all, this includes women with disabilities.<sup>304</sup> It further recommends that comprehensive sexuality education should address taboos and misconceptions about sexual and reproductive health rights issues, specifically those that perpetuate stereotypes harmful to women's health and wellbeing. This implies deconstructing misconceptions about women with disabilities perceived to be sexually inactive.

The government should ensure the free dissemination of sexual and reproductive health rights education and information in all public and private health care facilities, and information should be disseminated in disability friendly language and use of disability friendly materials for such. Furthermore, the government will need to repeal Act 80/10 of 1980 and Act 90/035 which prohibits the advertisement of birth control products that may lead to an abortion.

In conclusion, this study emanated from the gaps in research on women with disabilities in the context of accessing safe and legal abortion services in Cameroon. It questions why despite the existing international and regional human rights frameworks that guarantee the right to abortion, and to which Cameroon is a state party, women with disabilities still encounter a myriad of barriers that prevents them from safely procuring abortion. This study concludes that issues pertaining to disability are understood from medical and social perspectives rather than from a rights-based approach. The study further concludes that generally, while it is challenging for women to procure safe abortion, it becomes more cumbersome for women with disabilities as stigmatisation, restrictive abortion law, lack of comprehensive disability rights policies, the high cost of procuring abortion, conscientious objection intersect with disability and hinder women with disabilities from accessing safe and legal abortion.

---

<sup>304</sup> African Commission Comments 2 (n 15 above) para 26.

**Word Count: 20,694, (including footnotes, excluding bibliography, front page, abbreviation, and table of contents.).**

## **Bibliography**

### **Books and book chapters**

Baynton, DC *Disability and the justification of inequality in American History: In PK Longmore & L Usmank (eds) The new disability history: American perspective* (New York University 2001).

Carlson, L *'The faces of intellectual disability: Philosophical reflections'* (Indiana University Press 2009)

Creamer, D *'Disability and christian theology: Embodied limits and constructive possibilities'* (Oxford University Press 2009)

Duyan, V *'The community effects of disabled sports'* in Centre of excellence defence against terrorism *Amputee sports for victims of terrorism* (IOS Press 2007) 70-77.

Fathalla, MF *'Abortion and public health ethics'* in AC Mastroianni et al. *The Oxford Handbook of Public Health Ethics* (2019) 403-414.

Jeffe, C *'Abortion and medicine: a sociopolitical history'* in Paul, M et al (eds.) *Management of unintended and abnormal pregnancy* (Wiley Blackwell 2009)

Giddens, A *Sociology*, 5th ed. (Polity Press 2006)

*Olkin, R What psychotherapists should know about disability* (1999) Guildford Press, New York.

## Journal articles

Adamczyk, A 'The Effect of Personal Religiosity on Attitudes Towards Abortion, Divorce, and Gender Equality: Does Cultural Context make Difference' (2013) 43 (1) *EurAmerica* 213-53.

Ade CM 'The legal status of juveniles in Cameroon' (2001) 25 (2) *International Journal of Comparative and Applied Criminal Justice*, 149-165.

Anderson, P & Kitchin, R. 'Disability, space, and sexuality: access to family planning services' (2005) 51 (8) *Social Science Medicine* 1163-73.

Addlakha, R et al 'Disability and sexuality: claiming sexual and reproductive rights' (2017) 25 (50) *An International Journal on Sexual and Reproductive Health and Rights* 4-9.

Agejo, PA 'Legal framework to gender-based violence, sexual and reproductive health rights of indigenous women in Cameroon' (2019) 11 (4) *African Journal of Legal Studies* 371-387.

Amponsah-Bediako, K 'Relevance of disability models from the perspective if a developing country: An Analysis' (2013) 3 (11) *Developing Country Studies, E-Journal* 123.

Areheart, BA 'Disability trouble' (2011) 29 *Yale Law and Policy Review* 348.

Assifi, AR et al 'Women's Awareness and knowledge of Abortion Laws: A Systematic Review (2016) 11 (13) *PLOS ONE*.

Awasom-Fru, A et al 'Doctors' experiences providing sexual and reproductive health care at Catholic hospitals in the conflict-affected North-West region of Cameroon: a qualitative study' (2022) 19(1) *Reproductive Health*, 126.

