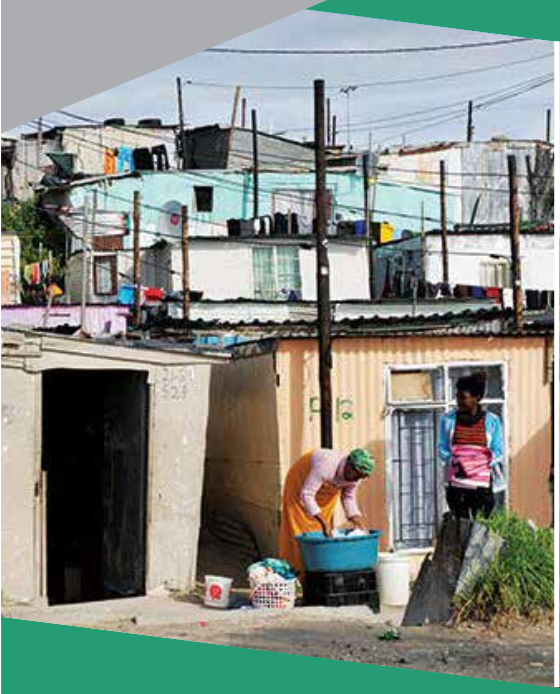

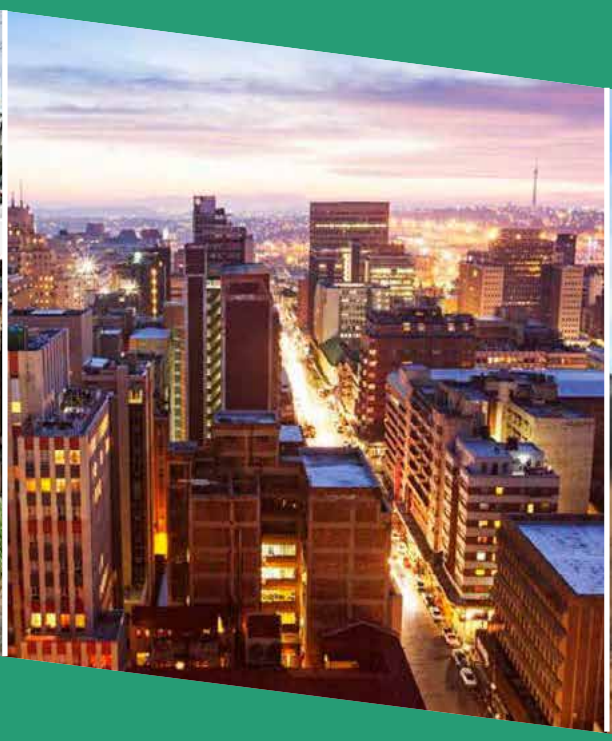

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ENSURING **RIGHTS** MAKE REAL **CHANGE**

SPECIAL EDITION ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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Editorial

Welcome to the ESR Review special edition on advancing sexual and reproductive health rights (SRHR) in Africa. SRHR encompasses a wide range of issues related to the well-being and autonomy of individuals in matters concerning sexuality, reproduction, and family planning. These issues are of paramount importance in Africa, which faces complex and multifaceted challenges in the realm of SRHR that are shaped by a social, cultural, economic, and political factors. Despite some progress in various countries in areas such as adolescent sexual and reproductive health, access to family-planning services, and reduction in maternal mortality, the realisation of comprehensive SRHR remains elusive for many Africans.

This edition of ESR Review features contributions that look into the SRHR challenges of various groups in Africa and important strategies to advance SRHR.

The first feature article examines laws on access to abortion in Kenya to determine whether their language or construction constrains the realisation of SRHR. The second article demonstrates that in the rapidly evolving landscape of health care, including digital interventions, there are opportunities to overcome long-standing barriers and improve access to sexual health services, including by enabling young people to take control of their sexual and reproductive health. The third article explores opportunities within regional integration initiatives in Africa to advance the enjoyment of SRHR, while the fourth delves into the plight of female refugees in accessing SRHR, with a special focus on barriers to accessing care and support by victims of sexual violence.

This edition includes a policy review that assesses South Africa's guidelines on self-managed abortion against the World Health Organization guidelines and examines the extent to which the South African guidelines restrict access to self-managed abortion.

To advance SRHR in Africa, government policies must reflect a commitment to upholding SRHR. Advocating for the inclusion of SRHR in the national health agenda is essential for ensuring adequate funding and resources. Policy makers must engage with civil society, healthcare providers, and communities to create responsive, inclusive and sustainable frameworks that address the unique SRHR needs of diverse populations. We hope you find this issue useful in taking forward research, conversation and advocacy for advancing access to sexual and reproductive health services in Africa.

Aisosa Jennifer Omoruyi
Guest Editor

FEATURE

Language-Conscious Interpretative Approaches to Sexual and Reproductive Rights Claw-backs in Kenya

Maina Nyabuti

Introduction

Kenya's human rights corpus robustly safeguards sexual and reproductive health rights (SRHR). The Constitution of Kenya (2010), together with ratified international and regional human rights instruments as well as relevant statutes, judicial precedents, and policies, safeguards SRHR. Article 2(5) and (6) of the Constitution incorporate it as part of Kenya's laws. Article 19(3)(b) of the Constitution also recognises other rights, including SRHR, conferred by other laws. Additionally, the Bill of Rights implicitly protects SRHR through interrelated rights, such as access to abortion services, dignity, non-discrimination, privacy, conscience, and expression. Significantly, article 43(1)(a) of the Constitution explicitly safeguards the right to the highest attainable health standards, which includes reproductive healthcare services.

Kenya's framing of reproductive health care as a 'stand-alone' right departs from other constitutions in Africa, where SRHR safeguards lie within the gamut of interrelated rights. It also marks a major shift from the traditional framing of SRHR as a subset of rights (the 1968 Proclamation of Tehran). Indeed, this framing transforms Kenya's Bill of Rights into a progressive and transformative charter, paralleling section 27(a) of South Africa's Constitution and article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), both of which clearly and explicitly embed reproductive health-care rights and SRHR, respectively.

However, despite these constitutional safeguards, sexual and gender minorities still experience sexual and reproductive health-care (SRH) constraints in expressing their sexual orientation, sexual characteristics and gender identities (SOGIESC) because their same-sexual conduct is criminalised and their sexualities lack full legal recognition. This facilitates their harassment by state officers, familial and societal stigma, expulsion from learning institutions, exposure to blackmail, extortion and sexuality-based violence, and poor access to SRH services (KNHRC 2012: 21, 41).

Moreover, women and girls experience insurmountable SRH constraints in accessing contraceptives and safe abortion services. Ziraba et al. (2015: 2) link high maternal mortalities in Kenya to complications arising from unsafe abortion. Of the country's 362 maternal deaths per 100,000 live births (KNBS 2015: 329), approximately 17 per cent of them result from unsafe abortions (Mutua et al. 2018: 2). A recent study reveals that maternal deaths have increased to 530 per 100,000 live births (IAHO & WHO 2023: 2).

Adolescent children also experience SRH constraints, including sexual violence and abuse, high rates of sexually transmitted infections (STI) and diseases, unintended pregnancies, and lack of full access to contraceptives and SRH information (Nyabuti 2024: 32–41). Approximately 33 per cent of adolescents are sexually active but 52 per cent of them have unmet family-planning needs, while 50 per cent lack sufficient information on SRH information (Sidze et al. 2017).

The persistence of SRH constraints despite Kenya's progressive legal framework warrants this research article. Most studies have recommended remedies based on SRH constraints' causative factors, such as socio-religious and political factors. Some have framed remedies after finding SRHR-specific laws absent or finding that existing laws contravene SRHR. Others have fashioned remedies based on the legal gaps within the SRHR laws. Few or none have examined how the language of laws can constrain SRHR. The law in this context includes the Constitution, statutes and judicial decisions.

This article thus critically examines whether the language in which progressive SRHR laws are framed and constructed constrains their realisation. After sampling some laws on access to abortion and on sexual and gender minorities and adolescent sexuality, it finds that sometimes language can claw back SRHR. The article then considers 'language-conscious' interpretative approaches for addressing language deficiencies with a view to achieving the maximum realisation of SRHR.

Access to abortion services

The abortion clause was contentious during Kenya's constitution-making process. Some opposed the 2010 Constitution on the grounds that it provides carte blanche to abortion services for women (Mwai 2017: 2). Indeed, article 26(4) of the Constitution states as follows: 'Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.'

Unlike the 1969 Constitution (repealed), which was silent on abortion, the 2010 Constitution, in article 26(4), safeguards women's right to access abortion services. However, its language contains deficiencies that claw back on the right's maximum enjoyment. Accessing abortion is all about women's agency and their autonomy over their bodies, yet article 26(4)'s language seems negative, restrictive and conditional.

In particular, it frames access to abortion as an exception to a non-permissibility rule. It also predicates access to abortion over 'the mother is in danger' circumstances, which are, again, determined by trained health professionals. It places trained health professionals at the centre of women's access to abortion as the authorising agents. This takes away women's agency and autonomy. Arguably, 'authorisation' is not the same as 'advice'. While a health professional's advice is necessary, it should not replace the woman's agency in accessing abortion services.

Article 26(4)'s language also appears to equate foetal life with that of a pregnant woman, thus suggesting that both have the same status and rights. If a foetus of a few weeks cannot feel pain or suffer before 26 weeks (Wise, 1997: 1112), I would suggest that a foetal life cannot be equated with the mother's life, particularly in its early weeks. In conclusion, article 26(4) of the Constitution uses language that acts as a claw-back on women's access to abortion rights to the fullest extent possible.

