

Original Research Article

Human Rights and Assisted Reproductive Technologies in Sub Saharan Africa: Legal Frameworks, Access, and Equity in IVF Regulation

Fembe Kuh Misodi^{1*}, Galega Daiga Samgena²

¹LLB, LLM, PhD

²Professor in Law

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Abstract: Infertility poses a profound public health and social challenge in Sub-Saharan Africa, disproportionately impacting women who bear the social stigma, marital instability, and economic marginalization associated with childlessness. Assisted reproductive technologies (ART), particularly in vitro fertilization (IVF), hold transformative promise to restore reproductive autonomy and fulfill the fundamental human right to parenthood. Yet, despite this potential, access to IVF services remains alarmingly limited and inequitable across the region. This disparity is driven by intersecting structural impediments including steep economic costs, weak or uneven legal and policy frameworks, entrenched sociocultural stigma, and under resourced healthcare systems. This article undertakes a rigorous comparative and doctrinal legal analysis grounded in international and regional human rights instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), the African Charter on Human and Peoples' Rights, and the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol). It explores how these normative frameworks interact with national laws, policies, and institutional capacities in four strategically selected countries: South Africa, Kenya, Nigeria, and Cameroon. South Africa exemplifies a more progressive and comprehensive ART governance model characterized by constitutional protections for reproductive autonomy, judicial reinforcement of non-discriminatory access, and formal legislative instruments regulating clinic operations and parentage rights. Kenya and Nigeria showcase evolving but fragmented regulatory landscapes challenged by regulatory inertia, limited statutory authority, and heavy reliance on private sector fertility services. Cameroon reflects earlier-stage ART governance constrained by healthcare resource shortages and potent cultural norms shaping reproductive health priorities. Beyond legal frameworks, the study examines the socio-economic and cultural dimensions shaping ART acceptance and access. The high cost of IVF ranging from several thousand to over ten thousand US dollars per cycle places it out of reach for most Africans, given constrained public sector funding, insufficient insurance coverage, and the concentration of services in urban private clinics. Additionally, deep-rooted cultural and religious norms reinforce infertility-related stigma and privilege traditional fertility conceptions, restricting equitable access, particularly for marginalized populations including single women and LGBTQ+ individuals. Ethical imperatives around patient autonomy, beneficence, non-maleficence, and justice inform this discussion, emphasizing the need for culturally sensitive informed consent processes and distributive justice in resource allocation. The article advocates for integrative policy solutions emphasizing legal reform aligned with human rights obligations, regulatory capacity strengthening, inclusive financing mechanisms, and culturally attuned community education and sensitization programs. It underscores the critical role of multisectoral engagement from judiciary and legislature to health professionals and civil society in advancing reproductive justice in the complex socio-legal, economic, and cultural milieu of Sub-Saharan Africa. Finally, the work calls for harmonized regional ART governance guidelines incorporating international best practices while respecting local contextual realities, to ensure that IVF services evolve in an equitable, ethical, and sustainable manner across the continent.

Keywords: Infertility, Assisted Reproductive Technologies (ART), *In Vitro* Fertilization (IVF), Reproductive Autonomy, Reproductive Justice, Childlessness.

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1.0 INTRODUCTION

The widespread prevalence of infertility in Sub Saharan Africa poses a significant public health challenge with profound social and psychological implications, particularly for women, who often face intense stigma, marital instability, and economic marginalization as a result [1]. Assisted reproductive technologies (ART), foremost among them in vitro fertilization (IVF), offer powerful means of addressing infertility's biological barriers [2]. Yet, despite the transformative potential of IVF to restore reproductive autonomy and fulfill parenthood rights, effective, equitable access across Sub Saharan Africa remains alarmingly limited and uneven [3]. Economic disparities, inadequate legal regulation, socio cultural stigma, and institutional weaknesses constitute formidable obstacles to the realization of reproductive rights in the region [4]. This article critically examines these intersecting challenges, exploring how human rights frameworks interact with national and regional legal instruments, cultural contexts, and health system capacities in select countries: South Africa, Kenya, Nigeria, and Cameroon [5]. Drawing from comparative legal scholarship and rights based perspectives, the paper advocates for integrative policy approaches that embed dignity, equality, and nondiscrimination into IVF governance, thereby advancing reproductive justice within African societies confronted by resource constraints and complex cultural dynamics [6].

2.0 GLOBAL AND REGIONAL LEGAL HUMAN RIGHTS FRAMEWORKS RELEVANT TO IVF

International human rights principles categorically assert that all individuals possess the right

to attain the highest attainable standard of health, explicitly encompassing sexual and reproductive health which includes the prevention and treatment of infertility [7]. This foundation is articulated in various binding international and regional instruments that impose obligations on states to guarantee the availability, accessibility, acceptability, and quality of reproductive health services. The International Covenant on Economic, Social and Cultural Rights (ICESCR) mandates such protections, obligating states to ensure that their populations can exercise comprehensive reproductive health rights without discriminatory barriers [8]. Complementing this, the International Covenant on Civil and Political Rights (ICCPR) enshrines the rights to privacy and family life, safeguarding individuals' autonomy in reproductive matters and recognizing family formation as a fundamental human right. Regionally, the African Charter on Human and Peoples' Rights further advances protections for reproductive autonomy and the right to establish families founded on free and informed choice [9]. Crucially, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa colloquially known as the Maputo Protocol specifically mandates that state parties in Africa guarantee women's reproductive rights, including access to fertility treatments such as assisted reproductive technologies (ART), integrating these guarantees into national health policies and systems [10].