Bain, LE et al 'Mandatory pre-abortion counselling is a barrier to accessing safe abortion services' (2020) 35 (80) *Pan African Medical Journal* 220-243.

Ballan, MS 'Disability and Sexuality within social work education in the USA and Canada: The social model of disability as a lens for practice (2008) 27 (2) *Social Work Education* 194-202.

Basson, Y 'State obligations in international law related to the right to an adequate standard of living for person with disabilities' (2017) 21, *Law, Democracy and Development*.

Barry, M 'Abortion at over 20 weeks' Gestation: Frequently Asked Questions' (2018) *Congressional Research Service* 4.

Bearak, J et al 'Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019' (2020) 8 (9) *The Lancet Global Health* 1.

- Berer, M 'Abortion law and policy around the world' (2017) 19 (1) *Health Human Rights* 13-27.
- Bongaarts, J & Westoff, C 'The Potential Role of Contraception in Reducing Abortion' (2000) 31 *Studies in Family Planning* 193-202.
- Brooke, RJ et al 'Conscientious objection to provision of legal abortion care' (2013) 123 (3) *International Journal of Gynecology and Obstetrics* 2.
- Calves, AE 'Abortion risk and decision making among young people in urban Cameroon' (2002) 33 (3) *Studies Family Plan* 249-60.
- Cook, R & Dickens, B 'Abortion Laws in African Commonwealth Countries' (1981) 25 (2) *Journal of African Law* 60-79.
- Crenshaw, K 'Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics: *University of Chicago Law Forum* 131-167.
- Dickens, B & Cook, R 'Development of Commonwealth Abortion Laws' (1979) 28 (3) *The International and Comparative Quarterly* 424-427.
- Durojaye, E 'The approaches of the African Commission to the right to health under the African Charter' (2013) 17, *Law, Democracy and Development*.
- Durojaye, E & Nabaneh S 'Human rights and access to health care for persons with albinism in Africa' (2019) 7 *African Disability Rights Yearbook* 35-58.
- Faundes, A et al 'Conscientious objection or fear of social stigma and unawareness of ethical obligations' (2013)123 (3), *International Journal of Gynecology and Obstetrics*.
- Fiala, C & Arthur, JH 'There is no defense for conscientious objection in reproductive health' (2017) 216 *European Journal of Obstetrics and Gynaecology and Reproductive Biology* 254-258.
- Finer, L & Fine, JB 'Abortion law around the world: progress and pushback, (2013) 10 (34) *American Journal of Public Health*.
- Fine, JB et al, 'The role of international human rights Norms in the Liberalisation of abortion laws globally' (2017) 2 *Health and Human Rights Journal*.
- FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health 'Ethical Guidelines on conscientious objection' (2006) 14 (27) *Reproductive Health Matters* 148-149.
- Freeman, E & Coast, E 'Conscientious objection to abortion: Zambian health care practitioners' beliefs and practices" (2019) 221 *Social Sciences and Medicine* 106-114.

- Ganatra, B et al. 'Global, regional, and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian historical model' (2017) 390 (10110). *Lancet*. 2372-81.
- Gostin, LO & Gable, L 'The Human Rights of Persons with Mental Disabilities: A global perspective on the application of human rights principles to mental health' (2004)63 *Maryland Law Review* 20.
- Green, D 'The Abortion Act 1967' (1968) 8 (1) *The British Journal of Criminology* 82-86.
- Hall, AL 'Memorandum submitted to the House of Commons Science and Technology Select Committee inquiry: Scientific developments relating to the Abortion Act 1967 (2007) *History and Policy*.
- Hessini, L et al 'Global Policy change and Women's Access to Safe Abortion: The impact of the World Health Organization's Guidance in Africa (2006) 10 (3) *African Journal of Reproductive Health* 14-27.
- Holcombe, SJ 'Medical society engagement in contentious policy reform: the Ethiopian society for Obstetricians and Gynecologists (ESOG) and Ethiopia's 2005 reform of its penal code on abortion'. (2018) 3 *Health Policy* 583-591.
- Hurst, H 'The status of the Universal Declaration of Human Rights in national and international law' (1995) 25 *Georgia Journal of International and Comparative Law* 287.
- Jewkes, R et al 'The Impact of Age on Epidemiology of Incomplete Abortion in south Africa After Legislative Change' (2005) 112 *BJOG* 355-59.
- Jill, O & Wodon, Q 'playing broken telephone: assessing faith-inspired health care provision in Africa' (2012) 22 (5-6) *Development in Practice* 819-834.
- Johnson, A 'Hush woman! The complex 'Disabled' woman in Nigeria's legal and human rights framework: A Deconstruction' (2020) *African Disability Yearbook*.
- Kane, R 'Conscientious objection to termination of pregnancy: The competing rights of patients and nurses' (2009) 17 *Journal of Nursing Management* 907.
- Kayess, R & French, P 'Outfit of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities' (2008)8 *Human Rights Law Review* 1-34.
- Laisidou, A 'Intersectional understandings of disability and implications for a social justice reform agenda in education, policy and practice. (28 (3) *Disability and Society* 299-312.
- Leke, RJI 'Reducing maternal mortality through prevention of unsafe abortion and their complication in Cameroon'. (2018) 8 *Gynecology and obstetrics* 60.