Nevertheless, Kenya's courts have promoted access to abortion rights by adopting 'language-conscious' hermeneutics to negotiate through article 26(4)'s claw-backs. In 2013, when the government arbitrarily withdrew *Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya*, which had been formulated to liberalise and expand access to safe abortion beyond article 26(4)'s claw-backs, the decision was challenged before the High Court in the Fida & others v AG & others case.

Here, the court fashioned 'language-conscious' interpretative approaches to expand access to abortion services. It appreciated that article 26(4) of the Constitution frames abortion as unlawful and only permits it as an exception (paras 303–304, 354). The court then adopted a 'language-conscious' interpretation to eliminate the abortion claw-backs. It profiled the language 'emergency treatment', 'life and health of a mother' and 'permitted by other laws' (para 311) and construed the phrases liberally to promote

> **Kenya's framing of reproductive health care as a 'stand-alone' right departs from other constitutions in Africa...**

the full realisation of abortion rights. For instance, 'mother's health' was construed to include physical, emotional, mental and psychological dimensions (para 362), while 'emergency treatment' was construed as situations calling for necessary immediate measures by nurses and clinical officers to prevent death or a worsening medical situation (paras 356, 358). Finally, the court construed 'permissibility by other laws' to include victims of sexual offences, which include rape, defilement, and incest, as entitled to abortion services (para 372).

In another case, PAK & another v AG & 3 others, the High Court ordered Parliament to review sections 158, 159 and 160 of the Penal Code that criminalise access to and procuring of abortion services (para 85) to conform to article 26(4)'s permitted grounds for abortion. It was 'language-conscious' when it observed that the problem of article 26(4) is equating a pregnant woman's life with continued foetal development, thus making it the single-greatest impediment to medical abortion services (para 52). It then negotiated this language-based constraint by interpreting the interrelated rights of dignity and privacy as anchoring women's autonomy and agency to access abortion services (paras 53–70).

Yet despite finding sections 158–160 of the Penal Code in violation of article 26(4) of the Constitution as well as reproductive rights (paras 101–123), the court slid into claw-back language by being unclear as to whether the sections stood annulled or remained operational (para 164).

The Children Act (2022) has introduced further claw-back language that, if unchecked, could conflict with women's rights to access abortion. Section 2 of Act defines age as the actual chronological age of the child from conception. This definition treats a foetus as a child, and its language connotes that a 'child' in the womb enjoys children's rights. Citing the provision, Macharia (2023: 46–47) advocates for 'unborn child' rights protection. This effectively elevates the foetus's life to the same level as that of the pregnant mother. It contradicts the *PAK decision* and progressive comparative jurisprudence.

In this regard, Nepal's Supreme Court has reasoned that the unborn owes its existence to the mother and thus that its interests cannot supersede the mother's physical and mental well-being (*Lakshmi Dhikta v Nepal*). South Africa's Constitutional Court has stressed that the foetus cannot be treated as an individual (*Christian Lawyers Association of SA and Others v Minister of Health and Others*).

Gender and sexual minorities

Sections 162, 163 and 165 of the Penal Code (anti-sodomy laws) criminalise expressions of non-normative SOGIESC. During the constitution-making process, some delegates opposed same-sex expressions, describing them as 'Western values' and against 'public morality', while others framed same-sex expressions as part of societally evolving ideas (CKRC Report 2003: 22, 130 & 247). This culminated in a recommendation to 'outlaw same-sex marriages' but it lacked unanimous support (CKRC Final Report 2005: 119, 401 & 402).

Apparently, the contentions on same-sex expressions came up in the drafting of the 2010 Constitution. Some drafters rejected the inclusion of gay rights for fear of public rejection, while a number of Kenyans opposed the 2010 Constitution because it promoted gay rights (Orago et al. 2022: 133, 124). I thus infer that the contentions relating to same-sex expressions reached some sort of compromise. For instance, article 45(2) of the Constitution evidently departs from the recommendation to 'outlaw same-sex marriages'. It states that 'every adult has the right to marry a person of the opposite sex, based on the free consent of the parties'. Its language shows the signs of a compromise that, on the one hand, recognises only opposite-sex marriages but, on the other, deliberately avoids outlawing same-sex ones.

> **"...the aim of SRHR laws on adolescent sexuality is to protect adolescents and ensure that they experience positive sexual development, as opposed to leaving them vulnerable to abuse.**

With this in mind, I argue that a 'language-conscious' interpretation needs to appreciate article 45(2)'s 'language of compromise', which does not outlaw same-sex marriages. It is different, for instance, to an amendment introduced to article 31(2a) of the Ugandan Constitution to explicitly prohibit same-sex marriages. In this regard, I fault the *EG & 7 others v Attorney General* decision, in which the High Court declined to decriminalise anti-sodomy laws, relying as it did on article 45(2) of the Constitution while connoting that it outlaws same-sex marriages. The court failed to appreciate article 45(2)'s 'language of compromise' that deliberately avoids outlawing same-sex marriages. A 'language-conscious' interpretation utilises the positive language aspects of SRHR legal provisions to eliminate claw-backs.

Moreover, the Constitution contains a progressive Bill of Rights that safeguards the rights to non-discrimination, dignity, privacy, conscience, and expression (articles 27, 28, 31, 32 and 33) and, thanks to the interrelationship of these rights, promotes sexual and gender minority rights. Jurisprudence inspired by 'language-conscious' interpretations combs out SRHR constraints to promote sex and gender minorities' rights through interrelated sexual rights. For instance, the constraining language in article 27(4) of the Constitution is its failure to list 'sexual orientation and gender identity' as non-discrimination grounds. However, in adopting a 'language-conscious' approach, the Supreme Court in *NGOs Co-ordination Board v EG & 4 others* relied on the words 'including' and 'or' in the clause to read 'sexual orientation' into the prohibited list of non-discrimination grounds. It thereby promoted the maximum enjoyment of rights to non-discrimination and association for sexual and gender minorities.

Comparatively, in the *Toonen v Australia* decision, the Human Rights Committee construed non-discrimination and privacy rights under articles 2, 18 and 26 of the International Covenant on Civil and Political Rights (ICCPR), which Kenya has ratified, in such a way as to decriminalise Tasmanian anti-sodomy laws. The High Court of Antigua and Barbuda also expanded the language and meaning of freedom of expression to encompass the sexual choices of consenting adults (*Orden David & Women Against Rape Inc v AG, 2022: para 80*), while its St. Christopher and Nevis counterpart expanded expression rights to include having sexual intercourse (*Jamal Jeffers & others v AG,2022: para 76*). Finally, the High Court of Botswana in *LM v the Attorney General* (2019) held that criminalising the only mode of sexual expression for sexual minorities through anti-sodomy laws deprives them of their self-worth, thus infringing their right to dignity (paras 129–165).

Seen in this light, the language of article 45(2) of the Constitution needs to be appreciated in the context of these interrelated rights as well as their comparative jurisprudence in order to warrant a review of Kenya's anti-sodomy laws with a view to promoting sexual and gender minority rights.

In *COI & another v Resident Magistrate Kwale Court & 4 others* (2018), Kenya's Court of Appeal held that forced anal examinations of suspects to fish out forensic evidence for sodomy charges violate their dignity and privacy rights. It overturned the High Court decision that had affirmed such examinations by stating (in para 47) that

> (n)either the mouth nor the anus is a sexual organ. However, if modern man and woman have discovered that these orifices may be employed or substituted for sexual organs, then medical science or the purveyors of this new knowledge will have to discover or invent new methods of accessing those other parts of the human body even if not for purposes of medical forensic evidence, but also curative medical examination.

The High Court's language here not only constrains the SRHR of sexual and gender minorities but also reeks of homophobia. Such judicial 'language-unconsciousness' or insensitivity appears as well in other decisions on sexual and gender minorities. In 2014, the High Court delivered a progressive decision that ordered the removal of gender mark and a change of name for a transgender applicant (*Audrey Mbugua v KNEC, 2013*). It highlighted the healthcare challenges of transgender people and not only linked health rights to human dignity but also presented such persons as human beings whose values and identities are violated when they are humiliated and dehumanised (paras 7, 11). Despite these progressive pronouncements, the court exhibited bouts of constraining language.

From the outset, it adopted a tone of disdain towards the transwoman applicant by stressing that 'although the Applicant has presented himself as a female, I will for the purposes of this application refer to the Applicant as a male' (para 2). The court also employed

language that pathologises transgender persons, describing them as people with 'the misfortune to be born with physical characteristics which are congruent but whose self-belief is incongruent' (para 7, emphasis added). By comparison, the South African court avoided this kind of language while safeguarding the SRHR rights of transgender persons in prison (*September v Subramoney NO and Others, 2019*).

In *R.M. v Attorney General & 4 others* – a 2010 case that upheld intersex persons' right not to be subjected to inhumane and degrading treatment by being forced to expose their genitalia publicly to prison authorities – the High Court of Kenya backslid into the language of constraint. Throughout the judgment, it adopted, endorsed, and defined intersex genitalia as 'ambiguous'. It should be noted that the petitioners who approached these courts did so as victims of SRHR violations as well as on behalf of other sexual and gender minorities. The homo/transphobic and pathologising language thus revictimises them and constrains them from seeking court remedies.

Kenya's progressive statutes addressing sexual and gender minorities issues also contain language of constraint. One such statute is the Persons Deprived of Liberty Act (2014), which defines an intersex person as 'a person certified by a competent medical practitioner to have both male and female reproductive organs' (section 2). This definitional language not only pathologises them but also constrains their full legal recognition by conditioning their intersex state on ascertainment and certification by medical practitioners. It fails to construct and frame intersex as a natural state of being. If for purposes of designation of prison or custody facilities, the issue should be dealt with by procedural laws, regulations, and policies rather than via a substantive provision that defines who an intersex person is by predicating their identity on medical certification. This language dehumanises and deprives them of dignity.