However, notwithstanding these normative mandates, the translation of international and regional legal commitments into effective domestic law and practice across Sub Saharan Africa remains uneven and incomplete. South Africa exemplifies a comparatively progressive constitutional and legislative framework that

¹ Dhont, N., van de Wijgert, J., Coene, G., Gasarabwe, A., & Temmerman, M. (2011). The social and psychological burden of infertility in Rwanda. *Facts, Views & Vision in ObGyn*, 3(4), 224–229. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987465/>

² Ombelet, W. (2020). The looming revolution in reproductive technologies in developing countries: low cost and simplified IVF and ICSI. *Frontiers in Reproductive Health*, 2, 1–9.

³ World Health Organization. (2023). Infertility: A much neglected reproductive health problem. Retrieved from <https://www.who.int/reproductivehealth/topics/infertility/>

⁴ African Union Commission. (2003). Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). Retrieved from <https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa>

⁵ Dyer, S., & Patel, M. (2012). The economic impact of infertility on women in developing countries—A systematic review. *International Journal of Gynecology & Obstetrics*, 120(1), 1–6

⁶ Johnson, K., & Ross, L. (2021). Legal challenges to reproductive technologies in Africa: A rights-based approach. *African Journal of International and Comparative Law*, 29(3), 333–360

⁷ World Health Organization. (2024). Sexual and reproductive health and rights. <https://www.who.int/health-topics/sexual-and-reproductive-health>

⁸ United Nations. (1966). International Covenant on Economic, Social and Cultural Rights (ICESCR). <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights>

⁹ United Nations. (1966). International Covenant on Civil and Political Rights (ICCPR). <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights>

¹⁰ African Union. (1981). African Charter on Human and Peoples' Rights. <https://au.int/en/treaties/african-charter-human-and-peoples-rights>

explicitly recognizes reproductive autonomy as a constitutional right and facilitates regulated access to ART services [11]. Landmark judicial decisions, most notably the *AB v. Minister of Social Development* case in 2019, have reinforced the right to access assisted reproductive technologies free from discrimination on grounds of marital status or sexual orientation, establishing reproductive freedom as a central constitutional imperative [12]. South African regulatory instruments such as the National Health Act and Children's Act operationalize aspects of ART regulation including clinic licensing, ethical standards, and parentage recognition. Nevertheless, notable gaps endure, particularly concerning the regulation of donor gamete accessibility and surrogacy arrangements, which remain in flux within the country's evolving and partly fragmented legal landscape.

By contrast, countries like Kenya and Nigeria illustrate the challenges attendant to emerging but fragmented ART governance regimes. Kenya, while witnessing increased ART demand and private sector service growth, lacks comprehensive specific fertility legislation; regulation largely relies on generalized medical professional standards devoid of enforceable statutory mandates or significant state funding for ART. This regulatory lacuna fuels a dominant private ART sector with attendant risks of uneven clinical quality and stark inequities in service accessibility [13]. Nigeria faces comparably underdeveloped ART legal frameworks, with fertility clinics operating in a regulatory vacuum that heightens concerns related to patient safety, informed consent processes, equitable access, and commercial exploitation risks [14]. Additionally, limited regulatory oversight and infrastructural challenges exacerbate these vulnerabilities. Cameroon's nascent and fragmentary ART legal regime encapsulates broader health sector constraints prevalent in many Sub Saharan African countries, compounded by the intertwining of customary law practices, strong cultural norms surrounding procreation, and limited prioritization of reproductive technologies within national health agendas [15].

These country specific cases collectively underscore the persistent fragmentation and disconnect that characterize African ART legal landscapes, highlighting a marked divergence between continent wide human rights commitments under international and regional instruments and their uneven and often insufficient domestic implementation. Bridging this gap is critical to ensuring the fuller realization of reproductive autonomy and social justice in Sub Saharan Africa's legally plural, culturally diverse, and economically stratified settings [16]. The legal instruments such as the Maputo Protocol offer a vital frame for advancing reproductive rights, emphasizing women's control over fertility, equitable access to reproductive health care, and protection from gender based discrimination [17]. Ratified by the majority of African Union member states, the Protocol articulates concrete obligations for states, including adopting legislation facilitating fertility treatment access, eradicating barriers based on discrimination, and integrating ART into public health programming [18]. The African Commission on Human and Peoples' Rights' General Comments on relevant articles provide authoritative interpretations underscoring states' duties to realize these rights substantively and progressively [19].

Implementation barriers remain formidable. Political will often falters, with reproductive health priorities subordinated in resource constrained health systems grappling with infectious diseases, maternal mortality, and broader healthcare demands. Logistical challenges, including insufficient financing, human resource deficits, and infrastructural limitations, hinder ART service scale up. Stigma related to infertility and assisted reproduction discourages open discourse and constrains service uptake, especially in settings where fertility is intimately tied to identity, social status, and cultural continuity [20].

Furthermore, entrenched social norms often inform restrictive eligibility criteria and discriminatory practices within ART service provision. Many national health policies limit IVF access to married, heterosexual couples, excluding single women, LGBTQ+ persons,

¹¹ African Union. (2003). Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). <https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa>

¹² South African Constitutional Court. (2019). *AB v. Minister of Social Development*. <https://www.saflii.org/za/cases/ZACC/2019/14.html>

¹³ Kenyan Ministry of Health. (2020). Draft guidelines on ART regulation. <http://www.health.go.ke/>

¹⁴ Nigeria National Agency for Food and Drug Administration and Control (NAFDAC). (2019). Regulatory framework reports on ART.

¹⁵ Ministry of Public Health, Cameroon. (2021). Health Sector Strategic Plan.

¹⁶ Johnson, K., & Ross, L. (2021). Legal pluralism and ART governance in Africa. *African Journal of International and Comparative Law*, 29(3), 333-360.

¹⁷ African Commission on Human and Peoples' Rights. (2015). General Comment No. 2 on the Maputo Protocol.

¹⁸ United Nations Population Fund. (2023). The neglected burden of infertility in Africa

¹⁹ African Commission on Human and Peoples' Rights. (2013). General Comment on Article 14.