- Lord, J & Stein, M 'Prospects and practices for CRPD implementation in Africa' (2013) *African Disability Yearbook* 100.
- Makleff, S 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.
- Mavusa, SS & Maharaj, P 'Access to sexual and reproductive health services: Experiences and perspectives in Durban, *South Africa Agenda*, (2015) 29 P. 79-88.
- Mbuwir, CB & Abanem, EEB 'Abortion practices among women in Buea: a socio-legal investigation'. (2019) 32 (146) *Pan African Medical Journal*.
- Moazzam, A & Nguyen, TT 'Defining counselling in contraceptive information and services: outcomes from an expert think tank' (2022) 48 (2) *BMJ Sexual and Reproductive Health*.
- Moodley, J & Graham, L 'The importance if intersectionality in disability and gender studies' (2015) 29 (2) *Agenda*, 24-33.
- Montez, P 'Women's Rights are Human Rights: CEDAW Limits and Opportunities' (2001) *Berkeley Journal of International Law*.
- Nawrot, OAG 'Conscientious Objection and European Vision of Human Right' (2016) 6 (1) *Prog Health Science*.
- Ndlovu, H 'African beliefs concerning people with disabilities: Implications for theological education' (2016) 20 *Journal of Disability and Religion* 31. Ngwena, C G 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa'. (2010) 32 (4) *Human Rights Quarterly* 783-864.
- Ngwena, C 'Access to legal abortion: developments in Africa from a reproductive and sexual health rights perspective' (2014) 19 (2). *South African Public Law* 328-350.
- Ngwena, C G 'Reproductive autonomy of women and girls under the Convention on the Rights of Persons with Disabilities' (2017) 14 (1) *International Journal of Gynecology and Obstetrics* 128-133.
- Ngowa, JDK et al 'Voluntary Induced Abortion in Cameroon: Prevalence, Reasons and Complications' (2015) 5 *Open Journal of Obstetrics and Gynaecology* 475-480.

Njotang, PN et al ‘Determinants of modern contraceptive practice in Yaoundé-Cameroon: a community based cross-sectional study’ (2017) 10 (1) *BMC Research Notes*, 219.

Ofuani, AI ‘The right to economic empowerment of persons with disabilities in Nigeria: How enabled?’ (2011) 11 (2) *African Human Rights Law Journal*.

Peta, C et al ‘Facilitating the voice of dabled women; the biographic narrative, interpretative Method (BNIM) in action’ (2019) 4 (515) *Journal of the Academy of Social Sciences* as cited in Rugoho et al ‘sexual and reproductive health barriers for Youth with disabilities in Zimbabwe’ (2020) *African Disability Rights Yearbook* 31-51.

Pizzarossa, BI & Durojaye, E ‘International human rights norms and the South African choice on termination of pregnancy act: An argument for vigilance and modernization’ (2019) 35 (1) *South African Journal on Human Rights* 50-69.

Price, K ‘It is not just about abortion: Incorporating intersectionality in research about women of colour and reproduction’ (2011) 21 (3). *Women’s Health Issues*: 55-57.

Retiel, M & Letsosa, R ‘Models of disability: A Brief Overview (2018) 74 (1) *HTS Teologies Studies/Theology of Studies* 47- 88.

Roberts, GS ‘Sexuality and HIV/AIDS education among deaf and hard hearing students’ (2006) 22 (1) *Deaf Worlds* 111-139.