The Children Act seems to have rectified this language constraint. It defines intersex children as children

> with a congenital condition, [in] which the biological sex characteristics cannot be exclusively categorised in the common binary of female or male due to inherent and mixed anatomical, hormonal, gonadal or chromosomal patterns, which could be apparent prior to, at birth, in childhood, puberty or adulthood (section 2).

It further safeguards their SRHR rights in regard to, for instance, registration and documentation, separate detention facilities, and 'stand-alone' children intersex rights (sections 7, 16, 21, 26, 64 and 6th schedule).

While protecting intersex children from harmful cultural practices, however, the statute adopts language that constrains the agency of a child with evolved capacities to participate in decisions about organ change or removal (section 23f). It makes this conditional based on the recommendation of a medical geneticist, language that erases the child's voice. An SRHR 'language-conscious' interpretation should ensure that the voice of the child with evolved capacity is audible. In comparative jurisprudence, the Colombia Constitutional Court has stressed the need for child consent rather than exclusive parental consent, and I add medical geneticist recommendation in corrective surgery for intersex children (Legal Grounds III 2017: 13).

Adolescent sexuality

One area that exhibits the language of SRHR constraint is that of the protection of adolescents from sexual violence and abuse. The Sexual Offences Act (2006), enacted to protect them from sexual abuse, criminalises sexual conduct with children regardless of consent and provides for deterrent punishment to offenders (sections 8–11). It thus adopts absolutist language that criminalises adolescents' consensual sexual activities.

Adolescent children technically fall within the age bracket of 10 to 19 years. So, if an 18- or 19-year-old adolescent engages in consensual sexual conduct with a 16-year-old adolescent, he or she can be charged with defilement or an indecent act and, if found guilty, be liable for minimum imprisonment of 15 years. Similarly, the language of the statute does not protect adolescents from prosecution if they are than 18 years of age and engage in consensual sex. In other words, the language in section 8 of the Sexual Offences Act erects constraints in realising adolescent SRHR.

In *CKW v Attorney General & another* (2014) decision, the High Court endorsed the criminalisation of adolescents' consensual sex (para 73) and affirmed

> **The introduction of mandatory third-party authorisation and parental consent is a claw-back that constrains adolescents with evolved capacities from accessing reproductive healthcare services.**

prosecuting an adolescent boy (14 years) as the accused while making the adolescent girl (12 years) with whom he was engaging in consensual sex with as the victim (para 59). The court claimed that the relevant section aims at 'achieving a worthy or important societal goal of protecting children from engaging in premature sexual conduct' (paras 95–99). It hence failed to appreciate that the section's language is gender-neutral and that setting up the adolescent boy for prosecution and framing the girl as a victim was discriminatory, given that their sexual activities were consensual. Significantly, the court failed to appreciate the bigger picture – namely that exposing adolescents to the criminal justice system, especially when they do not repeat offenders, does them more harm than good.

In *Wambui v Republic* (2019), a three-judge Court of Appeal bench decried the high numbers of young men in prison (para 41) as the unfair consequence of uncritical enforcement of the Sexual Offences Act (para 1). Although the judges did not disclose whether these young men were adolescents or not, they highlighted the harmful effects of section 8 of the Act's inflexible language. The court thus recommended a review of the age of sexual consent for adolescents. Increasingly, courts such as in the POO v Director General of Public Prosecutions and another and SNN v Republic cases have started categorising consensual sex cases between adolescents within age difference of two-to-three years as 'Romeo and Juliet' cases so as to avoid punitive sentences and provide them with care and protection.

Comparative lessons from South Africa provide insights. In *Teddy Bear Clinic for Abused Children & Another v Minister of Justice and Constitutional Development & another* (2013), the Constitutional Court declared the criminalisation of adolescent consensual sex as unconstitutional. The South African parliament then decriminalised consensual sex between adolescents aged 12–16 years as well as consensual sex between adolescents with a two-year age difference (Essack & Toohey 2018: 85).

It must be appreciated that the aim of SRHR laws on adolescent sexuality is to protect adolescents and ensure that they experience positive sexual development, as opposed to leaving them vulnerable to abuse. In this regard, judicial language that constructs adolescents as adults, as in the case of *Martin Charo v Republic* (2016), equally deprives them of their SRHR and increases their vulnerability to sexual abuse. Instead of protecting the adolescent sexual abuse victim from adults, the court constructed them as 'adults' and as naughty and not deserving legal protection (paras 24, 25). It stated, '[w]here the child behaves like an adult and willingly sneaks into men's houses for purposes of having sex, the court ought to treat such a child as a grown-up who knows what she is doing'.

Another area rife with the language of constraint is adolescent access to reproductive healthcare information and services. Section 16 of the Children Act safeguards children's right to reproductive healthcare services. However, it introduces a proviso that 'reproductive health services to children shall be subject to the express consent of the parent or guardian'. The introduction of mandatory third-party authorisation and parental consent is a claw-back that constrains adolescents with evolved capacities from accessing reproductive healthcare services. While parental authority is necessary in children's affairs such as access to contraceptives and the elimination of parental control erodes parental rights, the use of such absolutist language is fraught with danger.

In comparative jurisprudence, the decision in the English case, *Gillick v West Norfolk and another* (1984) developed a flexible approach worthy of consideration. First, a health provider must start from the premise that parental authority is necessary for an adolescent patient who wants access to reproductive healthcare

services, with the exception of emergency situations, court orders, or where there is evidence of parental neglect or abandonment. Secondly, if there is no parental authority (outside exceptions), the healthcare provider must explain to the adolescent patient the need to involve the parent. Thirdly, if the patient declines to involve parents for consent, the healthcare provider shall make a clinical judgment on whether to allow the patient to access the sexual and reproductive healthcare service, particularly where the patient may engage in sexual activity with negative outcomes.

I do not advocate for a copy-paste application of this approach to the Kenyan context. My argument is that 'language-conscious' interpretations of the proviso ought to consider permissive circumstances beyond the absolutist language claw-backing adolescents with evolved capacities and those with irresponsible or negligent parents from accessing reproductive healthcare services.

With respect to access to reproductive health-care information, section 16(4) of the Children Act also introduces the phrase 'age-appropriateness' in relation to access to reproductive health-care information and services. This language conforms with the principle of evolving capacity, which does not introduce age caps to children's participation in decision-making and consent, but rather, it is determined according to their level of maturity. A language-conscious interpretation of the section permits reproductive healthcare providers to allow adolescents to access appropriate information depending on their individual level of maturity (Coughlin 2018: 138).

Conclusion

The article sought to demonstrate that sometimes language in laws constrains the realisation of SRHR. It sampled some laws on access to abortion, on gender and sexual minorities, and on adolescent sexuality to demonstrate how such claw-back language works. It pointed out that the constitutional clause on access to abortion is laced with constraining language and that this calls for a 'language-conscious' interpretation to promote abortion rights. The article also argued that the Constitution employs the 'language of compromise' in not outlawing same-sex marriages and that this fact should be leveraged to expand the rights of sexual and gender minorities and review anti-sodomy laws.

Finally, it drew attention to the absolutist and protectionist language of the Sexual Offences Act. This criminalises adolescent consensual sex and exposes adolescents to the harms of the criminal justice system, all of which are antithetical to their SRHR and positive sexual development. In addition, the article pointed out the claw-backs in the Children Act that constrain adolescents' right to access reproductive healthcare information and services. The article also noted several examples of judicial language that not only constrain the realisation of SRHR but also revictimise sexual abuse victims and hinder gender and sexual minorities from approaching courts for justice.

The article thus demonstrates the need for 'language-conscious' interpretations and remedies that address constraining language in laws and help ensure the maximum realisation of SRHR.

Maina Nyabuti is a prosecution counsel in the Office of Director of Public Prosecutions, Kenya. *He writes in his personal capacity.*

References

Sidze, E.M., Stillman, M., Keogh, S., Mulupi, S., Egesa, C.P., Leong, E., Mutua, M., Muga, W., Bankole, A. and Izugbara, C., 2017. From paper to practice: sexuality education policies and their implementation in Kenya.

Ziraba, A.K., Izugbara, C., Levandowski, B.A., Gebreselassie, H., Mutua, M., Mohamed, S.F., Egesa, C. and Kimani-Murage, E.W., 2015. Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors. *BMC pregnancy and childbirth*, 15, pp.1-11.

Fida & Others v AG & Others Petition No. 266 of 2015 KLR 2019

PAK & another v AG & 3 others (Constitutional Petition E009 of 2020) [2022] KEHC 262

NGOs Co-ordination Board v EG & 4 others (Petition 16 of 2019) [2023] KESC 17 (KLR)

COI & another v Resident Magistrate Kwale Court & 4 others [2018] KLR

R.M. v Attorney General & 4 others 2010 KLR

CKW v Attorney General & another (Petition 6 of 2013) [2014] KEHC 3657 (KLR) (25 July 2014)

POO (A Minor) v Director of Public Prosecutions & another (Constitutional Petition 1 of 2017) [2017] KEHC 8341 (KLR) (17 August 2017)

Martin v Republic (Criminal Appeal 32 of 2015) [2016] KEHC 5619 (KLR) (25 April 2016)

Gillick v West Norfolk and another (1985) 3 All ER 402

FEATURE

The Impact of Digital Health Interventions on Improving Adolescent Sexual and Reproductive Health in Sub-Saharan Africa

Oyugi Emmanuel Miller

Introduction

In the rapidly evolving landscape of health care, digital interventions have emerged as a powerful tool to address the pressing sexual and reproductive health rights (SRHR) and needs of adolescents in sub-Saharan Africa. As a researcher and advocate deeply invested in this field, I argue that these technological solutions offer unprecedented opportunities to overcome long-standing barriers and empower young people to take control of their sexual and reproductive health. However, we must approach this digital revolution with both optimism and caution and ensure that interventions in relation to them truly serve the needs of the most vulnerable youth.

