



THE LEGAL AND POLICY FRAMEWORK ON MEDICAL ABORTION SELF-CARE IN UGANDA



CEHURD
social justice in health

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KEY DEFINITIONS

Abortion: Abortion is the ending of a pregnancy by removal or expulsion of an embryo or fetus before it can survive outside the uterus.

Abortifacient: An abortifacient is a substance/drug that induces abortion. Common abortifacients used in performing medical abortions include misoprostol and mifepristone, which can either be used independently or together.

Dispense: To supply a medicine or poison on and in accordance with a prescription duly given by a duly qualified medical practitioner, dentist or veterinary surgeon.

Dispenser: A dispenser is someone who dispenses/carries out the act of dispensation.

Drug: Any substance or preparation used or intended to be used for internal or external application to human or animal body either in the treatment or prevention of disease or for improving physiological functions, or for agricultural or industrial purposes.

Essential Medicines: World Health organization (WHO) defines these as Medicines that satisfy the priority health care needs of the population. These are the medications to which people should have access at all times in sufficient amounts.

Harm Reduction: Harm Reduction, or harm minimization, refers to a range of public health policies and practices designed to designed to lessen the negative social and/ or physical consequences associated with various human behaviors, both legal and illegal

Medical abortion: A medical abortion is an abortion that is completed using a combination of medicines either taken orally or through the vagina

Medical abortion self-care: An evidence-based approach that enables women and girls to realize their sexual and reproductive rights, through making own informed decisions to safely terminate a pregnancy and prevent mortality and morbidity associated with unsafe abortion

Prescription: An instruction written by a medical practitioner that authorizes a patient to be issued with medication or treatment

Self-care: The ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health worker. Also, WHO defines self-care interventions as tools which support self-care.

Supplier: A person who supplies or agrees to make available a good or service

LIST OF ACRONYMS & ABBREVIATIONS

AOGU	Association of Obstetricians and Gynecologists of Uganda
ASC	Abortion Self-care
CAC	Comprehensive Abortion Care
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CEHURD	Center for Health, Human Rights and Development
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organizations
ESCRs	Economic Social and Cultural Rights
EMHSLU	Essential Medicines and Health Supplies List for Uganda
FP	Family Planning
GBV	Gender Based Violence
HCPs	Healthcare Professionals
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IPPF	International Planned Parenthood Federation
MA	Medical Abortion
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
MPDSR	Maternal and Perinatal Death Surveillance and Response
MVA	Manual Vacuum Aspiration
PAC	Post Abortion Care
PHC	Primary Health Care
SA	Safe Abortion
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UDHS	Uganda Demographic and Health Survey
UHC	Universal Health Coverage
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization

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1. INTRODUCTION

Access to safe and legal abortion remains out of reach for women and girls in Uganda. Uganda suffers a persistently high maternal mortality ratio (MMR) currently at 336 per 100,000 live births (UDHS 2016) with the bulk of these deaths attributed to unsafe abortion. During the financial year 2019/2020, about 45% of all the maternal deaths reported were due to hemorrhage while abortion complications accounted for 8% of the maternal deaths up from 5% in the financial year 2018/2019 (MPDSR FY 2019/2020). This increase can largely be attributed to the difficulty in accessing services because of the restrictions imposed to combat COVID-19 at the time. Unsafe abortions are also largely due to inadequate access to contraceptives, teenage pregnancies and the restrictive legal and policy framework. This has a negative effect on the lives of several adolescent girls and young women as documented by the CEHURD in its publication titled “Facing Uganda’s Law on Abortion: Experiences of women and service providers.”

Unfortunately, evidence shows that only 50% of women who have unsafe abortions reach the health facility to make the statistics, while many who cannot be counted remain in

the community. The major reasons for these unfortunate statistics lie in the restrictive legal environment in Uganda, which criminalizes abortion providers, the woman, and anyone who knowingly supplies anything for termination of pregnancy as reflected in the Penal Code Act; yet also allows for termination of pregnancy to save the life of a woman. Also, it does not help that the laws on abortion in Uganda are very confusing and restrictive, the Government has neglected to operationalize Article 22(2) of the Constitution as a way of regulating safe and legal abortion in Uganda making healthcare service providers hesitant to provide safe and legal abortion services while law enforcement officers and judicial officers do not effectively enforce and implement laws that permit safe abortion. This denies women and girls access to safe and legal abortion health care services driving them into unsafe methods of termination of pregnancy leading to various complications.

Abortion and self-care fall entirely under the right to health and specifically under the Sexual and Reproductive Health and Rights. Regional and International Instruments emphasize the right to the highest attainable standard of physical and mental health for everyone and emphasize the need for States to put in place opportunities

and structures to ensure that women access suitable health care for their needs including abortion health care. Uganda has ratified several such Instruments and placed a reservation on a provision within the Protocol to the African Charter on Human and People's Rights on the rights of women in Africa (Maputo Protocol) which is core to access of abortion health care for women in Africa.

Therefore, the implementation of provisions of the instruments largely remains on paper as Uganda continues to grapple with many deaths of women and girls due to unsafe abortion. The legal and policy environment on abortion health care remains largely restrictive hence a barrier to women's access to Safe Abortion Care.

With an aim of transforming public policy and legislation to create an enabling environment for medical abortion self-care as a key part of a supportive health system for abortion care, CEHURD has developed this paper with an aim of building on the wealth of knowledge and resource materials on the legal framework on SRHR. This is intended to benefit health workers, members of the community, lawyers, members of Civil Society Organizations, academia among others.

2. BACKGROUND

2.1 The Concept of Self-care in Sexual and Reproductive Health

According to the WHO, 56 million women each year choose to have an abortion for many different reasons. Abortion is one of the most common medical procedures for women around the world and yet many women do not have access to safe abortion services and are forced to risk their lives and health. Unsafe abortion is a leading cause of maternal mortality and almost all abortion-related deaths occur in developing countries, with the highest number occurring in Africa. Each year, between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion. About 30 in every 100,000 women who have an unsafe abortion die from complications and that number rises to 220 deaths per 100,000 unsafe abortions in developing regions and 520 deaths per 100,000 unsafe abortions in sub-Saharan Africa.

Globally, 22,500 to 44,000 women die unnecessarily each year due to unsafe abortion. Many more women suffer long-term complications such as infertility and chronic pain. The average maternal mortality ratio is three times higher in countries with more restrictive abortion laws (223 maternal deaths per 100,000 live births) compared to

countries with less restrictive laws (77 maternal deaths per 100,000 live births). When considering all causes of maternal death, almost all (99%) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa and almost one third occur in South Asia.

Self-care strategies address the inequitable access to SRH services, including abortion care, through opportunity for increased access, autonomy, and reduced stigma for advancing SRH (Erdman, 2018; Narasimhan, 2019). Self-care interventions include practices, tools, and strategies for people to take an active role in managing their own health. These interventions are diverse and include self-injection for contraceptives, self-screening or testing for STIs and pregnancy, self-medication for abortion and HIV, and self-monitoring for fertility. The interventions are already in use around the globe and are expanding rapidly with minimal regulation. Although they can improve access for hard-to-reach populations and reduce the burden on overstretched health services, the potential for misuse and possible harms for users must be considered.

The WHO developed global normative guidance in 2019 on self-care interventions for SRHR.

The guidance emphasizes the importance of understanding places of access, the enabling environment, and accountability in order for self-care strategies to advance health, gender equality, and human rights across the life course (WHO, 2020). While some self-care strategies are widely known and available across different global settings, others may be less acknowledged, available, and accessible, such as abortion self-management or self-injectable long-acting contraceptives (Narasimhan et al, 2020).

Access to, and availability of SRH services has increased worldwide in the past decade (WHO, 2019). However, certain populations, including women, sex workers, and people who use drugs, may have lower levels of HIV knowledge than the general population (Mumtaz et al, 2020). Even where self-care policies are in place, such as in Pakistan and Qatar, there have been concerns that knowledge gaps in provision of SRH counselling and education may lead to misuse of diagnostic tests or incorrect medication dosage (Shaikh et al., 2005; Hajj et al., 2012). Stigma surrounding access to SRH services and sexually active unmarried persons presents barriers to SRH services access.

The stigma towards people living with

HIV and women accessing abortion services is a persistent concern. These intersecting forms of HIV and abortion stigma may be amplified for young persons, and both have similar root causes: harmful gender relations, poverty, misogyny, negative cultural practices and limited of women empowerment and gender discrimination. While some services are available at the PHC level, these services are developed for married women and may exclude young people and adolescents due to stigma surrounding nonmarital sex or adolescent sexuality.

Another phenomenon that highlights the relevance of self-care for SRHR is the presence of conflict, at-risk populations and refugee populations (Logie et al., 2019). Self-care interventions for SRHR have been described as particularly relevant for humanitarian and conflict-affected contexts that may have limited health care resources and insufficient health infrastructure, inadequate or delays to accessing healthcare and may not have widespread evidence-based SRH policies, practices, and resources. In light of scarce government resources, increased access to self-care SRH strategies may enhance access for all populations within conflict-affected countries. Despite their relevance, there are knowledge gaps regarding

SRH self-care access and priorities among forcibly displaced persons, including persons who may experience intersecting forms of stigma such as adolescents.

The benefits, risks, rights, and health concerns will vary by self-care intervention, health system, legal context, and characteristics of the user. When appropriate safeguards are in place, self-care interventions can contribute to improving health; when information, support, and quality control are lacking, the reverse may occur. Self-care SRH interventions have been identified as priority areas, but there is need to summarize the information on self-care focusing on what it is, requirements for access, missed opportunities, implementation frameworks, perceived challenges, and recommendations.

2.2 Principles for Successful SRH Self-care interventions

1. Implementing a holistic view of health that integrates the roles of individuals as active agents in their own health decision-making within the community and the healthcare system that includes social support and carers; with human empathy, respect and caring in both health maintenance and in coping with ill-health.

2. Realizing that people have varying perceptions of health risks, and these may shape their values and preferences toward self-care interventions, such that conceptions of risk-taking related to their health must be evaluated based on individual values and preferences.
3. Acknowledging that there are approaches to prevention, treatment and healing that are culturally and traditionally different among different societies and populations, and that offering opportunities for better access, choice and cost in health decision-making, in a way that is free of discrimination, coercion, violence, stigma and is critical for improved health outcomes.
4. When considering SRH self-care strategies, risk and benefit assessments may be different depending on the setting and population. However, with adequate normative direction, a regulatory framework, and a supportive enabling environment, SRH self-care programmes promote individuals' active participation in their healthcare and promise to enhance patient health outcomes.
5. Supporting a social ecological model, where key constructs and values place health practices, behaviors, capacities and decisions within the social context of the lives of individuals and communities.
6. Promoting self-resilience, autonomy and agency as expressions of human dignity and development;

3. THE CONCEPT OF MEDICAL ABORTION SELF-CARE

The WHO defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a health worker. WHO defines self-care interventions as tools which support self-care. Self-care interventions include evidence-based, quality drugs, devices, diagnostics and/or digital technologies which can be provided fully or partially outside of formal health services and can be used with or without the support of a health worker. Globally, between 2010-2014, an estimated 25% of all pregnancies ended in abortion, a large proportion of which were self-managed. When individuals do not have access to

safe abortion care, they may resort to unsafe abortions. Unsafe abortion can result in outcomes that negatively affect quality of life and well-being, with some individuals experiencing life-threatening complications.