Rubinfeld, P & Kallianes, V ‘Disabled women and reproductive rights’ (1997) 12(2) *Disability and Society* 203-222.

Saxe, A ‘The Theory of Intersectionality: A new lens for understanding the barriers faced by autistic women’ (2017) *Canadian Journal of Disability Studies*, at 153-154.

Schaaf, M ‘Negotiating sexuality in the Convention on the Rights of Persons with Disability’ (2011) 8 (14) *International Journal on Human Rights* 1131.

Schuster, S 'Women's experiences of the abortion law in Cameroon; "What really matters. (2010) 18 (35) *Reproductive Health Matters* at 137-144.

Schuster, S 'Abortion in the moral world of the Cameroon grassfields' (2005) 13 (26) *Reproductive Health Matters* 130-138.

Schuklenk, U 'Conscientious objection in medicine: accommodation versus professionalism and the public good' (2018) 126 (1) *British Medical Bulletin* 47-56.

Shah, IH et al, 'Access to safe Abortion: Progress and challenges since the 1994 International Conference on Population and Development (ICPD). ICPD Beyond 2014 Expert Meeting on Women's Health- rights, empowerment, and social determinants.' See MS Milligan & AH Neufeldt 'The myth of asexuality: A survey of social and empirical evidence (2001) 19 (2) *Sexuality and Disability* 91-109.

Shaw, D 'The ABCs of family planning' (2010) *The Partnership for Maternal, Newborn and Child Health*.

Sheldon, S 'The decriminalisation of abortion: An argument for modernisation" (2016) 36 (2) *Oxford Journal of Legal Studies*.

Singh, S et al, 'Adding it up: the costs and benefits of investing in sexual and reproductive health' (2014)

Silvers, A et al 'Reproductive Rights and Access to Reproductive Services for Women with Disabilities' (2016) 18 (4) *AMA Journal of Ethics* 430-437.

Sorhaindo, AM 'Qualitative evidence on abortion stigma, from Mexico City and five states in Mexico' (2014) 54 97) *Women Health* 622-40.

Starrs, AM et al 'Accelerate progress- sexual and reproductive health and rights for all: report of the Guttmacher-Lancelet Commission, (2018) 391.

Tandi, TE et al 'Cameroon public health sector: shortage and inequalities in geographical distribution of health personnel' (2015) 14 (43) *International Journal for Equity in Health*.

Tebeu, PM et al ‘Maternal mortality in Cameroon: a university teaching hospital report’ (2015) 21 (16) *Pan African Medical Journal*.

Tumasang, F et al ‘Expanding the use of manual vacuum aspiration for incomplete abortion in selected health institutions in Yaoundé, Cameroon’ (2014) 126 (1) *International Journal of Obstetrics and Gynecology* 28-30.

Viljoen, F ‘An introduction to the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa’ (2009) 16 *Washington & Lee Journal of Civil Rights and Social Justice* 11.

Jerman, J et al ‘Benefits of meeting the contraceptive needs of Cameroonian women’ (2014) Guttmacher Institute 1-18.

Wonkam, A et al, ‘Knowledge and attitudes concerning medical genetics amongst physicians and medical students in Cameroon (sub-Saharan Africa) (2006) 8 *Genetics in Medicine* 331-38.

Zampas, C & Ibanez A ‘Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standard and European Law’ (2012) *European Journal of Health Law* 231-256.

### **International Treaties**

African Charter on Human and Peoples’ Rights GA Dec 115 (XVI) (1981/1986)

Convention on the Elimination of All Forms of Discrimination Against Women (1979/1981)

Convention on the Rights of Persons with Disabilities, GA Res 61/106 UN Doc A/RES/61/106

Declaration on the Rights of Persons belonging to National, Ethnic, Religious or Linguistic minorities adopted by General Assembly Resolution 47/135 of 18 December 1992

International Covenant on Civil and Political Rights, GA Res 2200A (XXI), 999 UNTS 171 (1966/1976)

International Covenant on Economic, Social and Cultural Rights, GA Res 2200 A (XXI), (1966/1976)

Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, A/RES/48/96 of 20 December 1993

Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (2003/2005)

Universal Declaration on Human Rights, GA Res 217A (III), UN Doc A/811 (1948) UN

Vienna Convention on the Law of Treaties, signed in Vienna 23 May 1969, entered into force 27 January 1980

## **Cases**

*L.M.R V Argentina. Human Rights Committee*

*Purohit & Moore V The Gambia, African Commission on Human and Peoples Right*

*R v Bourne*

*Ramirez Jacinto V Mexico*

## **General Comments**

African Commission on Human and Peoples' Rights General Comment 1 on article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, para 26.