Adolescent sexual health: where curiosity meets chaos, and no one reads the manual

The state of adolescent SRHR in sub-Saharan Africa remains a critical concern. Despite progress in recent years, the region continues to grapple with high rates of unintended pregnancy, sexually transmitted infections, and HIV among young people. According to UNICEF, approximately 3.1 million adolescents and young people in Eastern and Southern Africa were living with HIV in 2023, with girls disproportionately affected (UNICEF 2021). These stark figures underscore the urgent need for innovative approaches to reach and engage youth with accurate information and essential services.

Harnessing Technology for Health Solutions

Digital health interventions, ranging from mobile apps and SMS-based services to social media campaigns and online counselling platforms, have shown promising results in addressing these challenges. Such tools leverage the increasing penetration of mobile phones and internet access across the continent to deliver tailored, youth-friendly SRHR information and services directly to adolescents' fingertips.

One of the most significant advantages of digital interventions is their ability to overcome the stigma and privacy concerns that often prevent young people

> **The Covid-19 pandemic further underscored the importance of digital health solutions.**

from seeking SRHR information and services in traditional healthcare settings. Through anonymous online platforms, adolescents can access confidential advice, ask sensitive questions, and receive accurate information without fear of judgment or reprisal. This anonymity is particularly crucial in conservative societies where discussing sexual health remains taboo.

The organisation mHealth Kenya offers mobile health interventions to young people and adolescents that exemplify how mobile phones can be used to inform youths about sexual health. This SMS-based programme provides young people with information on contraception and sexual health, resulting in increased knowledge and improved attitudes towards family planning among participants (Hightow-Weidman et al. 2018). Such initiatives demonstrate how digital tools can effectively bridge the information gap and empower youth to make informed decisions about their sexual and reproductive health.

Moreover, digital platforms offer unprecedented opportunities for peer-to-peer learning and support. Social media and online forums allow adolescents to connect with peers facing similar challenges, share experiences and offer mutual support. This peer-driven approach can be particularly effective in promoting behaviour change and challenging harmful social norms around sexuality and gender.

Importantly, these digital health interventions should align with international and regional norms. General Comment No. 25 of the Committee on Economic, Social and Cultural Rights highlights the need for accessible scientific and technological advancements in health (para 16). It emphasises that health services, including digital ones, must be non-discriminatory and inclusive (para 19) and underscores the obligation to provide comprehensive sexual and reproductive health services through digital technologies (para 22). It also notes the role of technology in disseminating information about sexual health rights and services (para 27). In addition, General Comments Nos. 1 and 2 of the African Commission on Human and Peoples' Rights likewise provide guidance on the use of technologies in promoting health rights.

Ethical Considerations in Digital Health Interventions

However, as we embrace these digital solutions, we must also acknowledge and address their potential pitfalls. The digital divide remains a significant concern in sub-Saharan Africa, with many rural and low-income youth lacking access to smartphones or reliable internet connectivity. There is a real risk that digital health interventions could exacerbate existing inequalities if not implemented thoughtfully and inclusively.

To this end, I advocate for a multi-pronged approach that combines digital interventions with traditional outreach methods to ensure that no young person is left behind. This could involve setting up community internet hubs, distributing low-cost mobile devices preloaded with health information, or integrating digital health education in school curricula. Telemedicine, which uses a combination of SMS reminders and visits by community health workers to improve immunisation rates, offers a compelling model of how digital and in-person interventions could be combined effectively (GSMA 2021)

Privacy and data security represent another critical concern. As we collect sensitive health information from vulnerable young people, we have an ethical and human rights obligation to ensure this data is protected from misuse or breaches. Implementing robust data protection measures and educating users about online safety must be integral components of any digital health initiative.

We must also be cautious about the quality and accuracy of information disseminated through digital platforms. The internet is rife with misinformation about sexual and reproductive health, which can have dangerous consequences for young people. As we advocate for digital health rights, states and other policy makers of digital health interventions have a responsibility to ensure that the information they provide is evidence-based, culturally appropriate, and regularly updated.

The Future of Sexual and Reproductive Health in Sub-Saharan Africa

The role of governments and policymakers in supporting and regulating digital health interventions cannot be overstated. While NGOs and private sector entities have led many successful initiatives, sustainable and scalable impact requires government buy-in and support.

As such, policymakers must work to create enabling environments for digital health innovation, including by developing clear regulatory frameworks, investing in digital infrastructure, and integrating digital health strategies in national health plans. The World Health Organization provides a valuable framework for countries to develop and implement comprehensive digital health strategies (WHO 2021). Sub-Saharan African nations should leverage this guidance to develop context-specific plans prioritising adolescent SRHR needs.

As we look to the future, the potential of artificial intelligence (AI) and machine learning to enhance digital health interventions is exciting. These technologies could enable more personalised health recommendations, predict individual risk factors, and even assist in the early diagnosis of STIs or other reproductive health issues. However, as we explore these advanced technologies, we must remain vigilant about ethical and human rights considerations, including algorithmic bias and the potential for AI to perpetuate or exacerbate existing health inequities.

The Covid-19 pandemic further underscored the importance of digital health solutions. With lockdowns and social distancing measures restricting access to traditional healthcare services, digital platforms became lifelines for many young people seeking SRHR information and support. The global crisis accelerated the adoption of telemedicine and other digital health tools, creating an opportunity for this momentum to be built on and digital solutions to be further integrated into mainstream healthcare delivery.

However, it is crucial to recognise that digital interventions are not a panacea for all adolescent SRHR challenges in sub-Saharan Africa. Deep-rooted issues such as gender inequality, poverty, and harmful cultural practices continue to impact young people's sexual and reproductive health outcomes. Digital tools should be seen as part of a comprehensive approach that also addresses these underlying social determinants of health.

Moreover, we must ensure that digital interventions do not inadvertently replace face-to-face interactions and hands-on care where they are needed. For instance, while online counselling can provide valuable support, it cannot substitute for in-person clinical services for contraception, STI testing, or prenatal care. The goal should be to use digital tools to complement and enhance existing health services, not replace them entirely.

To truly harness the potential of digital health interventions for adolescent SRHR in sub-Saharan Africa, we need a coordinated effort involving governments, NGOs, tech companies, healthcare providers, and, most importantly, young people themselves. Youth engagement should be at the heart of designing, implementing, and evaluating these interventions. After all, who is better to inform the development of youth-friendly digital health solutions than the young people they aim to serve?

The Y+ Global network of young people living with HIV offers an inspiring example of youth-led advocacy

> **...technological solutions offer unprecedented opportunities to overcome long-standing barriers and empower young people to take control of their sexual and reproductive health.**

and programme design in the digital health space. Their initiatives demonstrate how young people can effectively leverage digital platforms to amplify their voices, share experiences, and drive positive change in SRHR policies and services (Y+ Global 2022).

As we move forward, rigorous research and evaluation will be crucial to understanding the long-term impact of digital health interventions on adolescent SRHR outcomes. We need robust evidence to guide future investments and scale-up efforts. This research should not only focus on health outcomes but also explore the broader social and economic impacts of improved SRHR among youth.

Also, it is important to note that human rights bodies such as the African Commission and African Committee of Experts on the Rights of the Child have important roles to play with regard to digital health. Currently, the African Commission is conducting a study on AI and human rights in Africa, which could provide valuable insights for digital health interventions (ACHPR Resolution 2021).

Conclusion

In conclusion, digital health interventions hold immense promise for transforming adolescent sexual and reproductive health in sub-Saharan Africa. By providing accessible, confidential, and youth-friendly information and services, these tools have the potential to empower a new generation to take control of their sexual and reproductive health. However, realising this potential will require thoughtful implementation, ongoing innovation, and a commitment to addressing the digital divide and other underlying inequalities.

Therefore, as we advocate for these digital interventions, we must approach this digital revolution with both enthusiasm and critical reflection. We must celebrate the successes while remaining vigilant about potential risks and limitations. Most importantly, we must ensure that our efforts are always grounded in the real needs and experiences of the young people we aim to serve.

The journey towards comprehensive adolescent SRHR in sub-Saharan Africa is long and complex, but digital health interventions offer a powerful tool to accelerate our progress. By harnessing the power of technology responsibly and equitably, we can work towards a future where every young person in the region has the knowledge, resources, and agency to make informed decisions about their sexual and reproductive health. This is not just a matter of public health: it is a fundamental human right and a cornerstone of sustainable development for the entire continent.

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References

ACHPR Resolution (2021) ACHPR/Res. 473 (EXT.OS/ XXXI) 2021.

Hightow-Weidman, L. et al. (2018) 'Youth, technology, and HIV: Recent advances and future directions', *Current HIV/AIDS Reports* 15(6), 403–410.

GSMA (2020) Digital Health: A Health System Strengthening Tool for Developing Countries *https://www.gsma.com/solutions-and-impact/connectivity-for-good/mobile-for-development/wp-content/uploads/2020/11/Digital-Health-June-2020.pdf .*

UNICEF (2021) *HIV and AIDS in Eastern and Southern Africa Regional Overview.*

WHO (2021) *Global Strategy on Digital Health 2020–2025.* Geneva: World Health Organization. Available at https://bit.ly/3Z0NXY0.

Y+ Global (2022) Annual Report 2021. Available at https://bit.ly/4fKjB1D.