Due to restrictive laws and other regulatory barriers, poor availability of services, high cost of medical services including abortion services, stigma, conscientious objection of health-care providers, and unnecessary requirements designed to delay and restrict access (such as mandatory waiting periods, counselling, medically-unnecessary tests, third-party authorization), individuals around the world frequently lack access to safe abortion care. Among the many obstacles that limit access to safe abortion care are the lack of trained providers and the stigma associated with accessing services, which may leave some individuals, especially those who are already marginalized, without care. Access to medical abortion through self-care is essential to the realization of SRHR, provided that individuals have access to accurate information and support prior to and after self-care abortion. Abortions may be safe if they are performed or assisted by a medical professional with the proper training. Self-managed abortions refer to situations in which an individual

decides to securely manage their own abortion procedure.

The ability of individuals and communities to enjoy self-care depends on the availability, accessibility, affordability and acceptability of a range of quality, evidence-based self-care interventions; and on the enablers described in the WHO conceptual framework. The many reasons why individuals may choose a given self-care intervention include convenience, lower cost, empowerment, privacy, confidentiality, a better fit with values or daily lifestyle, or because the intervention provides the desired options, better decision-making and choice. People may also opt for self-care interventions to avoid challenges posed by the health system itself, such as lack of quality care (which includes stigmatization or lack of confidentiality by health workers), or a lack of access (such as in humanitarian settings or places that are geographically remote from health facilities, or long waiting lists). Self-care interventions fulfil a particularly important role in these situations, as the alternative might be no access to services at all. Self-care is not a new concept, nor does it apply exclusively to abortion.

MA self-care is an evidence-based approach that enables women and girls to realize their SRHR through

making their own informed decisions to safely terminate a pregnancy and prevent mortality and morbidity associated with unsafe abortion. The approach enables women and girls to overcome legal and regulatory policy restrictions and inadequate health care systems, while simultaneously challenging harmful social norms and patriarchal structures that either limit access to preventive measures of unintended pregnancy or access to safe abortion. Health workers and health experts have been advancing and encouraging this approach for decades, and even more so as technology increasingly supports more straightforward access to information, enabling individuals to make informed decisions about their health.

MA self-care refers to the use of medications to end a pregnancy through the use of pills. Abortion pills are a safe and effective way to end an undesired pregnancy, especially when administered in the first trimester. Misoprostol and mifepristone are the drugs used in medical abortion. Misoprostol can be taken either alone or in conjunction with mifepristone. These drugs trigger a miscarriage-like procedure. “Abortion with pills” or “medication abortion” are other terms for medical abortion. Self-managed MA is the use of abortion pills to end a pregnancy by women themselves outside of formal medical settings.

Women and other pregnant persons who want to terminate their pregnancy want knowledge on how to use the drugs efficiently, what to expect, precautions to take, and when medical treatment is required. Self-managing an abortion with tablets in early pregnancy has been demonstrated to be safe and effective when people have the right information, and it is common all around the world. Information on successfully self-managing MA can be empowering for women because it assists them in safeguarding their lives and health.

MA self-care is safe and effective, and it has the potential to improve access to abortion treatment (Moseson et al., 2020). Both the combination pack of mifepristone and misoprostol, as well as the less effective misoprostol-alone regimen, are available over the counter in many countries. Over the last decade, increased availability to MA through pharmacies has contributed to a reduction in unsafe abortion and its accompanying morbidity and mortality worldwide. It was especially useful during the Covid-19 outbreak, when health-care institutions were inaccessible owing to lock-down measures. Users of pharmacy-provided MA need: a) Quality goods; b) Adequate information about the drugs; and c) Access to follow-up help when making a diagnosis of complete abortion or in the event of

abortion complications. Incorporating MA self-care into health services is an innovative way to promote PHC, increase UHC, and help maintain continuity of health services that would otherwise be disrupted due to health emergencies.

The WHO produced global normative recommendations on MA self-care treatments, with the first volume concentrating on SRHR. Each recommendation is the result of extensive consultations and an evaluation of the available data. A human rights and legal analysis can identify potential issues and assist guide the enabling environment needed to ensure adequate and equal access to excellent self-care interventions, particularly for those in vulnerable situations. If used in the first trimester, Medical Abortion self-care using mifepristone and misoprostol has been shown to be safe and successful 95-98% of the time. Misoprostol-only abortion has also been demonstrated to be quite safe and effective 75-90% of the time if performed during the first 12 weeks of pregnancy (ACOG, 2014). Abortion using these drugs is a risk-free method of terminating a pregnancy.

Strengthening MA self-care constitutes a paradigm shift by equipping the user with the tools and autonomy to manage their own health. Under this paradigm,

health care professionals become facilitators of care, while individuals acquire higher responsibility for their own care. As such, pregnant individuals need to be appropriately equipped with accurate knowledge and available resources to support them before, during and after the process. MA self-care demonstrates the potential of enabling abortion care, regardless of legal restrictions in any country, the availability of clinicians, or geographical or financial barriers. Despite the technological possibilities and scientific evidence supporting MA self-care, access to this type of abortion care is not equal for all pregnant people. Since individuals can and will make decisions regarding pregnancy termination with or without the support of trained health workers, an enabling environment is needed to ensure that they do so safely.

This strategy can offer crucial support in providing access to safe abortion care. Health-care providers and potential users generally approve of the concept of self-management and believed that it could be done feasibly, effectively and safely. Through an appropriate regulatory policy, individuals clinically eligible for medical abortion may be offered the choice to self-administer a combination of mifepristone and misoprostol.

3.1 Practical Application of Medical Abortion Self-care

MA self-care supports individuals' SRHR by giving them the opportunity to control their entire abortion process from choosing an abortion method to managing confidentiality and costs and their post-abortion actions. Self-care options may also encourage termination of pregnancy at an early gestational age, which helps reduce the risks of complications. Abortion self-care is supported by availability of telemedicine services, virtual tele-support, tele peer-led support groups, hotlines and online information sources for both clients and healthcare providers, who are needed to support self-care with information to clients or support with management of abortion complications or side effects of MA medication.

With the increasing access to highly sensitive pregnancy tests and availability of simple, safe, highly-effective medication (misoprostol alone or mifepristone and misoprostol combined), more women and girls have the option of safely and effectively terminating their pregnancies without the involvement of a health care provider. This usually includes the self-administration of medical abortion pills, but could also mean being in charge of other aspects of the abortion process, such as the post-abortion

care or the decision of engaging (or not) other stakeholders throughout the process. Healthcare providers should be available and accessible if and when needed.

3.2 Requirements for Abortion Self-care

There should be clear client advice and instructions or access to information: A self-care MA uses medicines to end a pregnancy, usually in the first trimester (first three months after the last normal menstrual period). MA can be provided using tablets of mifepristone and misoprostol in combination or misoprostol alone. This is a non-invasive and highly acceptable option (Davey et al, 2006). These recommended abortion methods for the 1st trimester allow for provision of abortion services at the primary care level. The medicine may be taken during the clinic visit or at home. The second medicine (misoprostol) takes about 1 to 2 days to work, with bleeding usually starting within a few hours.

After a MA, one may experience bleeding, spotting, and cramping for the first two weeks, and a pregnancy test may be required 14 days after. A negative pregnancy test confirms that the abortion was successful. Sometimes, the medication is ineffective. If this occurs, clients may

be required to take a second dose of the second medication (misoprostol tablets). Women should be aware of the warning indication of abortion complications or pharmaceutical side effects. Women should expect a one-day fever, mild bleeding, or abdominal pain. If these symptoms persist or worsen, the women should seek medical attention. Finally, the recovery of fertility occurs quite early, and women can become pregnant within two weeks of having an abortion. Women who do not wish to become pregnant should use contraception.

Balancing risks and harms: The potential benefits of abortion self-care treatments must be evaluated against the contemporary risks. Self-care actions should be implemented only when adequate health-care system assistance is available, and they should be considered an alternative rather than the exclusive method of access. Attention may be required where the legislation restricts access to self-care interventions. A human rights analysis can highlight steps that can be taken to ensure the safe and successful delivery of self-care interventions to all potential users.

Issue of access to information on abortion medication: There is increasing evidence that Medical Abortion provided without ultrasonography and with minimal oversight from

health care professionals is safe and effective. Individuals must be provided with clear information related to self-management. Counselling should be available when desired. Abortion medications can be obtained from pharmacies or drug shops. Although pharmacy staff knowledge can be improved by training, improvements in knowledge do not necessarily improve pharmacy worker practice, including counseling and the challenge posed by stigmatizing attitudes, restrictive legal environments and high turnover of staff. While pharmacy worker training, detailing and information materials may result in some transfer of accurate information. Medical Abortion drugs are often purchased on behalf of the user by a partner, friend or family member, so verbal information provided by pharmacy staff may not reach the end-user.

Community support for clients: Accompaniment models, social networks and other forms of community engagement can ensure access to accurate and safe information about self-management. While having the abortion, it is ideal, even if it is not mandatory, for the woman to have someone close by; this can be a partner, friend or relative who knows about the abortion, who can help in the rare cases of complications, and who is available to provide emotional support. If a woman has any issues

such as depression, post-traumatic stress, or another condition that may make the experience particularly difficult or less safe, it is critical not to be alone. However, for some women, informing the partner, a friend or family member can result in violence, isolation or being blocked from doing a self-managed abortion.

Health system support: Strengthening product packaging and links to health facilities, hotlines/contact centers or web-based information can ensure better access to quality information and support. Pharmacies and drug shops can support access to MA drugs if they provide accurate information. Product inserts have limitations or lack of information to support self-management even when a combi-pack (combination regimen) is used. For instance, product packaging may be discarded by pharmacy staff or by users due to regulatory concerns. In legally restrictive settings, misoprostol products are often provided off label, with product leaflets lacking information on how to administer misoprostol for MA.

Provision of care continuum: There is need to provide additional information to the woman about Medical Abortion self-care as part of a continuum of care. First, there is need to ensure quality MA products are stocked and stored appropriately, and there should

be adequate information to explain the medications and how they may be used. Secondly, oral analgesics (Livshits et al., 2009) may be offered to clients, along with contraception for those interested in quick start of methods after self-managed MA, including oral contraceptives, condoms, self-injectables or emergency contraception. Nearly all methods of contraception could be given to clients after self-managed MA: WHO recommended in 2015 that qualified pharmacists can assess eligibility for MA, administer the medications and assess completion and the need for further clinic-based follow up. Lastly, there should be support to the women in case she has post abortion complications, or if she has any concerns after the self-managed abortion care. This may be achieved via telephone call support (Perriera et al., 2010).

Clients/patients should know their rights: Staying up to date with the country and state laws is essential when accessing or supporting self-managed abortion. To understand the full range of options available and confidently plan pathways to care, it's necessary to know rights and limitations of the policy and legal framework.

Clients should know their body: For individuals to make an informed choice

around whether self-management is right for them, it is important that they assess their eligibility. They should know when they are likely to conceive, and should be able to make a self-diagnosis of pregnancy, including how to access, use and interpret simple pregnancy tests where applicable.