General Comment 36 [2018] on article 6 of the ICESCR, para.8.

African Commission on Human and Peoples' Rights 'General Comment.2 on Article 14.1(a)(b)(c) and (f) and Article 14.2(a) and (c) of the Protocol of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2015), para 26.

African Commission on Human and Peoples' Rights General Comment 2 on Article 14(1)(a) (b)(c) and (f) and Article 14.2(a) and (c) to the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa, paras. 22, 24, 27 (2014)

Committee on Economic Social and Cultural Rights (CESCR) General Comment 22, para 41.

Committee on ESCR General Comment 14: The right to the highest attainable standard of health (article 12 of the Covenant) 11 August 2000, E.C/2/2000/4 (2000), paragraph 8.

General Comment 22 (2016) on the right to sexual and reproductive health, paras 29,35 and 48.

Committee on Economic, Social, and Cultural Rights General Comment 20: Non-discrimination in Economic, Social and Cultural Rights, 2 July 2009, E/C/2/GC/20 para.29.

Committee on Economic, Social and Cultural Rights (CESCR (2016) paragraph.41; CEDAW Committee, Concluding Observations on Kuwait, Un Doc. CEDAW/C/KWT/CO/3-4 (2011)) paragraph 43 (b); Concluding Observations on Hungary, UN Doc.CEDAW/C/HUN/CO/7-8 (2013) paras. 30-31.

UN Committee on Economic, Social and Cultural Rights General Comment 22: Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) 4 March 2016, E/C./2/GC

### **UN Concluding Observations**

Concluding Observation on the Combined fourth and fifth periodic reports of Cameroon, CEDAW Committee (28 February 2014), UN Doc. CEDAW/C/CMR/CO/4-5.

Concluding Observation on the fourth periodic report of Cameroon, ESCR Committee (25 March 2019) UN Doc E/C. 12/CMR/CO/4.

### **Domestic Legislation**

Act No 90/035 on the Practice of the Profession of Pharmacists

Act No.92 of 1996.

Constitution of Cameroon 1972 as amended in 2008.

Constitution of Ghana 1992.

Decree N0 90/1516 of 26 November 1990.

Education Framework Act No-98/004 of 14 April 1998.

Law 83/13 f 21 July 1983 relating to the Protection of Persons with Disabilities

Law No 80-10 of 14 July 1980.

Law 2010/002 of 13 April 2010.

Ministerial Order of Rwanda, 2019, article 8.

Republic of Cameroon Doman of Health Law of 4 January 1996 (96/03).

Penal Code of Cameroon, Law 65 LF/24 of 12 November 1965 and 67/LF 1 of 12 June 1967.

### **UN General Recommendations**

Convention on the Rights of the Child Committee (CRC) General Comment No.20, CEDAW Committee, General Recommendation No.35.

CEDAW General Recommendation No 24, Article 12 of the Convention 1999 (Women and Health) A/54/38/rev.1.

Committee on CEDAW General Recommendation No 24: Art 12 of the Convention (Women and Health) (1999) A54/38/Rev 1, chap 1.

### **Websites and Database**

Amnesty International ‘Bolivia briefing to the UN Committee on the Elimination of Discrimination Against Women’ (2015) <https://www.justice.gov/eoir/file/627876/download>

[https://www.upr-info.org/sites/default/files/document/cameroon/session\\_30\\_-\\_may\\_2018/cameroon\\_30\\_table.pdf](https://www.upr-info.org/sites/default/files/document/cameroon/session_30_-_may_2018/cameroon_30_table.pdf)

Guttmacher Institute <https://www.guttmacher.org/report/benefits-meeting-contraceptive-needs-cameroonian-women>

Inclusion London ‘The Social Model of Disability’. Fact sheet 31 [https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets\\_TheSocialModel.pdf](https://www.inclusionlondon.org.uk/wp-content/uploads/2015/05/FactSheets_TheSocialModel.pdf)