FEATURE

Reimagining Regionalism in SRHR: The Case of the EAC and SADC

Maurice Kabazzi

Introduction

It is generally recognised that Africa's integration initiatives have not produced the desired outcomes. In contrast to other regions that have effectively leveraged their integration strategies to enhance economic well-being, Africa continues to struggle with issues related to GDP growth, per capita income, capital inflows, and overall living standards. This challenge is prevalent throughout much of the continent despite the presence of numerous policy frameworks and ambitious plans.

This article addresses the role of regionalism—including regional institutions, actors, and stakeholders—in promoting sexual and reproductive health rights (SRHR) in Africa. It is desirable to employ regionalism for the human development of citizens across the region. The duty of African governments to provide healthcare can be strengthened when they pool resources and commit to progressively realising social and economic rights at a regional level. This article interrogates the significance of regionalism for SRHR on the continent. Each regional institution, including the East African Community (EAC) and the Southern African Development Community (SADC), works collectively with state and non-state actors to ensure that access to healthcare is progressively realised. The success of regional integration in health initiatives can be observed in the EAC and SADC initiatives regarding reproductive healthcare.

A Brief Historical Overview

Since the beginning of decolonisation in the 1960s, a variety of sub-regional economic communities have been established in Africa. These include the East African Community (EAC), Southern African Development Community (SADC), Economic Community of West African States (ECOWAS), Central African Economic and Monetary Community (CEMAC), Arab Maghreb Union (UMA), Common Market for Eastern and Southern Africa (COMESA), Community of Sahel–Saharan States (CEN–SAD), Economic Community of Central African States (ECCAS), and Intergovernmental Authority on Development (IGAD).

Regionalism was spearheaded in large measure by the Organisation of African Unity (OAU) and Economic Commission on Africa (ECA), partly as a response to the last vestiges of colonialism, partly to spur political and economic progress on the continent, and partly as a political instrument to deal with power imbalances in the international system. The core mandate of the OAU was to safeguard the newly acquired independence of African states and the territorial integrity of member states.

> **Historically, regionalism in Africa focused on political considerations and economic integration, often neglecting health concerns and social policy.**

The Role of Regional Institutions

As regards sexual and reproductive health rights (SRHR), regionalism is evolving to address the gaps in regional instruments and health policies. Historically, regionalism in Africa focused on political considerations and economic integration, often neglecting health concerns and social policy. In 1981, following a General Assembly resolution urging states to establish regional bodies, the Banjul Charter was enacted as an international human rights instrument aimed at promoting and protecting human rights and fundamental freedoms across the continent. This was a significant step towards integrating human rights principles in regional frameworks.

Currently, regionalism and regional integration in SRHR are reflected in the increasing enactment of regional laws and policies. Instruments such as the African Charter on Human and Peoples' Rights (ACHPR), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ('Maputo Protocol'), and the African Charter on the Rights and Welfare of the Child collectively provide a foundation for the recognition and protection of SRHR.

These regional instruments, alongside national legal frameworks and consensus documents, underscore Africa's commitment to advancing SRHR, emphasising the need for cohesive policies that prioritise health and social well-being as integral components of regional integration. By aligning health policies with human rights standards, Africa can better address the SRHR needs of its population.

As matters stand, however, integration initiatives have emphasised political and economic integration at the expense of public goods in health care, even though the continent has the highest proportions of young people, early sexual debut, child marriage, adolescent pregnancy, unmet needs for family planning, unsafe abortions, female genital mutilation, and HIV burden in the world.

Be that as it may, there are indeed efforts to collectively address the social issues of SRHR at the regional level, as illustrated by the African Union's policy framework on SRHR. The AU Agenda 2063 recognises the need to expand access to quality SRHR services to achieve its goal of eradicating poverty. Moreover, the Maputo Protocol define the rights of women that need to be promoted, realised and protected in order to enable them to fully enjoy all their human rights. Member states are obliged to report every two years on legislative and other measures undertaken towards the full realisation of the rights enshrined in the Maputo Protocol. An example of the sub-regional adoption of these regional instruments is the SADC Sexual and Reproductive Health Business Plan for the SADC Region 2011–2015.

Regionalism is the proneness of the governments and peoples of two or more states to establish voluntary associations and pool resources (material and non-material) in order to create common functional and institutional arrangements. According to El-Agraa (1999), there are various forms of regionalism:

- Legal integration, which is the unification of national (or municipal) legal systems on the basis of common legal principles and standards (that is, inter-state legal integration), is regarded as a synonym for the concept of integration of national legal systems.

- Economic integration, which encompasses measures to abolish discrimination between economic units belonging to different national states, involves the amalgamation of separate economies into larger free-trading regions.

"...regional instruments, alongside national legal frameworks and consensus documents, underscore Africa's commitment to advancing SRHR..."

- Political integration – the collaboration of states in policy-making and governance – often leads to joint institutions or agreements that strengthen regional unity and address collective challenges.

Rethinking regionalism for Africa calls for a new approach to collective resource mobilisation and for the involvement of non-state actors. Regional institutions are political in many ways, and some regional instruments are merely political statements. Indeed, Qobo (2007) argues that the traditional model of regionalism, rooted in Pan-Africanism, is ill-suited to addressing the challenges posed by globalisation.

African leaders, Qobo maintains, have struggled to achieve meaningful integration and development, often seeking to replicate at the continental level what they have failed to accomplish domestically. This form of regionalism can be seen as an escape from pressing domestic issues and a means to solidify political alliances among member states. There is also limited participation by non-state actors, which stifles the progress of social policy in areas of health and education.

The result is that the ideology of 'African solutions to African problems' is a political statement often not directed at social justice issues. Ultimately, however, successful regional integration in Africa depends on effective policies and achievements at the domestic level, as these are prerequisites for continental progress.

Regional integration or regionalism is critical to socio-economic development, including access to health care. The EAC is illustrative in this regard. A regional intergovernmental organisation initially established in 1967, It became defunct in 1977 and was re-established in 1999 via the adoption of a new treaty, the Treaty for the Establishment of the East African Community (2000) ('the EAC Treaty'). The mission of the community is to deepen political, social, economic, and cultural integration to improve the lives of the citizens of East Africa. The EAC comprises eight member states: Burundi, the Democratic Republic of Congo, Kenya, Rwanda, South Sudan, Somalia, Tanzania, and Uganda.

The legal framework for SRHR in the EAC is established through various treaties, protocols, and policies. The EAC Treaty serves as the foundational document, emphasising the promotion of social welfare and health in the region. The treaty does not take a human rights-based approach but is concerned with governance. Its article 112 commits member states to cooperate on health issues, including sexual and reproductive health.

Regional integration or regionalism is critical to socio-economic development, including access to health care.

The EAC Regional Strategy for Sexual and Reproductive Health (2005) outlines key areas for action, such as reducing maternal and child mortality, preventing sexually transmitted infections (STIs), and promoting family-planning services.

Additionally, the EAC Health Sector Policy (2017) aims to harmonise health systems across member states and stresses the importance of SRHR in broader health initiatives. This policy advocates for increased access to reproductive health services and calls for the integration of SRHR in national health policies.

Furthermore, the Protocol on the Establishment of the East African Community Common Market (2010) includes provisions related to health services, particularly promoting the free movement of health professionals and services across borders, which can enhance access to SRHR.

Turning to SADC, this is a regional economic community founded in Lusaka in 1980 following the Lusaka Declaration, which had the aim of liberating the southern African economy. Its mandate, according to the SADC Treaty (1992), is to realise economic development, peace, and security, and improve the standard and quality of life of the people of Southern Africa. SADC consists of 16 member states, including Angola, Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia, and Zimbabwe.

While the treaty focuses on regional integration for the sake of economic development, it provides a strong basis for the inclusion of gender equality and the rights of girls and women in the development agenda. As with the EAC, SADC's legal framework for SRHR is structured through treaties and protocols. The SADC Treaty emphasises regional cooperation and integration in various sectors, including public health in general and SRHR in particular.

The SADC Protocol on Health (1999) focuses on improving health systems and promoting health-care access across member states, explicitly addressing reproductive health and advocating for the provision of comprehensive SRHR services. The SADC Strategic Plan (2020–2030) outlines the region's priorities, highlighting health and social development. It emphasises the importance of addressing SRHR issues as part of broader health initiatives. Additionally, the SADC Gender Protocol (2008) aims to promote gender equality and empower women, recognising SRHR as a critical component of women's rights and health.

The role of regionalism in advancing SRHR

Rethinking regional integration schemes in Africa and basing them on an outwardly oriented approach aimed at integration in the global economy is no longer an option for Africa. It is a necessity if economic progress is to be achieved and integration to be meaningful. This new regionalism must take into account the social well-being of Africans in the area of health.

Advancing SRHR Through Community Legislation

The EAC Sexual and Reproductive Health Bill of 2021 is testament to the workings of regional bodies and non-state actors. Introduced in 2017 by Odette Nyiramilimo, former representative of Rwanda at the Assembly, the bill is regional legislation premised on article 118 of the EAC Treaty. It recognises partner states' obligation under several international, continental, and community frameworks to respect, protect and fulfil the right to health by facilitating, providing and promoting the highest attainable standard of health and providing measures towards the full realisation of the right to health.

The objectives of this Bill are to facilitate the attainment of the life-course SRHR all persons in the community; to achieve the progressive realisation of integrated sexual and reproductive health information and services as part of the universal health coverage of each partner state; to prohibit harmful practices in the community; and to provide for related matters. Community legislation on SRHR is critical to ensure compliance and accountability across the states. The EAC SRHR bill, if passed into community law, would have a stronger influence on the health governance of member states in the region.