In their recently updated abortion guidelines (WHO, 2022), the WHO outlines key factors that women should consider if they're thinking of self-managing their abortion: a) Being no more than 12 weeks pregnant, which can be ascertained through medical examinations or using a pregnancy calculator; b) Double checking that there are no existing medical conditions that could increase risk of complications. For example, women who have blood clotting conditions or severe anemia are strongly advised against having MA, and women who are currently fitted with an IUD are advised to seek in-facility care; c) Be able to make a diagnosis of a successful procedure, including how to interpret pregnancy tests.

Clients should understand the process: It's important to understand the process, including how medication should be taken, and what to expect, for example, how long the process will last, how much pain and bleeding to expect, and any warning signs of possible complications. For individuals

accessing care supported by a facility, for example through telemedicine, this may mean receiving counselling from a midwife. For clients who access MA medications from their home, this might mean going through written or pictorial instructions within the product or accessing digital support through a reputable platform.

Clients should access quality medication: Accessing quality pills from a reputable provider is essential to having a safe and effective abortion. MA medications should be properly stored. Misoprostol is prone to degradation when exposed to heat and moisture, reducing effectiveness, and potentially leading to complications. Pills should always be within date and unopened in a 'blister pack', meaning each individual pill is stored between two materials (ideally double aluminum) in a 'bubble'.

Clients should know where to access supportive medical care: Abortion care goes beyond the abortion itself. Complications are rare, but just in case they do happen, or questions arise during the process, women seeking to self-manage their abortions should know exactly where they can access medical care before starting. Many women who choose self-managed abortion at home may need or want to go to a facility at some point. Thus, there is need to

create bridges between self-care and facility-based care by rooting its self-managed abortion programmes in partnerships with referral facilities with trained health providers. When women are given MA supplies, they are also informed about the signs which indicate (the danger signs of abortion complications or rarely, side effects of MA medications, when they should seek additional care, and where to go for this. Thus, there is need to engage providers, who are competent to provide post abortion care, to ensure quality and continuity of care.

Values clarification and Attitude Transformation (VCAT) workshops help health providers and key stakeholders re-conceptualize what self-managed abortion is, and better understand why women may opt for or prefer this approach over facility-based care. This ensures that facilities and providers act as positive points of continuing care by ensuring confidentiality, focusing on care and support for women rather than criminalization, and ensuring post abortion care within the overall continuum of care, as well as developing policies and guidance which support women's best interests.

There should be support networks: WHO recommends managing an early abortion with the combi pack without direct medical supervision when

pregnant individuals “have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process,” as well as self-assessing eligibility for MA and the completeness of the abortion using low-sensitivity urine pregnancy tests and checklists. Under its ‘accompaniment model’ IPAS trains community members to support women who opt for self-care with accurate information, guidance, and support when it is requested. Accompaniment persons can also help women with referrals to health care facilities when needed. To support this, IPAS has developed materials directly for women, including videos and information cards (pictorial and low literacy). The simple, accurate and evidence-based information supports women in the self-management process.

Vulnerable groups: Special consideration should be made when supporting abortion self-care to vulnerable groups, including very young adolescents; women with disabilities; sex workers; women subject to gender-based violence; transgender men; and women subject to human trafficking. a) To ensure that supply chains that support the distribution of abortion pills remain operational. b) To build alliances with humanitarian actors for the delivery of medical abortion supplies and

contraceptives, as well as accurate and comprehensive information on the use of abortion pills. c) To accelerate the development of digital initiatives focused on providing evidence-based information on abortion and abortion-related services, to ensure women's reproductive choices are not undermined as a result of circumstances that limit their mobility. d) To promote inclusiveness for marginalized persons.

There should be adequate data to inform or enable evidence-based policy or practice: There is need to collect data on the safety, effectiveness, and acceptability of self-care interventions to improve programming and support advocacy efforts. This can include operational research on how to improve women's experience of self-managed abortion, how to overcome barriers and challenges to facilitating abortion self-care, and the contribution of abortion self-care to reducing abortion stigma, increasing self-efficacy, and catalyzing sociocultural change

Community engagement: There is need to support community engagement initiatives that could help to build trust in the systems/structures that enable and facilitate abortion self-care, for instance, work with community leaders and local media to ensure they are supportive

of locally-led accompaniment groups. There is additional need to participate in forums that aim to catalyze sustainable social change for women and normalize and facilitate abortion self-care. There is increasing evidence that medication abortion provided without ultrasonography and with minimal oversight from health care professionals is safe and effective.

3.3 Underlying Principles of MA Self-care

- 1. Rights-based:** Bodily integrity and autonomy is a fundamental human right, central to sexual rights and gender and reproductive justice. People's right to make autonomous decisions about their own bodies and reproductive functions, is at the core of their fundamental rights to life, health, equality and non-discrimination, information, and the right to enjoy the benefit of scientific progress.
- 2. People-centered:** Providing options relevant to the individual's needs, preferences, and lived experiences supports people's self-efficacy to control their lives and decisions and tackle abortion stigma and the silencing that comes with it.
- 3. Inclusiveness:** All individuals who may need an abortion must

have access to care that considers their unique needs, irrespective of visible or invisible differences.

4. **Gender transformative:** Every woman has the right to a safe abortion, in a manner that respects their rights, autonomy, dignity, and needs, taking their lived experiences and circumstances into account, placing the individual at the center, enhancing their decision-making and control over their lives, and challenging gender norms, roles, and stereotypes that stigmatize women's reproductive autonomy.
5. **Issues of access:** Women and girls have access to quality medical abortion pills, either misoprostol alone or a combipack of mifepristone and misoprostol. Women have the conditions to implement the abortion with the desired level of privacy and confidentiality. There should be an enabling health care system and regulatory environment to support self-care for medical abortion.
6. **Equity in health:** Abortion self-care addresses inequity in access to healthcare, including both preventive and curative services related to unwanted pregnancy. Self-care contributes to efforts to address avoidable and unjust

differences in exposure to health risk factors, health outcomes and their social and economic consequences, healthcare access, and capacity to finance care. Qualitative studies show that abortion self-care is often a wanted alternative for some women; because it is affordable, it implies reduced transportation needs, ease of scheduling, earlier intervention in the pregnancy, privacy, reduced stigma, sense of control, comfort, and easier access for people with restricted mobility.

7. **Quality:** Care delivered should be in line with the available evidence and the needs, values, and preferences of the clients, free of stigma and with compassion and empathy. Provision of supportive care in case of incomplete abortion or other complications is key to safety (Winikoff et al., 2012).
8. **Autonomy:** Abortion self-care places women and girls firmly at the center of the abortion process, as the key decision makers in control of their bodies. To achieve this, multiple stakeholders can also play a role in enabling and facilitating this approach, by acting on three components of support for abortion self-care,

through delivery of accurate and accessible information to clients, enabling access to quality and affordable medication and through provision of supportive care in case of incomplete abortion or other complications. The safest environment for self-managed abortion is one where women and girls' health literacy is supported. That is, their capacity to obtain, process, and understand evidence-based health information, explore their options, ask critical questions about their choices, and actively participate in decisions and tasks concerning their care. Medical care is accessible when chosen as needed, with referral mechanisms in place for women to access in-clinic care, including in case of complications or for complementary SRH services.

- 9. Effectiveness:** Studies reporting on self-managed medication abortion report high-levels of effectiveness. Many women and girls who self-manage their abortions facilitated through pharmacies report no need for surgical interventions and are willing to use this service again if need be. To assure effectiveness, efforts to provide pregnancy self-tests that can be used at home or another preferred location could

support increased autonomy of individuals as well as support multiple programmatic settings to advance sexual and reproductive health and rights. Pregnancy self-tests are also an important self-care intervention that increase agency and autonomy in sexual and reproductive decision-making.

- 10. Acceptability:** A study conducted in Uruguay showed that services provided under a model known as “the harm reduction model” – in which providers offer evidence and rights-based information and care before and after an abortion, to the extent allowed by the law, and women and girls self-manage the procedure itself, contributed to a reduction in maternal mortality. Adapting the abortion harm reduction model to the local context – showed that these types of services are feasible and acceptable, and could provide an opportunity to reduce unsafe abortion.
- 11. Support networks:** Hotlines and websites have been shown to be highly effective in facilitating self-managed abortions, as most women do not present any complications nor require surgical intervention. Besides, information hubs may have a positive impact

on access to safe abortion for women, both in legal as well as in legally restricted contexts. Also, community-based distribution of misoprostol – which enables abortion self-care – can safely and effectively support abortion care. As well, accompaniment groups – networks of activists/volunteers/peers which provide people with step-by-step information on how to safely self-manage an abortion – are deeply appreciated by women who self-administer medical abortion, and may provide the technical information and emotional support that can ensure safe, complete abortions with few or no complications.

Such groups may advocate for an enabling self-care environment including decriminalization of abortion and access to quality MA medications, in legally restrictive environments. Support networks, in addition, include links between health facilities and community-based providers (i.e. other existing organizations, networks, hotlines and platforms, many of which may have supported self-managed medication abortion are critical to support women to access and use medication abortion safely and effectively. Such self-care approaches to abortion can empower women by allowing

them to manage their abortion in the comfort and privacy of their own home, removing financial burden and stress in countries where abortion is not culturally accepted.

3.4 Benefits of MA self-care

1. Abortion self-care is an abortion with pills without a prescription. The woman manages as much of the process as she wants on her own, with or without the involvement of a health provider. MA self-care is on the rise globally due to the increasing availability of simple, safe, highly-effective medications, but also because women's need for safe abortion, on their own terms, is not being met. Self-management can co-exist with other viable approaches to abortion care.

- Optimize health workforce.
- Address shortages.
- Reduces costs.
- Promotes equity.
- Empower women people-centered use.
- Promotes backup referral support in the healthcare system.
- Telemedicine is viable alternative to in-person abortion care.
- Promotes choice: There is no single recommended option for provision of PAC, and the choice of specific providers depending on patient preferences and values

2. Empowerment of clients, by promoting more empowerment on personal decision-making according to preferences and choices, through the following:

- The choice and decision-making to terminate a pregnancy
- Self-assessment of eligibility for MA self-care
- Self-administration of medications
- Self-assessment of complications of MA self-care
- More awareness about their bodies and its functions
- Advocacy to raise awareness and removal of regulatory barriers to abortion self-care

3. Opportunity to mobilize and link players of SRHR as entry point in the healthcare system

- Opportunity to enable CSOs to leverage advocacy through networking.
- Advancing the right to health through empowerment of women and SRH related human rights.
- Opportunity to strengthen post abortion care as an essential component of the healthcare

system.