International Conference on Population and Development 1994  
<https://undocs.org/en/A/CONF.171/13/Rev.1>

Women and Young People with Disabilities: Guidelines for Providing Rights-Based Gender Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights  
[https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI\\_Guidelines\\_Disability\\_GBV\\_SRHR\\_FINAL\\_19-11-18\\_0.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-WEI_Guidelines_Disability_GBV_SRHR_FINAL_19-11-18_0.pdf)

UN Women ‘Convention on the Elimination of All Forms of Discrimination Against Women, reservations to CEDAW’ UN Women ‘Convention on the Elimination of All Forms of Discrimination Against Women, reservations to CEDAW’ <https://www.un.org/womenwatch/daw/cedaw/reservations.htm>

United Nations ‘Abortion Policies: A Global Review’ (3).  
<https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf>

WHO Disability and health, available at <https://www.who.int/news-room/fact-sheets/detail/disability-and-health>.

### **Reports and other documents**

Access, Autonomy and Dignity: Abortion care for People with Disabilities (2021) Issue Brief, National Partnership for Women and Families, and Autistic Self Advocacy Network.

Acker-Verney, J et al ‘Intersectionality and the Rights of Persons with Disabilities in Global Development.’, *Center for International Policy Studies*.

Centre for African Family Studies (CAFS) ‘Determinants and consequences of adolescent pregnancies in Cameroon’ 1996 (8) CAFS News.

Cheka, C ‘Legal Aspects of family planning within the context of the reorientation of PHC in Cameroon. Part one: Contraception and Abortion. GTZ report 1996 (Unpublished).

De Costa, C ‘Abortion Law, Abortion Realities (2008) delivered at the James Cook University Townsville Campus.

DFID Scoping Studies ‘Disability Issues in Nigeria’ (2008) <https://icai.independent.gov.uk/wp-content/uploads/DFIDs-approach-to-disability-in-development>.

FIGO statement ‘Conscientious objection: a barrier to care’, *The Global Voice for Women’s Health*.

Frohman, C & Ortoleva, S, Issue Paper: The Sexual and Reproductive Rights of Women and Girls with Disabilities (2013) 4-5.

Institute National de la Statistique (INS) et ICF International Enquete Demographique et de la Sante a l’indicateurs Multiplies du Cameroun (2011).

ICPD: International Conference on Population and Development, 1994, Geneva: UNFPA.

IPAS Exploring ‘Abortion, stigma ends here: A toolkit for understanding and action’ (2018) 2.

Johnson, A ‘The Voiceless Woman: Countering Dominant Narratives Concerning Disabled Women in Nigeria’ Unpublished PhD thesis, University of Pretoria (2019).

Maguire, DC ‘Abortion and Religion’ in the Willer Blackwell Encyclopedia of Gender and Sexuality Studies 2016.

Nabaneh, S ‘A purposive interpretation of Article 14(2)(c) of the African Women’s Protocol to include abortion on request and for socio-economic reasons’ Unpublished Master’s dissertation, University of Pretoria (2012) 39.

Nabaneh, S ‘Power dynamics in the provision of legal abortion: A feminist perspective on nurses and conscientious objection in South Africa’ Unpublished PhD dissertation, University of Pretoria (2018).

Ngoh, VJ ‘The Political Evolution of Cameroon, 1884-1961’ MA Dissertation, Portland State University 1979 at 4-5.

N’Sengha, MN ‘The African Charter on Human and Peoples’ Rights: An African contribution to the project of global ethic’ (2010).

SAD Kamga ‘The rights of women with disabilities in Africa: Does the Protocol o the Rights of Women in Africa offer any Hope?’(2011) *Centre for Women Policy Studies*.

Special Rapporteur on the right to everyone to the enjoyment of the highest attainable standard of physical and mental health A/66/254 (2011) paras.44, 48. See also ICESCR, art 12.

The Alan Guttmacher Institute (AGI) ‘Sharing Responsibility: Women, Society and Abortion Worldwide’ (1999) New York: GI.

WHO & Guttmacher Institute Worldwide, an Estimated 25 million Unsafe Abortions Occur Each Year (2017).

United Nations Department of Economics and Social Affairs/ Disability and Employment Factsheet.

United Nations Population Division, Department of Economic and Social Affairs/ World Abortion Policies (2007).