The EAC and SADC can leverage regionalism to advance SRHR by adopting community legislation relating to it. By integrating regional laws and policies within the communities, legal access to SRHR can be facilitated. Regional and sub-regional judicial mechanisms can be utilised to advance SRHR through the interpretation of community laws. For instance, the East African Court of Justice has been called on to interpret the legal texts of the community, engage in dispute settlement, enforce community obligations, and adjudicate on human rights violations. As such, regional and sub-regional courts can facilitate access to justice for SRHR violations.

Collaborative Policy Design and Development

To ensure regional collaboration in policy design and development with civil society and non-state actors, the African Union initiated campaigns for the reduction of maternal mortality to complement the Maputo Plan of Action – the Accelerated Reduction on Maternal Mortality in Africa (CARMMA) – which was launched in 2009. It is an ongoing campaign to reduce maternal mortality in Africa and meet the SDG target of 70 maternal deaths per 100,000 live births.

Non-State Actors in regional SRHR work

The East African Community has a framework on engaging nonstate actors in regional work, the EAC facilitates them by granting them observer status; observer status is, however, excluded in respect of the Summit of Heads of State and Government. The strategy recognises the need to mobilise civil society for more

effective participation. SADC is characterised by a state-centric approach despite Treaty provisions for people's participation. To enhance citizens' participation, the SADC Council of Non-Governmental Organisations (SADC-CNGO) was formed in 1998 by CSOs and the SADC Secretariat to facilitate meaningful engagement of the people of the region with the SADC Secretariat at the regional level, and with member states at the national level through national NGO umbrella bodies.

Notably, there are opportunities for solving technical cooperation gaps via regional advocacy networks hosted by regional institutions through strategic partnerships. The SADC Treaty recognises that non-state actors are important stakeholders in the implementation of the SADC agenda (articles 5(2b), 16A and 23). These regional spaces can be leveraged for streamlining relations between civil society and the SADC Secretariat, as the latter is working on a framework agreement for interaction with non-state actors.

In this regard, a key regional advocacy network is the SADC Gender Protocol Alliance, a regional 'network of networks' that champions adoption of the SADC Protocol on Gender and Development. The Alliance was formally founded in 2005 and is made up of 15 national gender networks and 10 regional NGOs. Coordination of the network and the campaign rests with Gender Links. The national and regional members are national focal point organisations and/or lead the various themes of the SADC Gender Protocol.

The Alliance was the driving force behind the adoption as well as implementation and review of the SADC Gender Protocol. It also publishes the Barometer on an annual basis to advocate for women and girls' rights and gender equality in the region, using the SADC Gender Protocol as its reference point.

Engaging Regional Human rights mechanisms

Regionalism can be utilised to pursue greater rights by engaging with African regional human rights mechanisms such as the African Commission on Human and Peoples' Rights (ACPHR), the African Court of Justice and Human Rights (ACJHR), and the East African Court of Justice. Such mechanisms include cultural, religious and communal institutions that have historically enjoyed the respect of the African people. The fact that some are legally recognised and others are not is of little consequence – what is fundamental is that the communities themselves legitimise their leadership.

Conclusion

By rethinking regionalism, African countries can leverage their collective efforts and resources to enhance the accessibility, quality, and sustainability of SRHR services, ultimately contributing to improved health outcomes and the realisation of sexual and reproductive rights for all Africans. Notably, there is opportunity for regionalism to advance SRHR with non-state actors.

Overall, there is potential for African institutions to inform the discourse on health, human rights, and SRHR, and, indeed, Africa has established institutions working towards advancing health, human rights and SRHR. Regional institutions such as the East African Community and SADC enable African countries to come together and develop harmonised regional laws, policies, and frameworks for SRHR. This can help establish common standards, guidelines, and approaches across the region. Regional institutions like the African Union play a key role in facilitating the development and adoption of such regional SRHR frameworks.

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References

African Commission on Human and Peoples' Rights. Resolution on Maternal Mortality in Africa–ACHPR/Res.135(XXXXIV)08 https://achpr.au.int/en/adopted-resolutions/135-resolution-maternal-mortality-africa-achprres135xxxxiv08

El-Agraa, A. (1999) *Regional Integration: Experience, Theory and Measures*. Palgrave Macmillan.

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

Qobo, M. (2007) 'The challenges of regional integration in Africa', ISS Paper 145. Available at https://www.files.ethz.ch/isn/98933/PAPER145H.pdf.

FEATURE

Sexual and Reproductive Health Rights for Women: Sexual Violence, a Violation of the Rights of Female Refugees

Talumba Kateketa

Introduction

Many individuals are compelled to leave their home countries and relocate to different nations due to strife, catastrophes, or hostilities in their countries of origin. It is at these times that female refugees experience oppression and harassment that affect their health. Female refugees face a heightened risk of being sexually exploited while living in refugee camps (Ivanova et al. 2018: 2).

Various African countries host refugees. In 2017, Africa recorded 118,374,355 refugees. Egypt recorded 185,031 refugees, the highest number in North Africa; Liberia recorded 8,433,832, the highest in West Africa; the Democratic Republic of the Congo recorded 9,521,430, the highest in Central Africa; Somalia recorded, 19,217,481, the highest in East Africa; and Angola recorded 6,283,458, the highest in Southern Africa (Adesina et al. 2022: 3). Given its perceived economic and political stability, South Africa has long been an appealing haven for asylum seekers and refugees from the neighbouring region (Freedman et al. 2020:325).

It is undeniable that refugees face numerous forms of abuse, with sexual violence being extremely prevalent in refugee camps (Akinsulure-Smith 2014: 678). It is critical to recognise that women face a significantly higher probability of being raped than men. According to Matetoane (2019: 34), women are at a higher risk due to their economic status and the social and cultural inequalities in society.

This article focuses on sexual violence against female refugees in Africa while travelling to or upon arriving in the host country. In particular, it examines the obstacles that hinder their ability to access sexual and reproductive health care. It aims to provide recommendations to address these pressing concerns through meaningful and impactful change.

Female refugees' health is determined by pre-migration events and experiences during flight and after settlement (Mwenyango 2023: 1249). The circumstances that refugees face when relocating may impact their health and deepen their vulnerabilities due to hazardous activities. Rape is one of the atrocities that female refugees have to endure when they are in transit to the host country or when they have been

It is undeniable that refugees face numerous forms of abuse, with sexual violence being extremely prevalent in refugee camps.

accommodated in refugee camps. This is a deeply traumatic experience, as fleeing from a war zone, a circumstance beyond their control, is distressing; experiencing rape intensifies the pain an individual endures (Araujo JO et al.2019:10).

Sexual violence involves coercing a person into a sexual act irrespective of the relationship the individual has with the perpetrator. This includes rape, defined as non-consensual penetration of the vulva or anus using a body part (Ogunwale et al 2019:110). In this article, 'sexual violence' and 'rape' will be used interchangeably.

Sexual and reproductive health

Sexual and reproductive health (SRH) refers to total physical, psychological, and social welfare regarding the reproductive system. In this regard, article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) stipulates that women should have the opportunity for a fulfilling safe sex life, the ability to reproduce, and the autonomy to decide if, when, and how often they do so. In terms of article 14, maintaining SRH requires access to reliable information on safe, effective, affordable, and acceptable contraceptive options. It also involves ensuring that individuals are sensitised and given the means to protect themselves from sexually transmitted infections (STIs). These goals can be realised through the proper use of available sexual and reproductive health-care services. SRH encompasses human rights for both men and women.

Victims of sexual violence face unpleasant outcomes after they have been sexually assaulted. Refugees who are victims of sexual violence in refugee camps are often stigmatised by the wider community as well as rejected, even sanctioned, by their families, which may worsen their physical and psychological injuries (Eberechi 2019: 166). The primary need of someone who has experienced a trauma like rape is acceptance and comfort. Unfortunately, female refugees are hesitant to open up to counsellors due to the fear of facing social stigma. The stigma related to sexual violence often prevents survivors from receiving the support they need. Such support is frequently unavailable to female refugees anyway because state resources are usually limited to citizens and documented residents in the state. Geographical location and linguistic factors can pose even further barriers to accessing support.

The traumatic experiences that victims of rape undergo often have profound consequences, such as fistulas, sexually transmitted infections (STIs), contracting HIV, unwanted pregnancies, complications during childbirth, and unsafe abortions (Ivanova et al. 2018: 8). Furthermore, the psychological effects, including anxiety, shame, and post-traumatic stress disorder, can be devastating. During crises, female refugees who are victims of sexual violence are particularly vulnerable due to the unstable environment and heightened exposure to violence. This underscores the urgency of providing immediate care and support for rape victims, as their grief cannot be overlooked.

> **Refugees who are victims of sexual violence in refugee camps are often stigmatised by the wider community.**

Unfortunately, the devastating effects of sexual violence are often disregarded. It is important to acknowledge their significant impact, considering the historical marginalisation of women in diverse cultures. By addressing these hurdles, a way will be paved for a more inclusive and equitable realisation of women's right to access sexual and reproductive health (SRH) services.

Prioritising the provision of SRH services to marginalised individuals, including those who have been displaced, is crucial. Access to these services is a basic human right and can significantly impact their well-being and quality of life. By ensuring that these individuals have access to SRH services, ostracised individuals can find help to lead healthier and more stable lives. Despite the urgent need for refugee women to access SRH

services, these vulnerable persons encounter barriers that undermine their right to SRH care.

These challenges stem from the failure of stakeholders to understand the extent of the prevalence of sexual violence against female refugees and the reluctance of female refugees to report instances of sexual violence – reluctance often stemming from concerns about shame, social exclusion, and bringing dishonour to their families. This will be discussed next.