- Abortion self-care benefits women and health-care systems. A woman might prefer ASC because it gives her more autonomy and control over the experience, because it allows for greater comfort and privacy, or because it enables her to avoid stigma, discrimination or other barriers that she might face in a health-care facility.
- De-medicalizing abortion and meeting women where they are with a safe option.
- Supporting women in ASC could potentially help lower costs and increase access for the most vulnerable and marginalized groups, regardless of abortion legality.
- For health systems, MA self-care can improve outcomes despite health professional shortages—and potentially reduce unsafe abortion by decreasing the number of people who go to untrained providers or use dangerous or outdated methods

3.4.1 Improved health and well-being outcomes achieved by self-care interventions

(From WHO, A shared language to describe the uses of self-care interventions)

Table 1

Advancing the right to health and wellbeing	Health system responsiveness	Increased accountability
<ul style="list-style-type: none"> • Increased agency • Increased availability • Increased accessibility. • Increased acceptability • Increased affordability • Improved life-course approaches. • Improved people-centered approaches. • Improved gender equality. • Improved health promotion. • Improved health and digital literacy • Improved self-determination and self-efficacy. 	<ul style="list-style-type: none"> • Respect for dignity of the person. • Respect for autonomy of individuals to make choices about their own health. • Improved individuals' access to resources and support for better health management. • Respect for confidentiality, health priorities and preferences. • Prompt and tailored attention to health needs. • Availability of basic amenities for health and quality commodities. • Access to social support networks. • Choice of institution and individuals providing care. • Choice of self-care interventions. 	<ul style="list-style-type: none"> • Government accountability for commodities, regulation and policies. • Improved financial risk protection. • Donor accountability • Private sector accountability • Social accountability • Individual accountability

	<ul style="list-style-type: none"> • Health workforce equipped to promote and educate individuals on selecting, preparing and utilizing medications, therapeutics and other self-care interventions. • Improved ability to promote and to show use of evidence-based choice of interventions. • Rational delegation of tasks among health workers. 	
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3.5 MA self-care and Abortion Harm Reduction

Abortion restrictions do not prevent people from seeking MA and might put them at risk of obtaining poor quality MA drugs with little or no information on correct usage. Health systems play an oversight role to enable an environment in which abortion services and abortion self-care is safe and equitable for all. Healthcare providers have a responsibility to respect women’s choices and mitigating harms, through

ensuring access to information and/or services. MA self-care may be supported by an environment where the Abortion Harm Reduction Model is applied.

The Harm Reduction Model has been defined as;

“An evidence-based public health and human rights framework that prioritizes strategies that reduce harm and preserve health in situations where policies and practices prohibit, stigmatize and drive common human activi-

ties underground.”

Originally developed to prevent the spread of HIV/AIDS by encouraging the exchange of used syringes for new ones to limit syringe sharing, the HRM was re-conceptualized by the Uruguayan organization Iniciativas Sanitarias to prevent unsafe abortion in what has been referred to as the Harm and Risk Reduction Model which we now call the Harm Reduction Model.

The HRM seeks to prevent unsafe abortion by ensuring that women and girls of reproductive age facing an unintended pregnancy receive comprehensive information and care so that they can make autonomous decisions. It also mobilizes health professionals so that they become agents of change,

training them on medical ethics and clients’ right to information, health and confidentiality, and by providing opportunities for them to champion efforts to reduce the harm caused by unsafe abortions.

The HRM is purposed to: -

- Reduce morbidity and mortality related to unsafe abortions.
- Reduce the risks of unsafe abortion.
- Reduce the number of pregnancies that are terminated in unsafe conditions.

The HRM is primarily based on three key principles: neutrality, humanism and pragmatism as indicated in Figure 1 below;

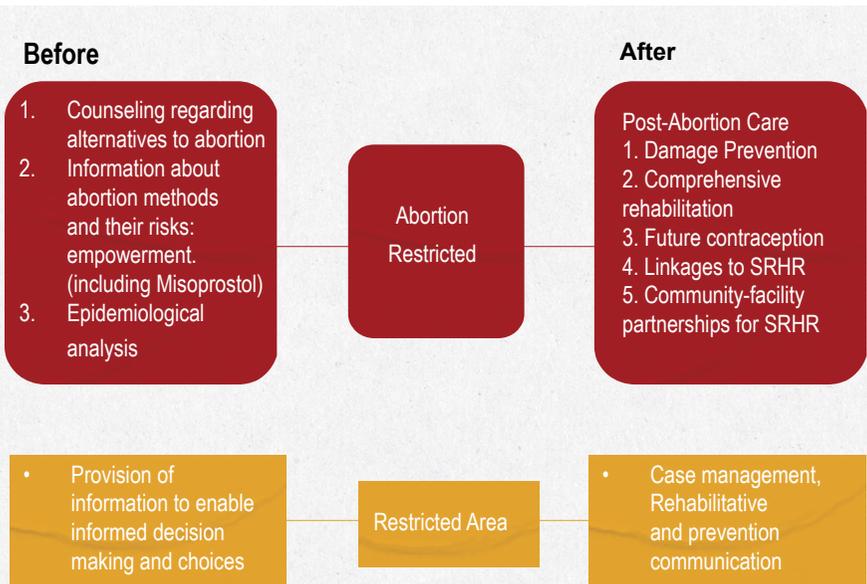
Figure 1

<u>NEUTRALITY</u>	<u>HUMANISM</u>	<u>PRAGMATISM</u>
<p>Health service providers should not judge the underlying activity’s legality or morality, but should concern themselves with the risks and harm associated with the given activity; unsafe abortion is, above all, a contributor to maternal mortality and morbidity. Therefore, health service providers have the obligation to provide</p>	<p>Regardless of how abortion may stand within the general moral opinion or legal norms, all women should be treated as deserving of concern for their health and lives. Irrespective of moral or legal considerations, women’s health needs should be understood and addressed.</p>	<p>Even in a restrictive regulatory environment, women may decide to have an abortion. Where there is evidence that women are continuing to attempt or undergo unsafe abortions, health service providers are obligated to attempt to mitigate as much harm as possible by providing women with information</p>

<p>information about technologies and procedures that minimize the personal and social harms of unsafe abortion, even in contexts where abortion is legally restricted or prohibited.</p>		<p>about the safest and most effective services and methods available to them.</p>
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Figure 2: Interventions continuum for the HRM

The HRM identifies the health workers' intervention before the abortion, during the abortion and after the abortion as illustrated below;



Abortion self-care shifts care, away from a medicalized and provider-led approach, to a people-centred model which empowers individuals and is supported by community social networks, however still backed-up by the healthcare system whenever needed or required. The goal is to: a) contribute significantly to reducing maternal mortality and morbidity from unsafe procedures. b) Increase access to health care services: This is achieved through increased access to abortion by individuals with unwanted pregnancy. c) Create an enabling environment: MA drugs are widespread in sale and use, but only health care systems have the power to steer an enabling environment to ensure equal and safe access to abortion self-care. The drugs currently available for MA are mifepristone and misoprostol, as well as the two packaged together - the combipack, which is more efficacious than misoprostol alone in evacuating the uterus and is considered the first-line medication for MA. Regardless of the legality of abortion where they live, women worldwide are using these medications to self-manage pregnancy termination inside or outside clinical settings.

In countries where abortion is permitted under at least some legal grounds and access to abortion services exists, actively ensuring the well-being of those who self-manage

an abortion is possible. Two minimal conditions are necessary for this: Facilitating the readiness of the market (through a variety of manufacturers, approved country regulations and affordability of drugs), and making step-by-step information on self-use readily available to all individuals and communities. In settings where abortion is broadly legal, self-management of abortion might be a part of an active policy to increase Universal Health Coverage and reduce inequalities. In more restrictive settings, the provision of information on self-care for abortion and the availability of quality MA drugs should become a part of a harm-reduction strategy.

To improve the health of individuals seeking an abortion in countries where abortion is restricted, advocacy should focus on availability and accessibility of MA self-care through inclusion of MA drugs in policy and service guidance documents, including regulatory guidelines, service delivery guidelines, essential medicines lists and procurement catalogs. To reduce informal sales of low-quality products and increase early MA self-care, countries' competent authorities should further consider the withdrawal of unnecessary regulations of over-the-counter sale of MA drugs. From the abortion HRM, increasing access points to MA drugs and information

for women is needed to ensure equal access to self-care (e.g., the concentration of pharmacies in urban areas can be a challenge to the availability of MA drugs in rural and interior settings). Also, national regulators and health authorities must provide oversight of product registration, pricing and quality throughout the distribution chain. Besides, markets too are needed to promote equal access to MA self-care. Governments should work to expand access to generic formulations and promote public-sector availability and competitive pricing in the private marketplace.

3.6 What doesn't constitute Abortion Self-care

1. Abortion self-care is not an approach limited to legally restricted settings or humanitarian settings. However, in such settings, it can play a significant role in increasing access, reducing mortality and morbidity associated with unsafe procedures, transforming negative abortion narratives and stigma.

2. Abortion self-care is not an approach that removes the duty of care away from the formal health care system, which still must facilitate access to information, services, commodities, and referrals, as needed, within the national legal and

policy framework. Abortion self-care is not an approach driven by the aim of reducing costs for the health care system, even if self-care interventions have potential to save resources both for users and the healthcare system.

3. Abortion self-care is not an approach that undermines or eliminates advocacy efforts to expand access to post abortion care and other SRH services.

4. Abortion self-care should be strongly guided by a people-centered approach and existing evidence on its safety and effectiveness. The decriminalization of abortion is still essential to ensure that all individuals can realize the right to a safe and legal abortion, on their own terms and informed by the values and needs most important to them, and to guarantee that health workers can perform their duty of care without fear of prosecution.

4. LEGAL & POLICY FRAMEWORK ON MEDICAL ABORTION SELF-CARE

4.1 Introduction

Many practices are already used by governments, non-governmental organizations and civil society to support self-management of MA from pharmacies, though limited evidence exists about the effectiveness of most of these mechanisms. In Uganda, the legal frameworks mechanisms have not allowed for engagements with health teams across the care continuum. The health service providers in public health facilities have remained cautious in their practice and communication. As a result of this uncertainty, the private pharmacies and drug shops are the only option accessible by MA users.

The restrictive and regressive environment and policy frameworks have not allowed HRM to test the day of light and has continually left MA users in dilemma and consequently resulted into poor outcomes. There is need to strengthen efforts to communicate directly with MA users, and signposts to further information from contact centers or online platforms. This will go a long way in mitigating challenges in the regulation of self-managed MA. HRM may be used to ensure MA users can receive

information from a clinic-based medical provider before and after self-managing MA from a pharmacy, in restrictive policy environments. This approach can optimize continuity of care in case clients have additional concerns or complications before or after abortion self-care. HRM may also involve pharmacy detailing In-person visits to pharmacy staff, used by pharmaceutical sales people to distribute and sell medications. During these visits, information and materials can be provided to improve pharmacist knowledge and access to hotlines.

Access to information about the medication supply chain: The current focus on improving pharmacists' the level of knowledge, information provision and counselling alone may not necessarily result in improved outcomes. There is need to focus on VCAT as acritical entry point for perceptions and mind set change for health service providers. This is a limitation of pharmacy staff's ability to respond positively to informational and promotional materials, and yet these types of materials in pharmacies may increase access to information for MA users. Besides, materials that directly promote a helpline to MA users in pharmacies may not be adequately targeted, yet inclusion of a helpline on product packaging can increase use of this source of information. Also, in countries with

restrictive legal and regulatory laws, pocket cards inside product packaging may not mention MA, reproductive health, or other sensitive content, but may encourage users to call a helpline if needed, an approach that might be subtle enough to be acceptable for pharmacy staff and clients in contexts where the packaging is usually thrown away. Depending on legal restrictions, whether using a contact center or hotline feels appropriate to clients will vary in different contexts, and digital, written or pictorial information may be more culturally or legally acceptable in some settings.