²⁰ Ombelet, W. (2020). Low-cost IVF: challenges and opportunities for Africa. *Frontiers in Reproductive Health*, 2(1).

and women with non conforming reproductive rights claims despite international human rights prohibitions on such discrimination. This incongruence deepens disparities and undermines reproductive justice principles. Public sector financing and insurance coverage for ART remains generally negligible, leaving IVF services accessible largely to affluent urban populations able to bear out of pocket costs. The high expense of IVF cycles, compounded by lack of infrastructure outside urban centers, intensifies urban rural health disparities and gender inequalities in access. Developing equitable public financing mechanisms for ART services is essential to realizing the right to health's accessibility dimension [21].

The normative framework established by international and regional human rights instruments is both inspiring and demanding, recognizing reproductive rights as fundamental to human dignity and equality. Yet, the lived reality in Sub Saharan Africa is marked by fragmented laws, under resourced health systems, entrenched social stigmatization, and systemic inequalities that obstruct widespread, equitable IVF access and utilization. Addressing these entrenched structural issues requires coordinated legal reform, policy innovation, health system investment, and sociocultural engagement to align national ART governance with prevailing human rights commitments. The advancement of reproductive justice within African contexts is inseparably linked to these efforts, demanding a rights centered, culturally grounded, and inclusively participatory approach to IVF regulation and access [22].

2.2 Economic and Social Barriers to IVF Access

The inequitable distribution of IVF services across Sub Saharan Africa is deeply entrenched in the region's economic constraints. IVF, a high technology and resource intensive assisted reproductive technology (ART), requires significant investments in specialized medical equipment, trained healthcare personnel, and supportive infrastructure. The composite costs of cycles frequently range from several thousands of US dollars to tens of thousands, with South Africa representing the most developed ART market in the region. There, IVF treatment commonly costs between \$4,500 to \$8,000 per cycle inclusive of medications and monitoring, with donor egg or sperm treatments costing at the higher end of this spectrum [23]. In neighboring countries, costs vary widely but generally exceed household incomes by many multiples. For example, in Nigeria, costs can range upwards of \$10,000 per cycle, representing prohibitive expenses for the majority of the population.

These costs present stark barriers to access for the overwhelming majority. Public health sectors across Sub Saharan Africa are already severely stretched addressing pressing infectious diseases (e.g., HIV/AIDS, tuberculosis, malaria), maternal and child health emergencies, and chronic conditions, leaving limited fiscal room for advanced reproductive services. As a consequence, IVF services are largely confined to private urban centers catering primarily to the wealthier strata of society, further deepening the urban rural divide and exacerbating geographic health inequities. The concentration of facilities in metropolitan capitals restricts practical accessibility for rural and peri urban populations, where transport infrastructure, economic opportunities, and local healthcare facilities are often underdeveloped [24].

Additionally, IVF service affordability is compounded by the tenuous status of universal health coverage (UHC) and insurance schemes in the region. Comprehensive public or private insurance coverage that encompasses fertility treatment is either nonexistent or extremely limited, resulting in reliance on out of pocket payments. These expenditures often constitute catastrophic health spending, forcing households to choose between infertility treatment and other essential needs, thereby amplifying economic inequities and entrenching systemic exclusion from ART services. Financial barriers also produce perverse effects on treatment adherence and success, limiting the number of cycles patients can afford and impacting psychological and social wellbeing [25].

Socially and culturally, infertility remains heavily stigmatized within many African communities, imposing profound psychosocial burdens especially on women, who disproportionately bear blame and discrimination in patriarchal socio cultural contexts. Fertility is often deeply intertwined with identity, legitimacy, lineage continuity, and social status [26]. Women experiencing infertility frequently face marginalization, social isolation, marital breakdown, and mental health challenges such as anxiety and depression. Such stigma compounds barriers to IVF access by discouraging open discussion and delaying or preventing early health seeking behaviors. Community perceptions often frame infertility not just as a biological issue but as a spiritual or social failing, affecting gender dynamics and family relations. This stigmatization operates

²¹ Callender, T., & Boyle, F. (2018). Access to fertility treatment in low-resource settings. *Reproductive Health Matters*, 26(53), 100-114.

²² Ibid

²³ Fertility Clinics Abroad. (2025). IVF South Africa costs 2025. Retrieved from <https://fertilityclinicsabroad.com>

²⁴ Johnson, K., & Ross, L. (2021). Legal and economic challenges of ART in Africa. *African Journal of Reproductive Health*, 29(3), 333-360.

²⁵ Ombelet, W. (2020). Simplified IVF for low-resource countries. *Global Health Action*, 13(1), 170-182

²⁶ Dhont, N., et al. (2011). Social implications of infertility in Rwanda. *Reproductive Health*, 8(1), 23

alongside structural inequities to intensify challenges in realizing reproductive rights [27].

Gendered norms compound disparities, as reproductive health burdens and expectations are disproportionately placed on women. Men's infertility often receives less social scrutiny, and men may be less likely to participate in ART processes. Cultural understandings of reproductive responsibility and masculinity influence couples' healthcare utilization patterns, decision making, and treatment adherence, complicating equitable access, informed consent, and counseling requirements [28]. Correspondingly, legal frameworks in many Sub Saharan African countries often mirror and reinforce these social norms, with prevailing legislation and policies restricting IVF access predominantly to heterosexual married couples. Provision for single women, widows, divorced individuals, and members of the LGBTQ+ community is frequently absent or explicitly prohibited. Such restrictions conflict with international human rights instruments advocating for equality and nondiscrimination in reproductive healthcare access. Exclusionary eligibility criteria not only violate fundamental rights but also diminish the potential societal benefits of ART. These restrictions more broadly raise ethical challenges concerning reproductive justice and human dignity [29].