Barriers to the exercise of SRHR of female refugees

In some cultures, victims of sexual violence face immense barriers to speaking out due to the taboo surrounding sex and the fear of having their privacy invaded if they report such traumatic experiences (Miller 2011: 78). Additionally, in numerous communities, these acts are regarded as disgracing the entire community and the victim's family (Stevens & Eberechi 2019: 166). This indicates that extraordinarily little sensitisation has been conducted in the community on sexual violence and the importance of disclosing it when it occurs.

It is crucial to recognise that many individuals are hesitant to report sexual violence incidents due to the fear of being stigmatised (Miller 2011:78). In certain societies, women are prohibited from revealing such adversities. It is important to encourage an environment of understanding and support rather than judgment and taboo around these issues. In most cases, a woman who has been raped may need to report the incident to the police before being able to receive a medical referral for treatment (Matetoane 2019: 31). This means that many female refugees do not access medical help, as many rape cases remain unreported.

Lack of knowledge about sexual violence against female refugees has contributed to the issue of rape being ineffectively addressed. There are several reasons why it is difficult to gather precise data on sexual violence. For example, many refugee women and asylum seekers who have been raped do not report the incident, which hinders their access to SRH care. Evidence also shows that police officials or humanitarian aid workers have been perpetrators of sexual violence (Sarkin & Morais 2023: 11). Victims are often afraid to report them for fear of not being able to seek help from these officials during xenophobic incidents. Moreover, some women are sexually assaulted by military officials meant to facilitate their relocation during armed conflicts (Freedman et al. 2020: 327).

In addition to the issue of underreporting, refugee women encounter various obstacles that prevent them from accessing SRH services. Limited access to HIV prevention services, such as pre- and post-exposure prophylaxis and testing, increases the risk of HIV infection among refugees. Insufficient health-care access also prevents many refugee women from starting HIV treatment. Furthermore, they often lack information about where to find SRH services.

Another major barrier is language, as refugees struggle to communicate with health-care providers (Ivanova et al. 2018: 9). While courts use translators in legal proceedings, it is equally important that state authorities employ translators in health-care settings to bridge this gap for vulnerable populations.

Furthermore, it sometimes takes many years for asylum seekers to acquire documentation. Asylum seekers who are raped thus face barriers in accessing health care due to a lack of documentation. Those who consequently become infected with HIV or STIs face challenges in receiving treatment at clinics and hospitals due to a lack of valid documentation

> **“ It is important to acknowledge the significant impact of sexual violence, considering the historical marginalisation of women in diverse cultures.**

(Freedman et al. 2020:324). This worsens their health conditions, as failure to obtain treatment for chronic diseases like HIV/AIDS is a serious health hazard.

In humanitarian settings, it is essential to include SRH services as part of the minimum health care package. The support that survivors of sexual violence need is often not included in current health services, such as reproductive and maternal health, mental health, and psychosocial support, and is not offered as a separate service (Moreno 2014: 2023).

According to Eberechi (2019: 166), the current state of the criminal justice system in African countries poses a major obstacle for victims of sexual violence, especially in refugee camps. In this system, victims cannot directly approach the courts to protect their rights, as offences are seen as crimes against the state rather than individuals. This creates challenges for victims in refugee camps, where court facilities are often unavailable. While access to courts is crucial for justice, in many African countries, victims are usually only witnesses in state prosecutions, limiting their ability to seek redress. Empowering victims to assert their rights and pursue remedies is fair and vital for creating a just and equitable legal system. Victims of sexual violence have the right to seek justice and hold perpetrators accountable, making it crucial to advocate for a system that prioritises their rights and well-being (Eberechi 2019: 163).

State actors have shown little positive response to sexual violence against refugee women. When asylum seekers arrive in a host country, they must begin applying for refugee status. In a country like South Africa, a major destination for refugees, processing these applications can take up to 19 years before a final decision is made (Amnesty International 2019: 5). Such administrative delays indicate weaknesses in the asylum system. Although South Africa's Immigration Act 13 of 2002 promises swift processing, little has been done to improve efficiency, and delays remain a persistent issue.

Many African countries have not effectively prosecuted perpetrators of rape within the host country. As mentioned, when police and military officials rape refugees, they are rarely prosecuted or convicted. A major reason for the lack of prosecution is insufficient evidence. This failure to prosecute fosters impunity, as punishment serves to deter repeat offences.

> **It is crucial to recognise that many individuals are hesitant to report sexual violence incidents due to the fear of being stigmatised.**

There is truly little community sensitisation on the issue of sexual violence against refugee women. As a result, refugees and asylum seekers continue facing sexual violence without any relief or closure. In addition, there is no provision of health-care services for these victims, especially before acquiring their status determination. It is also essential to highlight that countries like South Africa offer women who have suffered sexual violence an inherent right to seek asylum, but regrettably, these vulnerable individuals are typically unaware of this crucial entitlement (Freedman et al. 2020: 326).

It is clear from the evidence that the implementation of SRH programmes is feasible in humanitarian settings. However, they fail to meet high-quality standards, which might result in the needs of female refugees not being met. For example, research revealed that the range of contraceptive options provided in humanitarian settings was often restricted to just birth control pills and condoms (Ivanova et al. 2018:2). Therefore, it is crucial to broaden the spectrum of contraceptive options beyond mere pills and condoms to guarantee comprehensive reproductive health care for all female refugees in humanitarian settings. This expansion would empower women to make informed choices about their reproductive health and effectively plan their futures. Female refugees not only require family-planning services but also have many other needs, such as HIV/STI testing, treatment and mental health and psychology support. Thus, there is a need to broaden the SRH services provided.

It is essential to recognise that women have unique health needs related to their sexual and reproductive functioning. Acknowledging these factors is crucial for ensuring proper health care and support for women. The following recommendations are made to help address the issues impacting the well-being of female refugees.

- Healthcare workers must be trained to provide care for survivors of sexual violence effectively. Equipping them with the necessary skills in SRH services would help ensure that female refugees have unimpeded access to the care and support they require during such difficult times.

- Other African countries must take inspiration from South Africa's progressive approach and grant women who have suffered sexual persecution an automatic right to obtain asylum. Furthermore, it is crucial to ensure that women who have been victims of sexual abuse and are seeking refugee status in South Africa are fully informed of this automatic right to seek asylum.

- Communities need to raise awareness and educate women about the importance of speaking out about their experiences of sexual violence. By doing so, victims may be made aware of free psycho/social counselling services which would aid their healing process and educate them on their right to access sexual and reproductive health services. African states need to take action to remove obstacles such as language barriers between facilitators and female refugee victims by providing translators and interpreters to facilitate effective communication. This would significantly enhance the ability to collaborate and achieve these goals.

Conclusion

Female refugees are disproportionately affected by sexual violence both in transit to and within the host country. As a result, their risk of becoming infected with HIV/AIDS and STIs is remarkably high. One reason why this problem persists is that there is a lack of research, often due to female refugees not reporting crimes. It is also crucial to recognise that the barriers preventing female refugees from exercising their sexual reproductive and health rights are rooted in stakeholders' failure to comprehend the severity of sexual violence.

Nonetheless, the lack of understanding among these vulnerable individuals of their role in addressing sexual violence prevents them from accessing SRH care. Their reluctance to report sexual violence, often stemming from concerns about shame, social exclusion, and bringing dishonour to their families, obstructs their ability to access crucial information and support such as HIV/AIDS and STI testing and rape counselling.

To address these issues, African states should improve conditions so as to facilitate reporting, such as by raising awareness in communities about the prevalence of sexual violence and educating people about the steps victims should take. In addition, translators and interpreters must be available to eradicate language and communication barriers to helping female refugee victims.

The quality of SRH services for female refugees who have experienced sexual violence also needs to be improved. Finally, having access to accurate statistics on sexual violence is crucial for taking decisive action against these crimes and ensuring that the perpetrators are held accountable through prosecution.

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References

Adesina, M., Adeel, M., Omigbile, O et al (2022)'Trends and Drivers of Refugees in Africa' *European Journal of Environment and Public Health* 6(1)1-8.

Akinsulure-Smith, A. M. (2014) 'Displaced African female survivors of conflict-related sexual violence: Challenges for mental health providers', *Violence against Women* 20(6), 678–694.

Amnesty International (2019). *Living in limbo: Rights of asylum seekers denied*. Available at https://www.amnesty.org/en/documents/afr53/0983/2019/en/.

Araujo J., De Souza. S. M., Proença R., Bastos L.M., Trajman A. and Faerstein E. (2018). Prevalence of sexual violence among refugees: a systematic review. *Revista de Saude Publica*, 53:78, p.p. 1-15.

Eberechi, O. E. (2020) 'A comparative analysis of the application of the 1951 Refugee Convention to victims of sexual violence in South Africa, Tanzania and Uganda', *PER/PELJ* (23), 1–56.

Freedman, J., Crankshaw, T. L., & Mutambara, V. M. (2020) 'Sexual and reproductive health of asylum-seeking and refugee women in South Africa: Understanding the determinants of vulnerability', *Sexual and Reproductive Health Matters* 28(1), 324–334.

Geldenhuys M., Kauufulu-Kumwenda C., Nabaneh S. and Stefiszyn K. (2014). The African Women's Protocol and HIV: Delineating the African Commission's General Comment on articles 14(1)(d) and (e) of the Protocol. *African Human Rights Journal*, 14, p.p. 681-704.

Ivanova, O., Rai, M. & Kemigisha, E. (2018) 'A systematic review of sexual and reproductive health knowledge, experiences and access to services among refugee, migrant and displaced girls and young women in Africa', *International Journal of Environmental Research and Public Health* 15, 1–12.

Matetoane, G. (2019) 'The experiences of refugee women who were exposed to sexual violence' (mini dissertation, University of Pretoria). Available at https://bit.ly/4er2GzO.