The policy and regulatory frameworks, existing national sexual and reproductive health policies should be adapted, developed, and/ or harmonized to include abortion-related self-care interventions. Also, there is need for a supportive health system in terms of national policies and patient management guidelines, from which clear MA protocols are developed. Besides, self-management approaches require ready access to information or support by a trained provider/facility, where desired or needed. For quality MA products, the relevant regulatory agencies should ensure that quality products are available in adequate quantities and appropriate dosages. Furthermore, the development of combination packaging of mifepristone-misoprostol

could facilitate ease of use (Kapp et al., 2019; Sheldon et al., 2019). Countries can enable greater access if they register and include mifepristone and misoprostol on their national Essential Medicines Lists and work towards procurement of the medication.

The legal and regulatory environment in many countries constitutes a major barrier to the provision of information on self-managing MA. For example, despite the fact that most African countries have ratified the Protocol to the African Charter on Human and People's rights on the rights of Women in Africa (Maputo Protocol) which calls on governments to authorize abortion in the event of sexual assault, rape, incest, or if a woman's health is in danger [Article 14 (2) (c)], national abortion laws do not include these legal indications in many settings. As of July 2023, 44 African countries had ratified the protocol. Legal restrictions on abortion, and the perception of abortion's illegality, create barriers for the availability of quality information as pharmacists and MA users can be nervous to speak about abortion or to carry information about MA self-use. This impedes progress with regard to the recognition of MA self-care.

4.2 Legal rationale and defense for MA Self-care

There are several human rights implications in self-care interventions for SRH and these include;

a) The right to the highest attainable standard of physical and mental health—For the user, the ability to engage in self-care interventions that are available, accessible, acceptable, and of good quality is key. From the perspective of the duty bearer (usually a state actor who has an obligation to respect, protect, and fulfill human rights), this should form the basis of provision of a service when the woman or girl needs it.

b) Active and fully informed participation of individuals in how self-care interventions are rolled out. This supports other relevant rights, including informed decision making, privacy, and confidentiality

c) Non-discrimination—Highlights the challenges faced by people who may be marginalized or face discrimination and stigma when accessing services because of, for example, their gender, race, sexual orientation, ethnicity, or ability

d) The right to seek, receive, and impart information—This relates to how the provision of information is

regulated, including where liability falls for inaccurate or false information. It is particularly important for self-care interventions for which users must seek information themselves, often relying on publicly available information rather than health professionals to make appropriate self-care decisions

e) Informed decision making—For self-care interventions, this is shaped by whether government actors, manufacturers, service providers, or others facilitate such decision making, through provision of information that is accurate, accessible, clear, user friendly, and non-discriminatory to allow the users of MA self-care to make informed decisions.

f) Privacy and confidentiality are important for access, use, and results of self-care interventions. Within the formal healthcare system, there is generally some degree of adherence to medical and human rights standards of privacy and confidentiality. When self-care interventions are accessed online or in other non-medical settings, such guarantees may require further consideration

g) Accountability—The human rights and legal dimensions of accountability in relation to self-care interventions encompass the health sector as a whole, regulation of the private sector, the legal and policy environment

more broadly, and access to a system of redress. Assessment of the legal environment, including laws criminalizing certain behaviors or fostering discrimination, can help identify approaches that can ensure safe access to and use of self-care interventions.

Functional mechanisms such as judicial and administrative modalities are needed to ensure requisite protections and responses to potential rights violations. Individuals using self-care interventions benefit from some connection with the health system to enable appropriate support, including deciding whether to use the intervention, ensuring that they understand how to use it, and access to health professionals for follow-up as required. This requires that users of self-care interventions and healthcare providers are given appropriate information, as well as ensuring availability, accessibility, acceptability, and quality of the services.

The international, regional and domestic legal and policy frameworks discussed below are applicable in relation to MA self-care in Uganda;

4.3 International Instruments

Uganda is a party to various regional and international instruments that advance the realization of the right

to health, sexual and reproductive health and rights and hence self-care as an element of SRHR. These are expounded upon below;

The International Covenant on Economic, Social and Cultural Rights, 1967.

Article 12 provides for the right to the highest attainable standard of physical and mental health. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the WHO, or the adoption of specific legal instruments.

Article 15 provides for the right of everyone to enjoy the benefits of scientific progress and its applications. Self-care is the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health worker. Self-care is one of the benefits of scientific progress. It is now widely acknowledged that biomedical advancements can help advance a variety of rights, including the right to

health, especially when benefits are distributed without consideration of recipients' economic, social, or cultural status.

The UN Committee on the ICESCR specifically included the right to enjoy the benefits of scientific progress in biomedicine. Progress with regard to the development of effective medication for MA self-care ought to be included within such a right. However, it is important to make sure that the people who benefit from these breakthroughs actually see those benefits, and are shielded from any potential harm that arises from the advancement of science and technology on the exercise of human rights. The complex understanding of how the right to benefit from science requires safeguards is well recognized in the field of medical ethics. However, the obligation of states to ensure that scientific advances in biomedicine are not harmful are less clear under international law. Nonetheless, such a rights obligation, as recognized by the UN committee on the ICESCR would apply to all international and national legal frameworks elaborated in this paper's discussion on the legal and policy framework on MA self-care.

General Comment No. 14 of the Committee on Economic Social and Cultural Rights: Right to the Highest Attainable Standard of Physical and

Mental Health

The Committee on Economic Social and Cultural Rights under Paragraph 11 defines the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. Access to information on MA and MA self-care is a necessary component of SRH education and information.

Paragraph 18 recognizes the principles of non-discrimination and equal treatment in access to health care and the Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through adoption, modification or abrogation of legislation or the dissemination of information. Under Paragraph 35, the State's obligation to protect including the obligation to adopt legislation or take measures ensuring equal access to health-care and health-related services provided

by third parties including access to MA self-care. As discussed in Section 3.2, certain groups are disproportionately more vulnerable in accessing health care in relation to MA, and Paragraph 35 makes clear that the State bears an obligation to respond to such issues relating to access. Both Paragraphs 18 and 35 highlight inclusiveness as a necessary component of access to health care, and inclusiveness is also an underlying principle of MA self-care.

General Comment No. 22 of 2016 on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)

It explains the obligation to fulfill which includes adoption of appropriate legislation measures to ensure realization of SRHR, describes the obligation to protect and ensure that adolescents have full access to appropriate information on SRHR, of which this paper argues information on MA and MA self-care is a part, and the eradication of all barriers to full realization of this right.

It also provides that States parties should ensure, in compliance with their Covenant that their bilateral, regional and international agreements dealing with intellectual property or trade and economic exchanges, do not impede access to medicines, diagnostics

or related technologies required for prevention or treatment of HIV/AIDS or other diseases related to SRH. States should ensure that international agreements and domestic legislation incorporate to the fullest extent any safeguards and flexibilities therein that may be used to promote and ensure access to medicines and health care for all. These include medicines and commodities that support MA self-care. States parties should review their international agreements, including on trade and investment, to ensure that these are consistent with the protection of the right to SRH and should amend them as necessary.

General Comment No. 5 of 2017 on the right to live independently and be included in the community.

The General Comment recognizes that sexual and reproductive rights include the right to enjoy safe sexuality and keep well and healthy as well as the right to decide whether to have children or not as well as the necessary support to have healthy children. The ability to choose whether to have a self-care MA is a key component of the right to decide whether to have children or not.

The Convention on Elimination of All Forms of Discrimination Against Women, 1979

Under Article 12, States Parties are to take all appropriate measures to eliminate discrimination against women in the field of healthcare in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Also, under Article 14, States Parties are to ensure access to adequate health care facilities, including information, counselling and services in FP.

Article 16(1)(e) provides that States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women. The same rights to decide freely and responsibly on the number and spacing of their children and have access to the information, education and means to enable them to exercise these rights.

The preamble of the Convention explicitly acknowledges that discrimination against women continues to exist and emphasizes that such discrimination violates the principle of equality of rights and respect for human dignity. It emphasizes that the role of women in procreation should not be a justification for discrimination. It further aims to ensure that state parties are required to include family planning

recommendations and create family codes that protect women's rights to make decisions freely and responsibly about how many children they have and how far apart they should have them, as well as their access to information, education, and resources to exercise these rights. Regarding the Convention's preamble as well as Article 16(1)(e), this paper contends that access to information on MA is part of the necessary information for women to exercise their right in relation to deciding freely and responsibly on the number and spacing of their children.

United Nations Sustainable Development Goals (SDGs) Sustainable Development Goal 3 is on good health and wellbeing. The Goal addresses all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; UHC; and access for all to safe, effective, quality and affordable medicines and vaccines, which ought to include medication for MA.

4.4 Regional Instruments

African Charter on Human and Peoples Rights.

Article 16 provides for the right to enjoy the best attainable state of physical

and mental health. State Parties are to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in African (Maputo Protocol) - 2003.

The Maputo Protocol is the primary legal instrument for the protection of women and girls' rights in Africa. Under Article 14, States parties are to ensure that the right to health of women including SRH is respected and promoted including right to control their fertility, the right to choose any method of contraception, the right to self-protection, the right to decide how many children to have and how far apart they should be spaced, and the right to receive family planning education.

Under Article 14 (2)(c), States Parties are obligated to take all necessary steps to protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continuation of pregnancy endangers the mother's mental or physical health or the life of the mother or the foetus. However, Uganda, upon signing the Protocol, placed a reservation on Article 14(2)(c) of the Maputo Protocol,

meaning that the State reserves the right to not abide by the obligation imposed upon States by the article, per the Vienna Convention of the Law of Treaties (1969).

General Comment No. 2 on Article 14 (1) (a), (b), (c) and (f) and Article 14 (2) (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

The General Comment imposes four general obligations on State parties, namely the obligation to respect, protect, promote and fulfill women's SRHR. Paragraph 25 provides that the states shall ensure the right to health care without discrimination requires State parties to remove impediments to the health services reserved for women including access to abortion healthcare.

However, note that since Uganda expressed a reservation on Article 14(2)(c), some of these provisions are not applicable to Uganda. Uganda's reservation on Article 14(2)(c) effectively constrains access to safe and legal abortion for women. This therefore creates a barrier to legal and policy support for MA self-care at the domestic level, insofar as cases in which abortion are legal are narrowly defined at domestic level, and the State has not bound itself by Article

14(2)(c) of the Maputo Protocol.

African Commission Principles and Guidelines on the Implementation of Social and Cultural Rights in the African Charter on Human and People's Rights.

Paragraph 65 provides that the individual has the right to be free from unwarranted interference, including non-consensual medical treatment, experimentation, forced sterilization and inhuman and degrading treatment.

Paragraph 67 provides for minimum core obligations, and State Parties are to ensure that national plans and policies are designed to ensure that health systems are able to deal with an individual's health holistically by addressing all aspects that may affect his/her health. Paragraph 67 recognizes the rights of women to control their fertility.