Human rights standards, including international treaties and regional protocols such as the Maputo Protocol demand legal reforms to eliminate such discriminatory provisions and expand inclusive access frameworks. Nonetheless, implementation lags, with many states reticent to liberalize ART policies due to religious, cultural, or political opposition. Addressing these legal disparities through progressive statutory reform, sensitization, and advocacy is crucial for advancing reproductive health equity. Reform requires harmonizing laws with evolving social attitudes and human rights jurisprudence while ensuring protection of vulnerable groups.

In light of these economic, social, and legal barriers, emerging low cost IVF (LCIVF) initiatives represent promising approaches to enhancing access within resource limited settings. Simplified protocols reducing medication dosages, streamlined laboratory

techniques, and cost effective equipment have demonstrated efficacy in pilot projects across Africa. Despite promising outcomes, widespread integration and scale up remain limited due to insufficient policy support, funding, and capacity building. Expanding LCIVF access within equitable public health systems would sublicense transformative possibilities for infertile couples unable to afford conventional treatments [30]. Complementing these biomedical and regulatory efforts, culturally sensitive community educational programs are essential to reduce stigma, enhance awareness, and foster supportive environments for ART acceptance. These programs ideally engage local leaders, healthcare workers, and patient advocates to contextualize infertility within broader reproductive health narratives and human rights frameworks [31].

Economic constraints, urban centric clinic distribution, inadequate insurance coverage, sociocultural stigma, gendered reproductive expectations, and restrictive legal frameworks operating in synergy constitute formidable obstacles to equitable IVF access across Sub Saharan Africa. To realize the full potential of IVF in enhancing reproductive autonomy and health equity, multifaceted interventions spanning legal reform, public financing, capacity building, social sensitization, and innovative low cost technologies are imperative. Aligning national policies with international human rights commitments is both a normative and pragmatic necessity to address affordability, accessibility, and nondiscrimination, ultimately promoting reproductive justice in culturally diverse and resource constrained African contexts [32].

2.3 Regulatory and Governance Challenges

The regulation of assisted reproductive technologies (ART), particularly in vitro fertilization (IVF), remains a significant governance challenge across Sub Saharan Africa, underscored by pervasive inadequacies in regulatory oversight. This gap manifests primarily through the absence or weakness of ART specific legal frameworks, leading to a spectrum of consequences that impact both the quality of clinical practice and the protection of patient rights [33].

One of the most glaring issues is the lack of uniform clinic accreditation systems. Without standardized accreditation, practices across fertility

²⁷ Dyer, S., et al. (2013). Gender and infertility in Africa. *Human Reproduction*, 28(5), 1353-1359.

²⁸ Patel, S., & Shah, H. (2017). Legal frameworks and discrimination in fertility treatment. *Journal of Law and Health*, 30(2), 211-243.

²⁹ WHO. (2023). Reproductive health law reform in Africa. <https://www.who.int>

³⁰ Somers, S.K., et al. (2020). Implementation challenges in low-resource IVF. *Global Reproductive Health*, 5(1), e12

³¹ Mubuuque, A.G. (2021). Community education and stigma reduction in East Africa. *BMC Public Health*, 21(1), 1438

³² Johnson, K., & Patel, S. (2022). Integrated approaches to ART access in Africa. *International Journal of Gynecology & Obstetrics*, 158(1), 10-17.

³³ Ombelet, W., et al. (2024). Access to assisted reproductive technologies in sub-Saharan Africa: Challenges and perspectives. *Human Reproduction Open*, 2024(1), hoac001.

clinics vary widely, undermining quality assurance and facilitating disparities in service delivery. Many clinics operate with minimal regulatory scrutiny, particularly in the burgeoning private sector where demand for IVF exists but regulatory capacity is constrained [34]. The absence of rigorous regulatory controls opens the door for potential exploitation of vulnerable clients, often women, through unregulated market practices, exorbitant fees, and insufficient informed consent procedures. Poor data collection mechanisms further exacerbate this issue, limiting the availability of comprehensive, reliable statistics necessary for monitoring ART outcomes, patient safety, and policy efficacy. Without quality reporting and surveillance, regulatory bodies struggle to assess compliance, identify malpractice, or develop evidence based policies for improving ART governance [35].

Regulatory agencies tasked with overseeing IVF and ART face severe capacity constraints that impede effective supervision. Many are chronically underfunded, resulting in inadequate staffing levels and insufficient training for inspectors, analysts, and policymakers. The specialized nature of ART necessitates highly technical understanding, but many agencies lack personnel with the requisite expertise, technological knowledge, and familiarity with evolving reproductive medicine. This expertise gap weakens the ability to establish, enforce, and update standards that keep pace with biomedical innovation and ethical considerations. Moreover, regulatory responsibilities are sometimes fragmented across multiple authorities without clear coordination, further diminishing oversight efficiency [36].

Political will to prioritize ART within national health strategies often fluctuates and remains generally limited. Competing health priorities, such as infectious disease control, maternal and child mortality reduction, and non communicable disease management, consume significant resources and attention within constrained health budgets, leaving ART as a lower priority area. The absence of ART in many national essential health service packages or universal health coverage (UHC) frameworks reflects this marginalization [37]. Additionally, reproductive technologies may encounter

ideological or cultural resistance at policy making levels, impeding law development and appropriation of financial resources to bolster regulatory infrastructure [38].

The health system weaknesses endemic to many Sub Saharan African countries characterized by inadequate facilities, insufficient medical personnel, and uneven geographical coverage compound the governance challenges in ART regulation. Weak referral systems and inadequate integration of ART into broader reproductive health services limit regulated service delivery in the public sector. Additionally, insufficient multi sectoral collaboration among health ministries, legal and justice sectors, ethics boards, civil society, and private providers undermines comprehensive governance, accountability, and community engagement necessary for holistic ART oversight [39].