Miller, L. (2011) 'The irony of refuge: Gender-Based violence against female refugees in Africa', *Human Rights & Human Welfare* 11(1), 75–90.

Moreno, C. G. (2014) 'Responding to sexual violence in conflict', *The Lancet* 383, 2023–2024.

Mwenyango H (2023) 'Gendered dimensions of health in refugee situations: An examination of sexual and gender-based violence faced by refugee women in Nakivale refugee settlement, Uganda' *SAGE* 66(4)1247-1261.

Ogunwale, AO., Oshiname, FO., & Ajajunna, FO (2019) 'A Review of the Conceptual Issues, Social Epidemiology, Prevention and Control Efforts Relating to Rape in Nigeria' *African Journal of Reproductive Health* 23(4)108-123.

Sarkin, JJ& Morais, T (2023) 'A Cost-benefit Assessment of Refugee and Asylum seeking Women Reporting Sexual and Gender-based Violence in Uganda: Assessing Women's Resilience as a Means to Protect their Ethno-religious Group' 38(1)1-29 available at https://doi.org/10.25159/2522-6800/13424.

Stevens, GP & Eberechi, OE (2019) 'A critical analysis of Article 16 of the UN Refugee Convention in relation to victims of sexual violence in refugee camps in Africa' *De Jure Journal* 163-180.

POLICY REVIEW

Bridging the Gap: How South Africa's Guidelines on Self-Managed Abortion Fall Short of WHO Standards

Lydia T Chibwe

Introduction

Self-managed abortion (SMA) with drugs such as mifepristone and misoprostol is widely recognised as a safe and successful method of terminating pregnancies, especially in the first trimester (Foster et al. 2020). The World Health Organization (WHO) has developed guidelines to encourage SMA, emphasising access, safety and respect for women's autonomy (WHO 2022). By contrast, South Africa has progressive abortion legislation, yet its National Clinical Guidelines for the Implementation of the Choice on Termination of Pregnancy Act restricts access to SMA, thus contradicting WHO recommendations.

The policy review aims to recommend how South Africa's guidelines can be aligned with international standards to better support women's reproductive rights and health.

Overview of the WHO guidelines for SMA

According to the WHO's complete standards for abortion treatment, countries should:

- make it easier to share correct information on the use of medical abortion medicines;
- empower community health workers to assist with SMAs (WHO 2022);
- eliminate legal sanctions for anyone seeking or conducting abortions outside of established health institutions (WHO 2022); and
- allow women to safely manage abortions outside of clinical settings if they have access to quality information and support services (Ganatra et al. 2017).

South Africa's abortion policy: Context and current guidelines

South Africa's Choice on Termination of Pregnancy Act (CTOPA) of 1996 permits abortion up to 12 weeks after conception, with provisions for up to 20 weeks for specified cases. While the Act is a major step forward for reproductive rights, it has restrictions that limit SMA. Although abortion is a legal right, safe abortion services are primarily facility-based, posing challenges for women who want or require SMA (Guttmacher Institute 2020).

> **... legal restrictions drive women to unsafe abortion practices, increasing health risks and mortality.**

> **Stigma not only hinders women from using facility-based treatments but also makes them unwilling to seek help for SMA.**

Analysis of Gaps Between National Abortion Guidelines and WHO 2022 Guidelines

In 2019, the National Clinical Guidelines on the Implementation for the Choice on Termination of Pregnancy Act ('National Abortion Guidelines') were introduced by the National Department of Health. The guidelines are a key regulatory instrument that provides a clinical framework for abortion care and aims to operationalise legal provisions for abortion. This instrument may thus either inhibit or facilitate the availability, accessibility and acceptability of abortion services.

Legal and regulatory barriers

Although CTOPA does not criminalise SMA, ambiguity in overlapping regulations might result in prosecution and stigma for women who perform abortions outside of health institutions (Morroni et al. 2022). For example, the Medicines and Related Substances Act restricts the availability of abortion-inducing medications to licensed institutions and skilled healthcare practitioners (Kumar 2013).

The WHO's position: The WHO asserts that legal restrictions drive women to unsafe abortion practices, increasing health risks and mortality (WHO 2022). South African guidelines do not provide specific legal protection for women who self-manage abortions, in contrast to WHO recommendations that call for full decriminalisation (Berer 2017).

In South Africa, home use of misoprostol is limited to pregnancies up to 10 weeks + 0 days' gestation. Beyond this period, facility-based termination-of-pregnancy (TOP) care is required for managing medical TOPs and addressing severe complications. The South African guidelines emphasise that individuals must have access to professional medical advice and emergency care in case of complications, restricting the use of abortion medications to clinical settings supervised by health-care professionals.

The WHO's position: The WHO supports a flexible approach, recommending that individuals with gestational ages of less than 12 weeks can safely manage medical abortions on their own using a combination of mifepristone and misoprostol or misoprostol alone. The WHO argues that this method improves access to safe, timely, and affordable abortion care, particularly in contexts where formal health-care facilities are inaccessible.

Mandatory facility-based abortion services

Current South African guidelines prioritise in-clinic procedures for medical abortions (Rasweswe-Choga et al., 2023). Although this strategy is consistent with the purpose of safety, it may be a barrier for some who would prefer home-based care owing to privacy concerns or practical problems, such as travel expenses and stigma.

The WHO's position: The WHO advocates for SMA with adequate support for women up to 12 weeks pregnant, as long as they have access to credible information and referral services (Ganatra et al. 2017). According to research, SMAs can be just as safe and successful as those performed in clinical settings (Foster et al. 2020). Lack of comprehensive information and counselling services

While South African policy requires pre- and post-abortion counselling, it focuses on facility-based treatments, leaving little guidance for SMA (Rasweswe-Choga et al., 2023). Many women do not have access to evidence-based information about the use of mifepristone and misoprostol for SMA.

The WHO's position: The WHO supports comprehensive information campaigns to help people make informed decisions about abortion treatment (WHO 2022). According to research, when women are properly educated, they can safely manage abortions with medication (Constant et al. 2014). South Africa's inability to give this information demonstrates a severe policy gap that jeopardises women's capacity to safely self-manage abortions.

Social, cultural and stigma barriers

Despite the legalisation of abortion, societal stigma remains strong in South Africa, resulting in judgment

of and discrimination against women seeking abortion services (Harries et al. 2019). Stigma not only hinders women from using facility-based treatments but also makes them unwilling to seek help for SMAs.

The WHO's position: The WHO emphasises the need for comprehensive efforts to decrease abortion stigma by pushing for legislation and public health campaigns that normalise and promote abortion as a valid element of reproductive health care (Berer 2017). South Africa's present legislation does not aggressively tackle widespread stigma, limiting women's access to safe SMA services and support networks.

Policy recommendations for South Africa

South Africa should take the following steps to harmonise its national policy with WHO standards and enhance access to SMA services:

- Develop updated guidelines that aim to both mitigate documented barriers to abortion and be aligned with WHO recommendations, including those on SMA.
- Implement policies that equip non-clinical health-care personnel to give counselling and support for SMAs, based on the WHO's task-shifting model (Ganatra et al. 2017).
- Launch nationwide public health initiatives to spread correct information about SMA and prepare health-care practitioners to give nonjudgmental assistance. This technique would help women make educated decisions regarding their reproductive health (Constant et al. 2014).
- Create community engagement activities to reduce social stigma and educate the public on abortion rights and self-management safety. This could contribute to a friendlier atmosphere for women seeking SMA services (Harries et al. 2019)

Conclusion

Despite South Africa's progressive abortion regulations, its existing SMA guidelines do not meet the WHO's requirements fully. Legal ambiguity, restricted access to medical abortion medication, required facility-based services, and cultural stigma all impede women's autonomy and access to safe abortion management. South Africa would improve reproductive equity and SMA practice safety by implementing a more supportive policy framework in line with WHO recommendations.

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References

Bankole, A., Remez, L., Owolabi, O., Philbin, J., & Williams, P. (2020). From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress. https://doi.org/10.1363/2020.32446

Berer, M. (2017) 'Abortion law and policy around the world: In search of decriminalisation', *Health and Human Rights Journal* 19(1), 13–27.

Constant, D., Grossman, D., Lince, N., & Harries, J. (2014) 'Self-induction of abortion among women accessing second-trimester abortion services in the public sector, Western Cape Province, South Africa: A cross-sectional study', *BMC Women's Health* 14(1), 1–6.

Foster, A. M., Arnott, G., & Hobstetter, M. (2020) 'Community-based distribution of misoprostol for early abortion: Evaluation of a program along the Thailand-Burma border', *Contraception* 101(4), 235–241.

Ganatra, B., Gerdts, C., Rossier, C., Johnson, B. R., Tuncalp, O., Assifi, A., & Bearak, J. (2017) 'Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model', *The Lancet* 390(10110), 2372–2381.

Guttmacher Institute. (2022) South Africa country profile, 2022, https://www.guttmacher.org/regions/africa/south-africa#.

Harries, J., Stinson, K., & Orner, P. (2019) 'Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa', *BMC Public Health* 9(1), 1–9.

Kumar, A. (2013) *Health Consequences of Restrictive Abortion Laws in Sub-Saharan Africa. Public Library of Science.*

Morroni, C., Moodley, J., & Cleland, K. (2022) 'The South African Choice on Termination of Pregnancy Act: Time for reform?', *South African Medical Journal* 112(5), 349–352.

Rasweswe-Choga, M., Lince-Deroche, N., & Blanchard, K. (2023) 'Barriers to safe abortion services in South Africa: Findings from the most recent abortion barriers study', *South African Journal of Obstetrics and Gynaecology* 29(1), 42–47.

World Health Organization (WHO) (2022). *Abortion Care Guideline.* Available at https://bit.ly/40GNGdS.

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