4.5 Domestic Laws

The Constitution of the Republic of Uganda 1995, as amended

The constitution does provide for abortion and self-care but in a restrictive manner. Article 22 (2) provides as follows,

“No person has the right to terminate the life of an unborn child except as may be authorized by law”

Therefore, the language in Article 22 is restrictive as far as termination of a life is concerned. However, it is important to note that abortion or termination of pregnancy is not prohibited but rather restricted. The constitution, therefore, provides an arena where exceptions can be created. The wording, “as may be authorized by law” clearly gives parliament, as a legislative body, the leeway to enact laws that deal with abortion and MA self-care.

Article 286 of the Constitution gives legitimacy to International and Regional Human Rights Instruments signed and ratified by the Government of Uganda.

The Constitution is to the effect that where any treaty, agreement or convention with any country treaties and or international organization was affirmed by Uganda or the Government on or after the ninth day of October, 1962, and was still in force immediately before the coming into force of this Constitution; or where the Government was otherwise a party immediately before the coming into force of this Constitution to any such treaty, agreement or convention, the treaty, agreement shall not be affected by the coming into force of this Constitution and the Government shall continue to be a party to it.

This therefore indicates that any treaty

or convention to which Uganda was a party shall not be affected by the coming into force of the constitution and as such it validates any instrument or treaty ratified by Uganda. As a country, there is a need to adhere and uphold the provisions of the various treaties, conventions and regional treaties that the country is party to.

Restrictions in the Law

The Penal Code Act Cap 120

The Penal Code Act Cap 120 specifies instances in which abortion is not permitted.

These include;

Section 141 criminalizes attempts to procure an abortion.

The Section provides that: “Any person who, with intent to procure the miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means, commits a felony and is liable to imprisonment for fourteen (14) years.” This means that health workers and others are prohibited from taking any of the above-mentioned actions, such as provision of medication for an MA, as they will be violating the law.

Section 142 criminalizes the

procuring of a miscarriage.

The Section provides that: “Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or noxious thing, or uses any force of any kind or uses any other means, or permits any such things or means to be administered to or used on her, commits a felony and is liable to imprisonment for seven (7) years.” This means no woman is allowed to terminate or even allow another person to terminate her pregnancy unlawfully.

Section 143 criminalizes the supply of drugs etc. to procure abortion.

The Section provides that: “Any person who unlawfully supplies to or procures for any person anything, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, commits a felony and is liable to imprisonment for three (3) years.”

Section 212 criminalizes the killing of an unborn child.

The Section states that: “Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that if the child had been born alive and had then died, he or she would be deemed to have unlawfully killed the child, commits a felony and is liable

to imprisonment for life. The Law at this point does not look at intention to terminate but goes an extra step to protect a child that is about to be born.

Despite the above however, the Penal Code Act under **Section 224** provides for surgical operation

The Section states that: “A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother’s life, if the performance of the operation is reasonable, having regard to the patient’s state at the time, and to all the circumstances of the case.”

There is therefore no absolute prohibition on termination of pregnancy in Uganda. It is permitted to preserve the life and health of the pregnant woman. Health is defined by WHO as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Other Laws

Other Acts of Parliament also highlight aspects of medical abortion self-care and these include;

Pharmacy and Drug Act, Cap 280

The Pharmacy and Drug Act, Cap

280 imposes a duty on pharmacists to supply drugs under Section 28 and establishes the Pharmaceutical Society of Uganda under Section 5 of the Act which provides guidance to suppliers on their work. This law imposes an obligation on a pharmacist to supply drugs when presented with a valid prescription to a client or to a medical profession when they request for it. This therefore means that a pharmacist has an obligation to fulfill a prescription for Misoprostol or Mifepristone (or both) if presented with a valid prescription.

National Drug Policy and Authority Act.

This is an Act that establishes a national drug policy and a national drug authority to ensure the availability of essential, efficacious and cost-effective drugs to the entire population of Uganda, as a means of providing satisfactory health care and safeguarding the appropriate use of drugs. These drugs also include abortifacients whose supply is largely restricted in Uganda.

Section 8 of the Act also establishes the essential drugs list to which Misoprostol is listed for PAC, ulcers and hemorrhage and Mifepristone is listed for medical abortion. These are the major abortifacients we have in the country and a supplier can supply these without fear of prosecution

as long as they do so to a medical professional or a person who has a valid prescription.

There is a classification of drugs that need a prescription as restricted under Section 13 of the Act. This law imposes an obligation on suppliers to have the necessary skill to dispense drugs according to the regulations set by the National Drugs Authority which require the dispensation of abortifacients to be as against a valid prescription and only to responsible persons. Supply of restricted drugs can be done by a licensed person and a person registered or enrolled under the Nurses and Midwives Act or any other authorized person in accordance with regulations made by the Minister on that behalf.

The Traditional and Complementary Medicines Act, 2019

Section 3 of the Act provides and defines Complementary, Conventional and Traditional medicines. It also puts in place checks and balances to ensure that practitioners and places where these medicines or practices are administered are duly registered and licensed.

Many women and girls resort to using herbal medicines/traditional options to carry out abortions when they cannot access safe abortion

services. This Act plays a major role in the regulation of the practice and use of Complimentary, Conventional and Traditional medicines but the non-implementation of this Law remains a missed opportunity in so far as local or traditional self-care interventions for MA may include the self-administration of herbs and medicines among others.

The HIV Prevention and Control Act, 2015

The Act seeks to make HIV/AIDS testing and counseling services available and accessible at all Health facilities in Uganda, encourages voluntary testing of HIV/AIDS premised on the express acquisition of informed consent under Section 9. The Act further makes consent to HIV/AIDS research mandatory and expressly prohibits all forms of discrimination on the basis of one's HIV/AIDS status. The Act is self-care compliant which can be used to benchmark to embrace self-care in other respects of SRH.

The Uganda National Bureau of Standards Act, Cap 327

This Act establishes the Uganda National Bureau of Standards whose mandate is to ensure that products/commodities available on the Ugandan Market including health commodities are duly certified and adhere to quality checks and standards and this includes combating counterfeit and pirated products. Where goods and

commodities do not conform to the quality standards set by the Bureau, the goods are rejected accordingly and penalties for non-compliance are prescribed within the Act.

There is need to ensure that quality checks of health commodities including self-care commodities are done in a timely manner so as to ensure their availability on the market.

The Electronic Transactions Act, 2011

This Act recognizes the role of electronic transactions in accessing health commodities and services. It provides for the use, security, facilitation and regulation of electronic communications and transactions and encourages the use of e-Government services. It provides for Consumer Protection and this regulates the conduct between the buyer and seller.

Increasingly, electronic transactions have been embraced for healthcare services, consultations and purchase of health commodities. This supports the concept of medical abortion self-care and there is need to have a progressive legal environment for women and girls to freely access these services and commodities.

The Data Protection and Privacy Act, 2019

This Act seeks to protect the privacy

of an individual and personal data by regulating the collection and processing of personal information; provide for the rights of the persons whose data is collected and the obligations of data collectors, data processors and data controllers and regulate the use or disclosure of personal information.

This Act gives effect to Article 27(2) of the Constitution of Uganda, which provides for the protection of privacy and this includes personal data and information. The Act establishes a personal data protection office responsible for personal data protection under the National Information Technology Authority (NITA) – Uganda, and where rights of data subjects are infringed under the Act, they can lodge complaints on the same. There is a penalty levied for unlawful access or disclosure of data regarding data subjects.

4.6 Policy Framework on Medical Abortion Selfcare in Uganda

Policies are strictly not legally binding, but nevertheless they contain benchmarks, standards and targets against which the performance of government may be measured. The policy framework is more progressive than the legal framework is. The following are the policies in relation to MA Selfcare.

National Policy Guidelines and Service Standards for Sexual, Reproductive Health & Rights, 2012

These Guidelines are currently pending review and they recommended that in some instances, women or girls should be assisted to terminate the pregnancy. These instances include severe maternal illnesses threatening the health of a pregnant woman e.g., severe cardiac disease, renal disease, severe pre-eclampsia and eclampsia; severe fetal abnormalities which are not compatible with extra-uterine life like molar pregnancy and anencephaly; cancer of the cervix; HIV positive women requesting for termination; rape, incest and defilement.

Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Uganda – Standards and Guidelines, 2015

These Guidelines were issued by the Ministry of Health and they are currently stayed. They recognize the challenge of unsafe abortion within the country which causes mortality and morbidity. They require the need for primary prevention, management of unintended and risky pregnancies and PAC. They establish guidelines and standards for access to FP, contraceptive services and safe abortion.

The Guidelines were therefore aimed to ensure access to family planning

and contraceptives in order to prevent unsafe abortion. The guidelines also make clear provision for the safe termination of pregnancy and post-abortion care. The guidelines also clarify that abortions are permissible in order to save the mother's life; when the pregnant women's mental and physical health is at risk or where the pregnancy is a result of rape, defilement, incest or other forms of GBV.

According to the Standards and Guidelines, the filing of a police report is not to be a requirement for access to SA services for survivors of rape, defilement or incest and other forms of GBV. The guidelines also call upon health care workers to provide abortion services in order to preserve the life or health of a girl or woman and while taking into consideration the circumstances of each case and the state of the patient at the time. It is a guiding principle of this policy that high quality services for termination of pregnancy should be available and accessible to all women and girls regardless of age or marital status. However, the MoH stayed the dissemination of these guidelines in December 2015 because they considered it necessary to consult further with various stakeholders; religious leaders in particular.

Uganda National Self-care Guidelines for SRHR.

These Guidelines are still in draft and provide for self-care and elements and parameters to implement self-care which include; health promotion, disease prevention, maintaining health and coping with illness.

National Sexuality Education Framework, 2018.

The Framework was developed as a response to the urgent need for a National Policy Framework to guide the teaching of Sexuality Education and Development and dissociation of related materials in schools.

It sought to create an overarching national direction for the response to sexuality education in the formal setting of educating the young people in Uganda. It should be noted that sexuality education in Uganda has been a contentious topic that frequently portrays false information about sexuality through traditional beliefs and mainstream media. However, the creation of the National Guidelines serves as a model for age-appropriate, culturally and religiously sensitive sexuality education instruction in schools.

With the National Sexuality Framework in place, this will support and enable the creation and implementation of sexuality education programs in

Uganda's education system, which will significantly advance the promotion and accomplishment of the SDG and Uganda Vision 2040 (discussed below).

The Essential Medicines and Health Supplies List for Uganda (EMHSLU)

This is a list of safe, efficacious, and cost-effective medicines and health supplies that suit the health care needs of the majority of the Ugandan population. Access to essential medicines and health supplies is fundamental to ensuring equitable health care to the population. In addition, availability of proper diagnostic supplies and technologies ensures the appropriate use of these medicines and guarantees the overall quality of care received by the patients. The EMHSLU 2016 is made up of four sections i.e., essential medicines list, general health supplies list, specialist health supplies list, and the laboratory supplies list.

Under this list, Misoprostol is listed for PAC, ulcers and hemorrhage and Mifepristone is listed for medical abortion. These are the major abortifacients we have in the country and a supplier can supply these without fear of prosecution as long as they do so to a medical professional or a person who has a valid prescription.

Uganda Vision 2040

This recognizes that during the Vision period, there will be a paradigm shift from facility-based to a community-based health delivery system. The main thrust of this paradigm is an empowerment of households and communities to take greater control of their health by promoting healthy practices and lifestyles. This shift will be anchored on preventive over curative health service delivery approaches.