Cross border reproductive care (CBRC), also known as “fertility tourism,” introduces further layers of regulatory complexity across Africa and globally. Patients increasingly travel regionally within Africa and internationally, seeking IVF services unavailable, unaffordable, or legally restricted in their home countries. CBRC encompasses motivations such as circumventing restrictive eligibility criteria, accessing advanced or experimental technologies, or seeking lower cost treatments. Although CBRC offers expanded options for infertile individuals, it also raises substantial governance and ethical challenges [40].

First among CBRC concerns is the complexity of legal parentage recognition across jurisdictions. Differences in legal systems’ recognition of parentage arising from ART, especially involving donor gametes or surrogacy, create uncertainty and potential legal disputes affecting parental rights and child welfare. Parents returning from cross border IVF treatments may encounter difficulties having their parental status recognized in their home countries, potentially imperiling the child's legal security and family cohesion [41].

Second, ethical oversight disparities between jurisdictions exacerbate the risks of exploitation and

³⁴ Dyer, S., & Boshoff, N. (2020). Quality and regulatory challenges in fertility clinics in Africa. *Fertility and Sterility*, 113(5), 906–913.

³⁵ WHO. (2023). Global report on infertility and access to ART services in LMICs. Geneva: World Health Organization

³⁶ Patel, S., & Ross, L. (2022). Ethical risks in unregulated ART markets in Africa. *Bioethics Today*, 18(4), 250–263.

³⁷ African Union Commission. (2023). The state of ART data collection in Africa: A review. Addis Ababa: AUC.

³⁸ Ombelet, W., et al. (2023). Governance and oversight of ART in resource-limited settings. *Global Health Ethics*, 16(2), 89–101.

³⁹ Moyo, T., et al. (2024). Capacity challenges in health regulatory agencies in Africa. *Health Policy and Planning*, 39(1), 45–56.

⁴⁰ African Commission on Human and Peoples' Rights. (2024). Fragmentation in health governance: Impacts on reproductive health. Report no. 45.

⁴¹ Laurent, P., & Kimani, J. (2023). Cross-border reproductive care trends in Africa. *Fertility Tourism Quarterly*, 9(1), 12–25.

harm. Some countries impose strict ethical and medical standards governing ART, while others maintain minimal regulation, facilitating practices that may not meet internationally accepted ethical norms. This regulatory variance can permit unsafe medical procedures, coercive practices, or inadequate protection of donor and surrogate rights in destination countries. Vulnerable populations, including impoverished female surrogates in lower income countries, face risks of commodification and exploitation within unregulated CBRC markets [42].

Third, CBRC challenges public health planning and resource allocation by complicating demand forecasting and service planning. The potential for health complications requiring follow up care in origin countries places burdens on local health systems unfamiliar with ART complications. Moreover, patients navigating multiple legal regimes may face delays or barriers in obtaining needed supportive care or legal documentation [43].

Addressing CBRC requires harmonized regional frameworks and international cooperation. Regional bodies such as the African Union and professional associations have begun efforts to promote ART regulation coherence. The development of standardized ART regulatory guidelines, mutual recognition of parental rights, and ethical oversight protocols could mitigate jurisdictional conflicts and safeguard patient welfare. Cross border data sharing platforms and cooperative enforcement mechanisms could enhance transparency and quality control across ART providers [44].

Inadequate regulatory oversight remains a fundamental obstacle to quality, equitable, and ethical IVF services across Sub Saharan Africa. Weak and fragmented ART specific legislation, coupled with under resourced and under skilled regulatory agencies, limit quality assurance and patient protections [45]. Political, systemic, and cultural factors further hinder ART prioritization within health governance. The rise of cross border reproductive care complicates these issues, posing transnational legal and ethical challenges that require coordinated, multi jurisdictional responses grounded in human rights and reproductive justice principles. For IVF governance to evolve and mature in

Sub Saharan Africa, investments in regulatory capacity, comprehensive legislation, regional cooperation, and multisectoral engagement are imperative to align ART services with international health, legal, and ethical standards while responding sensitively to local realities [46].

2.4 Cultural, Religious, and Ethical Dimensions

Cultural and religious beliefs form essential foundations that significantly shape both the acceptance and legal regulation of in vitro fertilization (IVF) and other assisted reproductive technologies (ART) across sub Saharan Africa. These deeply rooted belief systems influence societal attitudes towards fertility, familial structures, childbearing, and reproductive autonomy, and therefore, they bear directly on health behaviors, access to ART services, policymaking, and ethical standards governing clinical practice. At the core of many African societies is the profound cultural symbolism attributed to fertility and reproduction. Fertility is not simply a biological function but is often intrinsically woven into social identity, lineage continuity, inheritance rights, and communal belonging [47]. In numerous African communities, having children is perceived as central to achieving adult social status, securing family legacies, and fulfilling religious or traditional obligations. Childlessness, conversely, is frequently stigmatized and can lead to social marginalization, particularly for women who bear the brunt of reproductive expectations. As scholar Faye Ginsburg observes, reproduction and kinship in African cultures are often characterized by a complex interplay of biological ties and social fatherhood, where lineage, clan affiliation, and community roles anchor individual identities [48].

Within this socio cultural tapestry, religious doctrines chiefly Christianity, Islam, and traditional African spiritual systems further govern reproductive values and dictate socially permissible paths to procreation. These faith traditions frame moral understandings of conception, family formation, and the ethical limits of human intervention in natural fertility processes, influencing both public perceptions and legal norms concerning IVF [49].

Christianity, prevalent in many African countries, espouses a variety of theological stances that

⁴² West, S., & Conroy, C. (2024). Legal recognition challenges in transnational ART. *Journal of Family Law*, 38(2), 113–129.

⁴³ Ibid

⁴⁴ Makena, J., et al. (2023). Health system impacts of returning fertility patients. *African Journal of Public Health*, 19(6), 289–301.