By including family planning in its strategic planning, the Government of Uganda has acknowledged the role that family planning plays in the social and economic change of the nation. The government has stressed the necessity of advancing the well-being of people, families, and communities as well as accelerating the demographic transition of the nation by contributing to the reduction of the nation's mortality and fertility rates. The benefits of family planning are also acknowledged by the government in its 2040 major plans. This aligns with international legal instruments discussed, such as the Convention on the Elimination of All Forms of Discrimination Against Women.

Uganda Vision 2040 aspirations in the Third National Development Plan (NDP III) 2020/21 – 2024/25 seeks to reduce neonatal mortality, maternal mortality and the unmet need for

family planning. This is a critical step forward in Uganda's effort to eliminate preventable child and maternal deaths. Goal 3 of the Plan focuses on improvement of the general health of the people in order to minimize needless suffering from preventable diseases and mortality. The Goal also seeks to increase health funding, risk management, research and development.

In conclusion therefore, the international and regional legal frameworks are progressive on aspects of SRHR and self-care. Despite the recommendations for domestication of these international and regional frameworks, the Uganda legal framework still remains restrictive because of the reservation placed on Article 14(2)(c) of the Maputo Protocol. However, the Ugandan Policy framework is slowly embracing aspects SRHR and selfcare.

4.7 Case Law

This section provides brief jurisprudence on cases litigated around SRHR in Uganda, across the region and internationally. These cases demonstrate a journey of the judicial systems embracing conversations around SRHR and self-care progressively. The litigation journey has not been without challenges and setbacks, but has ultimately gained

some milestones illustrated below;

Jurisprudence from Uganda:

Center for Health, Human Rights and Development (CEHURD) & 3 Others v Attorney General (Constitutional Petition 16 of 2011) [2020] UGCC 12 (19 August 2020);

This case hinged on access to healthcare in Uganda and the Constitutional Court of Uganda recognized the right to health and access to basic maternal healthcare which is not expressly provided for under the 1995 Constitution of Uganda. In this decision, the Court acknowledged that access to basic maternal health commodities and emergency obstetric care was fundamental in ensuring women's constitutional right to health, life, dignity and the rights of women. Court also made orders for the government to put in place resources and increase funding for maternal healthcare in order to actualize dignified maternal healthcare and the rights of women in Uganda.

Uganda. Kato Frederick Criminal Case No. 56 of 2020

Case brief

In April 2020, the accused was arrested for allegedly committing the

offense of Supply of Drugs to procure abortion contrary to Section 143 of the Penal Code Act, Cap. 120 of the Laws of Uganda. The case was dismissed for want of prosecution. This case is a classic manifestation of the general avoidance of courts to create a precedent in matters concerning abortion and abortion self-care. The prosecution in this case totally avoided starting the prosecution case at the expense of the accused who lost morale, and confidence to practice his profession. This case demonstrates that medical practitioners can provide post-abortion care without fear of getting prosecuted. This case also manifestly shows the reluctance both the prosecution and the court system in Uganda have in relation to the issues of abortion and self-care in Uganda. The magistrates and the judges are not willing to handle the substantive matters of these concepts given that this will bring about progressive jurisprudence on issues that surround abortion. This is ultimately a constraint to the strengthening of and advocacy for MA self-care in Uganda.

Jurisprudence from East Africa:

Patricia Asero Ochieng & 2 Others V. Attorney General, Petition No. 409 of 2009

This was a case on access to HIV/AIDS medicines; the Petitioners were

citizens of Kenya living with HIV/AIDS. They claimed that provisions of the Anti-counterfeit Act, 2008 restricted their access to affordable, essential medicines including generic medicines for HIV/AIDS, and therefore violated their right to health, dignity and life under Articles 26(1), 28 and 43 of the constitution of Kenya. The court held that a law which has the effect of limiting the accessibility and availability of HIV medicines threatens the lives and health of people living with HIV/AIDS and violates their rights under the Kenyan Constitution. This undermined access to affordable generic medicines since it failed to clearly distinguish between counterfeit and generic medicines. It was also held that intellectual property rights should not override the right to life and health.

PAK & Salim Mohammed V. Attorney General & 3 Others Constitution Petition EOO9 of 2020 [2022] KEHC 262 (KLR)

This case involved the right of a minor to receive reproductive care, the right of a clinician to treat her, and the Constitutional obligations of Kenya under its Constitution. This case also sought to align the country's Penal Code with its Constitution.

In this landmark case, the Kenyan High Court affirmed abortion as a

fundamental right under the 2010 constitution and ruled that the arbitrary arrests and prosecution of patients and health care providers for seeking or offering abortion services was illegal. Court further directed the Kenyan Parliament to enact an abortion law and policy framework that aligns with the Constitution.

Jurisprudence from South Africa:

Soobramoney V. Minister of Health (Kwazulu-Natal) (CCT 32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997)

This was a case premised on the right to access health care services and the right not to be refused emergency medical treatment. The Court had to decide on the constitutional right to health care for everybody in light of the problem of scarce resources for the funding of the healthcare system.

The Applicant, a 41-year-old and unemployed man, was suffering from chronic renal failure resulting from diabetes. This condition was irreversible. His life could only be prolonged by an on-going dialysis treatment. He approached a state hospital for this treatment but the hospital refused him admission to its renal unit following a set policy. According to the policy, the primary

requirement for this treatment was eligibility for a kidney transplant. The treatment could be administered until a donor was found and the transplant completed. Furthermore, to be eligible for a kidney transplant, a patient has to be free from other “significant” diseases. The Appellant failed to satisfy the requirements for a kidney transplant as he was suffering from other serious diseases such as heart disease. This refusal prompted the applicant to ask for a court order directing the hospital to provide him with on-going dialysis treatment, and restraining the provincial Minister of health from refusing him admission to the renal unit of the hospital.

The High Court dismissed the Application and he appealed to the Constitutional Court. The Court held that the right to emergency medical treatment had only limited meaning: One who suffers a sudden catastrophe, which calls for immediate medical attention, should not be denied the available emergency services, and should not be turned away from a hospital equipped to administer the necessary treatment. The Court also accepted that rationing of resources is integral to health service delivery in the public sector even though this might support ongoing inequities between the private and public sector. However, the Court implied that there might be grounds for the challenge

of executive policies if such policies were unreasonable or if they were not applied fairly and reasonably.

Minister of Health & Others V. Treatment Action Campaign TAC (2002) 5 SA 721 (CC)

Treatment Action Campaign filed a case in Court challenging the Government’s failure to provide pregnant HIV positive women with drugs that could prevent the transmission of the virus to their babies during labour. These restrictions on the provision of antiretroviral drugs to HIV positive pregnant women were resulting in tens of thousands of unnecessary infections and deaths which was a violation of the right to health care services as provided for in the South African Constitution.

Court ordered the Government to extend availability of Nevirapine to hospitals and clinics, to provide counselors; and to take reasonable measures to extend the testing and counseling facilities throughout the public health sector. The Court rejected the argument advanced by one of the interveners for a distinction between a minimum core content of the right to healthcare and the obligations imposed on the state in Section 27(2) that are subject to progressive realization and available resources. The judgment in this case is estimated

to have saved tens of thousands of lives. In addition, it served to mobilize affected individuals and groups across the country. The Court asserted its right to order effective relief, and to maintain supervisory jurisdiction, but chose to simply order immediate implementation of the remedy. Follow-up pressure was needed in some provinces to achieve compliance, including the filing of a contempt of court action against one provincial authority.

This decision establishes a conceptual and remedial framework for judicial review and enforcement of the obligation to ensure access to healthcare and other ECS rights. It provided an inspiring model for integrating political and legal action. It highlighted the unimaginable suffering of so many from an epidemic that has its origins in earlier and ongoing violations of ECS rights in South Africa and around the world.

Jurisprudence from International/ Global Cases:

Roe V. Wade 410 U.S. 113 (1973)

This case involved a woman who was pregnant with her third child and wanted an abortion but lived in Texas where abortion was illegal except when necessary to save the mother's life. In this case, it was alleged that Texas'

abortion laws were unconstitutional. The Supreme Court ruled that the unduly restrictive state regulation of abortion was unconstitutional and that the Due Process Clause of the Fourteenth Amendment to the United States Constitution provided for the fundamental right to privacy which protects a pregnant woman's right to an abortion. The Court further held that the right to abortion is not absolute and must be balanced against the government's interests in protecting women's health and prenatal life. The Court resolved these competing interests by announcing a pregnancy trimester timetable to govern all abortion regulations in the United States.

The decision struck down many federal and state abortion laws, and it caused an abortion debate in the United States about whether, or to what extent, abortion should be legal, who should decide the legality of abortion, and what role of moral and religious views in the political sphere should be. The decision also shaped the debate concerning which methods the Supreme Court should use in constitutional adjudication. In June 2022, this decision was overturned in the case of *Dobbs V. Jackson Women's Health Organization* 597 U.S.

Dobbs V. Jackson Women’s Health Organization 597 U.S.

This case challenged Mississippi’s Gestational Age Act that prohibited abortion after the fifteenth week of pregnancy and alleged that it violated the Court’s precedents establishing a constitutional right to abortion. The state used this as an opportunity to ask the Supreme Court to take away the federal constitutional right to abortion recognized 50 years ago in the case of Roe V. Wade. The Supreme Court accepted the State’s invitation and held that the Constitution of the United States does not confer a right to abortion and overturned the case of Roe V. Wade eliminating the federal constitutional right to abortion, paving way for states to ban abortion. A regression, as opposed to a progression, is observed within the American legal framework.

ABC V. Ireland (Application No. 25579/05)

This was a landmark case of the European Court of Human Rights on the right to privacy under Article 8. Three women challenged Ireland’s restrictive abortion laws arguing that the criminalization and inaccessibility of abortion in Ireland endangered their health, wellbeing and life in breach of their rights under the European Convention on Human Rights.

The Grand Chamber of the Court

unanimously held that failure to implement Article 8 of the Convention on abortion constituted a violation of the Convention. It also held that under the Convention, women’s access to abortion is related to the right to a private life because it concerns personal autonomy, sexual life and physical and psychological integrity.

Women on the Web International Foundation (WOW) V. Administration of the State (Spanish Agency of Medicines and Health Products “AEMPS”) CA No. 6147/2021

This case challenged the action of the Spanish authorities in blocking the website of an international organization called Women on the Web. This case sought to defend the right to information on the internet about Sexual Reproductive Health and Rights especially on safe abortion.

The Supreme Court in its decision ordered for the partial unblocking of the website of Women on the Web which offered information on SRHR and access to safe abortion via online services. The Court considered that the information, recommendations, and opinions on SRHR that Women on the Web provided on its website is protected by the right to information and freedom of expression and therefore, under the Spanish Constitution, the website could not be blocked without judicial authorization. The Supreme

Court further affirmed the importance of the organizations that promote reproductive rights, adding that they carry out an activity that has a political dimension in contemporary society.

This decision created an important judicial precedent in terms of the right to information and freedom of expression on the internet, since for the first time, it established that judicial authorization will always be mandatory when blocking information published on the internet.

In conclusion, for a while, regional and international case law has been progressive on the right to health and abortion healthcare save for 2022 when *Roe V. Wade* was struck down by the US supreme Court as discussed above. This new jurisprudence will have far reaching consequences for abortion advocacy and litigation efforts in Uganda, East Africa, regionally etc geared towards achieving a progressive legal and policy framework for abortion and MA self-care.