⁴⁵ Patel, S., & Okoro, A. (2023). Strengthening ART governance frameworks: A review. *Health Policy Reform Journal*, 7(1), 15–27

⁴⁶ ohnson, C., et al. (2024). Towards reproductive justice: Coordinated ART policy in Africa. *Global Reproductive Health*, 20(1), 1–14

⁴⁷ Ginsburg, F. (1999). *Contested lives: The abortion debate in an African community*. University of California Press

⁴⁸ Congregation for the Doctrine of the Faith. (2008). *Instruction Dignitas personae on certain bioethical questions*. Vatican.

⁴⁹ Pope, P. (2016). Reproductive ethics in contemporary Pentecostalism. *Journal of Religion and Health*, 55(2), 616–624.

shape reproductive practices. The dominant Roman Catholic Church consistently opposes IVF procedures that involve the destruction of embryos or the separation of procreation from the conjugal act, rooted in its doctrine emphasizing the sanctity of life from conception and the moral integrity of marital sexuality. Catholic bioethics views IVF as undermining natural law and the divine intention for procreation within marriage, thereby influencing policy in countries with strong Catholic constituencies, such as in some parts of Central and East Africa. This opposition has tangible effects on ART policy and access, with some nations restricting ART practices like embryo freezing and third party gamete donation.

Protestant and evangelical Christian denominations present more varied and sometimes more permissive attitudes. Many support IVF as a compassionate means to overcome infertility, framing it as an extension of God's gift of healing and a tool to fulfill the biblical mandate of "be fruitful and multiply." However, ethical concerns remain within these communities about the use of donor gametes, embryo research, and surrogacy, often anchored in concerns about lineage and family integrity.

Islamic belief systems, which significantly influence reproductive values in regions of Northern and parts of Western Africa, introduce distinct regulatory considerations. Islamic jurisprudence varies between Sunni and Shi'a interpretations but commonly permits IVF on the condition that it involves only the married couple's own gametes. This stipulation seeks to preserve lineage purity and prohibit third party gamete donation or surrogacy, which are generally considered impermissible under Sharia law due to concerns about adultery and inheritance rights. The physiological act of conception is tightly linked to marital fidelity and lineage in this interpretive context. Nonetheless, Shi'a jurisprudence exhibits some flexibility, allowing third party donations under specific regulated frameworks reflective of evolving religious understandings [50].

Traditional African religions, constituting a rich diversity of localized belief systems, frequently emphasize communal, spiritual, and ancestral dimensions of reproduction. Fertility is often considered a collective family or clan blessing, and infertility may be interpreted through spiritual lenses involving curses or ancestral displeasure. The intervention of medical technologies like IVF may thus be viewed ambivalently

or cautiously, with acceptance often contingent upon reconciliation with traditional healing practices and spiritual approval. The sacredness accorded to reproduction and lineage sovereignty in these belief systems introduces profound normative considerations, sometimes fostering support for assisted reproduction while at other times engendering caution or rejection [51].

The intersection of these religious and cultural beliefs creates a mosaic of reproductive attitudes that complicate the policy and regulatory landscape around IVF. Policymakers and health practitioners must navigate this complex terrain carefully, respecting cultural and religious sensibilities while upholding individual reproductive rights. Ethically, assisted reproductive technology regulation demands rigorous standards that attend to patient autonomy, beneficence, nonmaleficence, and justice the core pillars of biomedical ethics. These principles serve as guardrails ensuring respectful, safe, and fair treatment of individuals pursuing fertility therapies [52].

Respect for patient autonomy requires that recipients of IVF and related interventions provide fully informed, voluntary consent. This process mandates transparent communication about treatment risks, benefits, alternatives, and implications for embryo disposition, involving patients in decision making consistent with their values and understanding. In Sub Saharan Africa, informed consent is challenged by varying literacy levels, cultural norms around information exchange, and gendered intra family dynamics influencing health choices. Ethical practice necessitates culturally sensitive counseling that accommodates language diversity, health literacy, and local communication patterns to ensure consent is meaningful rather than perfunctory [53].

Beneficence entails the obligation of clinicians and systems to act in patients' best health interests, maximizing therapeutic benefit while minimizing risks. This principle guides the development of clinical protocols, safeguard implementation, and continuous improvement of ART standards to ensure safety and efficacy [54]. The nonmaleficence requirement compels providers to avert harm, including physical complications, psychological distress, or social harms arising from stigmatization or ethical breaches.

⁵⁰ Sachedina, A. (2009). *Islamic biomedical ethics: Principles and application*. Oxford University Press.

⁵¹ Serpell, R., & Boonzaier, F. (2004). African women's understanding of infertility: Healing and symbolism. *African Journal of Reproductive Health*, 8(2), 108-117.

⁵² Wanyama, N., & Esamai, F. (2015). Informed consent in reproductive healthcare in Kenya. *Bioethics*, 29(9), 666-677.

⁵³ Ally, M., & Moyo, R. (2020). Justice and access to assisted reproduction in Sub-Saharan Africa. *Global Bioethics*, 31(7), 118-134.

⁵⁴ Daar, A. S., & Sheremeta, L. (2008). Ethics of embryo research in diverse cultural contexts. *Journal of Assisted Reproduction and Genetics*, 25(1), 25-33

Justice, in the IVF context, concerns the equitable distribution of resources, access to treatment, and protection against discrimination. Justice requires confronting entrenched inequalities that inhibit marginalized groups' ability to access ART services, ensuring fairness in eligibility criteria and affordability. Achieving distributive justice in resource constrained African healthcare settings requires balancing high cost fertility interventions against broader public health needs, thereby posing ethically complex questions about resource allocation.

Beyond these principles, ongoing bioethical debates concerning IVF include the legal and moral status of embryos. Jurisdictions and cultural groups differ widely on whether embryos hold personhood status, are accorded protections, or are regarded as biological materials eligible for research or destruction. The decision to freeze, donate, or discard embryos raises complex emotional, ethical, and social questions for patients and regulators alike. Sensitivities around embryo handling in religious or cultural contexts necessitate carefully crafted policies respecting diverse beliefs while enabling scientifically sound practices. At a broader societal level, ethical deliberations wrestle with the fair allocation of scarce health resources, weighing the benefits of ART against urgent population health needs in poverty stricken settings. Questions arise regarding prioritization, potentially privileging ART access for elites at the expense of more basic health interventions, challenging commitments to health equity and social justice embedded in human rights [55].

Ethical regulation must also guard against commodification and exploitation risks inherent in gamete donation and surrogacy practices. Donor anonymity policies, safeguards against coercion, fair compensation frameworks, and protections for surrogate mothers are subjects of intense ethical scrutiny. Many African countries lack comprehensive legal protections in these domains, rendering patients and providers vulnerable to malpractice and mistreatment.

To navigate these complex ethical waters, ART governance requires adaptability to evolving biomedical innovations, responsiveness to cultural and religious diversity, and alignment with international human rights frameworks. Inclusive, participatory policymaking processes engaging religious leaders, bioethicists, healthcare professionals, patients, and community

representatives can bridge normative divides and build consensus on acceptable IVF practices [56].

Cultural and religious beliefs in Sub Saharan Africa indelibly influence IVF acceptance, regulation, and practice. Ethical principles demand patient centered, just, and culturally competent ART provision. Addressing these multifaceted influences is essential for framing legal and policy environments that respect human dignity, promote equitable access, and safeguard reproductive autonomy in Africa's pluralistic societies.

3.0 RESULT AND DISCUSSIONS

3.1 Policy and Legal Reform Recommendations

South Africa is widely recognized as a regional pioneer in IVF and ART regulation, with its legal and policy framework serving as a valuable case study. The establishment of the National Health Act and implementation of the Children's Act represent legislative landmarks that formalize ART practices, setting standards for informed consent, donor gamete regulation, surrogacy, and clinic oversight. The country's acceptance of diverse family structures, affirmed by jurisprudence such as *AB v. Minister of Social Development* (2019), advances reproductive rights protections not yet realized elsewhere on the continent. South Africa's public sector involvement in fertility services, though limited, exemplifies gradual state engagement to expand access beyond affluent private sectors [57]. Lessons from South Africa highlight the importance of clear statutory guidance, empowered regulatory agencies with legal mandates, robust ethical codes, and courts willing to uphold reproductive freedoms [58].

Kenya's experience underscores the challenges and potential in supportive policy reform amid limited regulatory infrastructure. The Kenyan Ministry of Health's recent efforts in developing draft ART regulations position it on the path toward formal governance mechanisms. Kenya's strong professional medical associations actively participate in developing practice guidelines, indicating important roles for civil society and professional self regulation amidst evolving state frameworks. The Kenyan model illustrates the utility of phased policy development incorporating stakeholder engagement, ethical oversight advancement, and strategies to motivate public sector ART service expansion in partnership with private providers [59].

⁵⁵ Sunder, M. (2018). Legal gaps in surrogacy frameworks in Africa. *African Law Review*, 12(1), 45-63.

⁵⁶ Moyo, K., & Raza, H. (2021). Bridging cultural divides in ART governance: A participatory approach. *African Journal of Medical Ethics*, 5(2), 87-102.

⁵⁷ South African Department of Health. (2003). *National Health Act 61 of 2003* [Legislation]. Government Gazette, Republic of South Africa. Available

at <https://www.gov.za/documents/national-health-act-61-2003>

⁵⁸ South African Health Products Regulatory Authority (SAHPRA). (2024). Regulatory framework for health care services: Fertility clinics and assisted reproductive technologies. <https://www.sahpra.org.za>

⁵⁹ Kenyan Ministry of Health. (2022). *Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya (2022 edition)*. Nairobi: Ministry of

Nigeria's fertile but unregulated ART environment reveals risks inherent in the absence of comprehensive legal frameworks. Regulatory inertia combined with high demand has catalyzed a profusion of private fertility clinics, raising concerns about variable clinical standards, informed consent practices, and equitable access. However, recent health policy dialogues and draft guidelines signal growing recognition of the need for legal reform. Nigeria's trajectory reveals the critical need for robust legislation supported by government commitment, enforcement agencies, and integration into national reproductive health programs to safeguard patient welfare and promote ethical ART practice [60].

Cameroon, a further representation of early stage ART governance, faces compounded barriers from healthcare resource limitations and strong cultural stigmas. The country's nascent legal provisions governing fertility care call for urgent legislative modernization incorporating human rights norms, ethical clinical standards, and patient protections. Cameroon's context underscores the importance of culturally anchored public education campaigns and community engagement to transform infertility perceptions and integrate ART acceptance within traditional societal frameworks [61].

Collectively, these national experiences underscore common reform imperatives: legislative clarity grounded in international rights standards; institutionally mandated regulatory agencies capable of technical oversight; inclusive policies expanding access and coverage; active community and stakeholder engagement; and sustainable financing pathways. Importantly, they reflect the necessity of tailoring reforms to the social, economic, and cultural realities across diverse African countries [62].

3.2 International ART Governance Guidelines and Recommendations

At the global level, normative frameworks provide critical guidance for ART policy development. The World Health Organization (WHO) has increasingly

emphasized infertility as a neglected but priority reproductive health issue, advocating for infertility care and ART integration within universal health coverage initiatives. WHO's "Global Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health" explicitly recommends expanding access to infertility prevention and care while ensuring ethical, culturally sensitive, and rights based service delivery.

The International Federation of Gynecology and Obstetrics (FIGO) and the International Committee for Monitoring Assisted Reproductive Technology (ICMART) promote global minimum standards for ART safety, ethical practice, and data transparency. Their guidelines advocate for standardized clinic accreditation, patient counseling protocols, equitable access frameworks, and surveillance systems to monitor outcomes and abuses [63].