5. CHALLENGES AND RESEARCH GAPS FOR MA SELF-CARE

A key concern is that MA self-care interventions may contribute to individuals becoming disconnected from health providers. A clear distinction exists between people using self-care interventions who know they can connect to a strong health system if required and people using self-care interventions because the health system is not available to them or does not meet their needs. Self-care interventions must complement, rather than replace, interaction with the health system. To be safe, effective, and available to people who are hard to reach, a self-care intervention may need more, not less, support from the health system. For example, different ways have to be devised to provide information through non-traditional channels to populations with diverse needs, including different levels of literacy.

Enduring challenges for which research or data are needed include:

1. Recognizing that self-managed medical abortion with accompaniment support is an increasingly visible and salient model of abortion care <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9225767/> with great promise to expand access to

high-quality abortion regardless of legal setting, there is need to explore partnerships between researchers and accompaniment groups to document this model and generate data that may inform efforts for raise awareness about it.

2. With the assumption that MA self-care may be an entry point of women into the healthcare system to be able to access a variety of SRH services, there is also need to explore the experiences of people self-managing medical abortion with and the accompaniment support needed, as well as the as well as the trajectories of the aftermath of the procedure.
3. Assessment of the accompaniment models (friends, partners, family members, community health intermediaries, pharmacists, activists, Non-profit Organizations, hotline operators, accompaniment networks etc.) who undertake a number of activities (such as provision of accurate information, sourcing of pills, accompaniment through the process, or provide PAC and linkage with SRH services).
4. Development and adaptation of validated materials to provide

individuals engaging in self-management of abortion with the information they need to make informed decisions about the risks/benefits of and the alternatives to the use of different medical abortion regimens.

5. Development and validation of quality training materials for use in training of providers on a range of abortion care services (e.g., to train pharmacists, pharmacy workers and community health workers to effectively provide – or support self-management of all tasks involved in medical abortion at gestational ages < 12 weeks).
6. Development of effective and user-friendly information for abortion seekers, e.g., leaflets and web pages or information for use in the context of hotlines and telemedicine services.
7. Understandings of MA self-care, while continuing to improve access to safe abortion and center the needs of those seeking an abortion, need to expand to account for, acknowledge and consider how these actors and their roles are theorized, supported and understood, especially within the shifts and changes in the abortion landscape, its contexts and its actors.

8. There is need for prospective data to assess effectiveness of MA self-care versus provider-assisted MA, as well as the dis-enabling factors (hindrances and barriers from the legal and regulatory landscape).
9. There is need to assess the constellation of factors and contexts that inform the name for the procedure (the multiple behaviors and navigations that surround abortion self-care (such as information seeking, self-sourcing medications, assessment of eligibility, self-management of symptoms or complications, confirmation of completion of abortion)
10. The advent of telehealth and telemedicine and the growing network of organizations supporting safe self-care has fundamentally altered the abortion landscape, and the extent to which this opportunity may be optimized needs to be assessed.
11. Assessment of outcomes of MA to inform local effectiveness and acceptability
12. Generating new clinical and programmatic evidence and MA self-care models;
13. Pushing for broader access to essential abortion commodities for health systems and women directly, including pharmacy over-the-counter access and protecting the abortion medication supply chain
14. Conscientious objection by healthcare providers
15. Working in communities to train clinical and non-clinical providers already supporting women in safe abortion, including MA self-care
16. Employing user-centered design and other participatory methods to better understand what and how women need and want from MA self-care
17. Reshaping the discourse by developing an MA self-care Values Clarification and Attitude Transformation training, advocating for positive policy changes and conducting trainings for providers to consider self-care from a harm-reduction and rights perspective;
18. Using technology and low-literacy materials to convey essential information to women and link them to support and back-up care when needed;

19. Tackling legal barriers to MA self-care, including laws that criminalize self-care;
20. Ensuring that MA self-care includes the needs of women in low-resource settings

6. RECOMMENDATIONS AND OPPORTUNITIES FOR ADDRESSING CHALLENGES AND INCREASING ACCESS TO MA SELF-CARE

1. Access to information: Health systems should provide adequate and easily understandable information on MA and self-use available to individuals and communities. At a minimum, such information must include MA regimen (protocol, dosage and route of administration), warnings and precautions, possible side effects, signs of complications and clear step-by-step guidance on how to assess a trained health worker. Policies on task sharing and shifting—in addition to telemedicine protocols and guidelines—are key to promote MA self-care, as well as availability of healthcare providers should a woman need it or want it at any stage of the process. Medical professionals who may be reluctant to shift tasks to mid-level providers and health care workers, may benefit from understanding that their contributions to training, supervising and managing difficult cases and possible complications will remain key to women's well-being.
2. There is need to address MA drug access and quality. Innovations in retail-market options—such as bundling pregnancy tests and MA products—could help bring an economic advantage and improve consumer convenience for safe abortion self-care. Governments may subsidize access to these products for poorer and marginalized populations, while allowing out-of-pocket expenses for better-off populations. Government agencies responsible for the safety, efficacy and security of medicines can monitor online information provision on MA, and sanction misleading and inaccurate information that put individuals at risk of complications.
3. Promotion of a contact number on product packaging and through other media and community-based activities can increase access to accurate information and support for intending users. Using hotlines or contact

centers may not be appropriate to all settings, but web-based information or accompaniment programmes may be a more culturally acceptable way to consume information. Hotlines/contact centers staffed by trained professionals offer support to users of MA from pharmacies and the pharmacy staff themselves. Websites, instructional videos, e-learning courses and apps may be used to provide interactive audio-visual information on how to take MA products and signpost users to hotlines. Product inserts can provide understandable client-facing information about how to use the medications for a range of literacy levels, where approved by regulatory bodies.

4. Opportunity to promote an enabling environment: Finally, as self-care moves forward, the current discussion among researchers, practitioners and policymakers on what constitutes quality abortion care should consider indicators for abortion self-care beyond clinical settings. Under an enabling environment, abortion self-care represents a win-win for pregnant people and health systems.

6.1 Role of advocacy for MA Self-care Advocacy may be needed to:

- a) Generate safe spaces for dialogue between health workers and groups leading the conversation on and implementation of abortion self-care, to discuss challenges and opportunities for collaboration. Disseminate these stories in relevant spaces. This may involve engagements between partner organizations, including professional bodies of health providers, and nursing and medical institutions, with civil society organizations and policy makers
- b) Improve knowledge and attitudes around abortion self-care and catalyze sociocultural change by creating positive narratives and social movements to remove stigma.
- c) Develop positive messaging and narratives on abortion self-care, including response to concerns or opposition to abortion self-care from a range of actors
- d) Develop public campaigns to increase health literacy regarding abortion care and to inform individuals about their right to manage their care, based on the available evidence and within the restrictions of their legal context. Information should be made available in local languages and in a format that supports the

needs/information-seeking practices of overlooked populations. This could include developing factsheets to address common myths and misconceptions, and using evidence and rights-based arguments to counter opposition.

e) Advocacy should include content on client agency, abortion self-care, abortion stigma as part of evidence-based CSE programmes and outreach to young people. Advocacy enables implementing participatory processes to gather the stories of individuals who have experienced abortion self-care, as well as of those who have played a role in enabling and facilitating abortion self-care.

f) Advocacy may engage students of health-related professions in dialogues around self-care. This contributes to long-term change, gradual transformation of the provider-client relationship, and de-medicalization of issues. Advocacy may also educate the medical community about the safety and effectiveness of abortion self-care, in order to reduce unnecessary clinical concern, overmedicalization and overtreatment of clients, and stigmatization or criminalization of women seeking abortion care.

g) Through collaboration with legal experts, advocacy may enable assessment of the legal framework

to understand how the regulatory framework supports or restricts abortion self-care initiatives. Any restrictions should be understood in order to create risk mitigation strategies while, at the same time, supporting women and girls in their abortion process. Collaborations may facilitate mapping existing interventions that enable or limit abortion self-care in your geographical areas of operation. Such collaborations may avoid duplication of efforts by like-minded stakeholders. Collaborations may facilitate review of organizations' existing strengths, initiatives, and models of care and consider how they can be adapted to integrate components of support for abortion self-care. For example, a strong network of community health workers could be leveraged to create an accompaniment. Collaborations through advocacy may facilitate delivery of accurate and accessible information on abortion and, particularly, on MA (dosage, regimen, contraindications, side effects, and signs of complications). Strategies may include hotlines, peer provision, websites, or referral to other reliable sources of information and support.

h) Advocacy is key to providing supportive care during the self-care process. Strategies may include adaptation of clinical protocols to ensure readiness to meet the needs of a woman at any point in her abortion

process; provision of on-demand abortion counselling when requested; and setting up referral networks in case of doubts or for treatment of complications, post-abortion care, or other relevant services, as needed. At project or program level, advocacy may strengthen the capacity of organizations to undertake abortion self-care programming. For example, update institutional policies and guidelines on abortion to include self-care, conduct values clarification exercises for staff and volunteers at all levels to build support and commitment for abortion self-care, and provide training for health providers on how to provide person-centered care for a woman self-managing an abortion.

i) Advocacy is key for clinical, psychosocial, and protection services must be available for vulnerable groups to address other sexual and reproductive health needs before, during, or after their abortion

6.2 The future for MA Self-care

1. Creating, promoting, and protecting legal and regulatory environments that support health care professionals to support access to safe and affordable abortion self-care.
2. Advocacy to strengthen the work

of champions, to strengthen national coalitions, from quality assurance of the processes, policy and curriculum review.

3. Decriminalizing and regulating abortion care like any other health care provision.
4. Utilizing the full benefit of the safety and efficacy of abortion medication, by promoting medication quality, protecting the medication supply chain, and providing information to intending users using variety of information sources including the advances offered by digital technologies to enable telemedicine and telehealth support to self-management access to abortion, as recommended by the WHO Abortion Care Guideline.
5. Investing in robust health systems that are human rights-centered for abortion care information, counselling and services.
6. Providing supportive care during the self-care process. Strategies may include adaptation of clinical protocols to ensure readiness to meet the needs of a woman at any point in her abortion process; provision of on-demand abortion counselling when requested.

7. Promoting and safeguarding the supply chain: setting up referral networks in case of doubts or for treatment of complications, post-abortion care, or other relevant services. Strategies may include digital prescriptions, partnership with pharmacists, and sending pills by post or dispensed by community health workers.
8. Strengthen the capacity of your organization to undertake abortion self-care programming. For example, update institutional policies and guidelines on abortion to include self-care, conduct values clarification exercises for staff and volunteers at all levels to build support and commitment for abortion self-care, and provide training for health providers on how to provide person-centered care for a woman self-managing an abortion.
9. Development of informational materials, such as posters, job aids and brochures, highlighting the 2022 World Health Organization guidelines and recommendations on abortion care and post abortion care, which can be placed in health-care facilities and other appropriate places.
10. Development of user-friendly decision-support tools for

healthcare providers and policy-makers, created with the input of end-users who will be engaged in the process of determining how best to translate the guidance (2022 World Health Organization guidelines) to users and beneficiaries.

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