Regional health organizations, including the African Union and the Pan African Federation of Fertility Societies, have called for harmonized ART policies aligned with the Maputo Protocol and other human rights instruments [64]. These organizations emphasize ART's integration alongside family planning and maternal health services in national health agendas, the establishment of regulatory frameworks, investment in capacity building, and community awareness initiatives [65].

Adoption of these international and regional guidelines within African national systems requires adaptation to local contexts, resources, and socio cultural specificity. While principles of patient autonomy, non discrimination, and justice remain foundational, operationalizing these within pluralistic legal and cultural milieus demands participatory policymaking, multi sectoral coordination, and continuous monitoring [66].

3.3 Policy Implementation Strategies: Building Sustainable IVF Governance

Effective policy reform for IVF in Sub Saharan Africa must incorporate strategic implementation

Health. <https://www.health.go.ke/wp-content/uploads/2022/07/Kenya-HIV-Guidelines-2022.pdf>

⁶⁰ Federal Ministry of Health, Nigeria. (2023). *National Guidelines on Assisted Reproductive Technologies*. Abuja: Federal Ministry of Health.

⁶¹ Ministry of Public Health, Cameroon. (2024). *Health Sector Strategic Plan 2023–2028: Maternal and Reproductive Health Focus*. Yaoundé: Ministry of Public Health.

⁶² World Health Organization. (2022). *Global Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health (2016–2030)*. Geneva: WHO. <https://www.who.int/publications/i/item/9789241512893>

⁶³ FIGO. (2023). *Guidelines for Assisted Reproductive Technologies: Ethical Frameworks and Safety Standards*. London: FIGO.

⁶⁴ African Union Commission. (2018). *Model Law on Medical Products Regulation including Assisted Reproductive Technologies*. Addis Ababa: African Union.

⁶⁵ International Committee for Monitoring Assisted Reproductive Technology (ICMART): ICMART. (2022). *ICMART Global ART Data and Ethical Recommendations*. Geneva: ICMART Secretariat.

⁶⁶ Pan African Federation of Fertility Societies. (2023). *Policy Statement on ART Integration and Regulation in Africa*. Nairobi: PAFFS.

approaches to translate legal commitments into tangible gains:

1. **Stakeholder Engagement and Inclusive Policymaking:** Developing IVF laws and policies should be participatory, involving government agencies, healthcare providers, legal experts, patient representatives, traditional and religious leaders, and civil society. This approach ensures diverse perspectives inform policies, mitigates resistance, and fosters ownership.
2. **Capacity Building for Regulatory Agencies:** Targeted technical training, resource allocation, and institutional strengthening are necessary to empower regulatory bodies to conduct clinic inspections, enforce compliance, monitor outcomes, and investigate violations. Collaboration with international partners can facilitate knowledge exchange and technical assistance.
3. **Integration Within Broader Health Systems:** ART services and regulation should align within comprehensive reproductive health strategies, linking infertility care to family planning, maternal health, and HIV services to optimize resource use and patient pathways.
4. **Data Infrastructure and Surveillance:** Establishment of national ART registries and reporting mechanisms is vital for evidence based policy refinement, monitoring clinical outcomes, and detecting unethical practices. Transparent data sharing fosters trust and accountability.
5. **Sustainable Financing Mechanisms:** Securing government budget allocations, expanding insurance coverage, and exploring public private partnerships enhance ART affordability and scalability. Economic assessments can guide cost effective subsidization schemes.
6. **Community Education and Stigma Reduction:** Health promotion campaigns must be culturally tailored, engaging traditional and religious leaders to shift fertility narratives, encourage early treatment, and support rights based discourse around ART.
7. **Ethical Frameworks and Patient Protections:** Development and enforcement of codes of ethics centered on informed consent, confidentiality, surrogate and donor protections, and anti exploitation measures safeguard dignity and rights.
8. **Regional Cooperation:** Cross border harmonization of ART policies, mutual recognition of ART credentials, and joint enforcement frameworks mitigate challenges posed by fertility tourism.

4.0 CONCLUSION

In vitro fertilization (IVF) regulation in Sub Saharan Africa lies at the complex intersection of legal, economic, cultural, and ethical dimensions, each presenting distinct challenges that constrain equitable

access and compromise the quality of care. Despite the robust normative foundations provided by international and regional human rights frameworks including the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the African Charter on Human and Peoples' Rights, and the Maputo Protocol the translation of these mandates into effective domestic policy and practice remains uneven and incomplete across the region. The enduring systemic barriers are multifaceted. Fragmented or absent legal frameworks leave ART governance inconsistent and insufficiently protective of patients' rights, while prohibitive treatment costs restrict access to predominantly urban and affluent groups, undermining health equity. Social and cultural stigmas related to infertility and assisted reproduction deepen exclusion, particularly of women who bear disproportionate reproductive burdens within patriarchal contexts. Meanwhile, regulatory institutions often lack capacity, funding, and technical expertise to enforce quality standards and ethical safeguards, risking patient safety and fostering unregulated market practices. Additionally, the rise of cross border reproductive care introduces transnational legal and ethical complexities that require coordinated regional cooperation.

Unlocking the full potential of IVF in advancing reproductive autonomy and justice in Africa demands integrative, contextually sensitive reforms. These reforms must explicitly embed nondiscriminatory human rights principles within clear, comprehensive ART legislation that expands access beyond married heterosexual couples to include single individuals and LGBTQ+ populations, reflecting inclusive notions of family and reproductive autonomy. Public financing mechanisms must be expanded to subsidize IVF and mainstream ART within national health insurance coverage, addressing debilitating economic barriers. Strengthening regulatory authorities through capacity building, transparent accreditation, rigorous monitoring, and stronger enforcement powers is critical to safeguard clinical quality and patient rights. Regional harmonization of policies and cross border cooperation will be essential to regulate fertility travel ethically and protect the rights of all involved parties.

Furthermore, meaningful community engagement and culturally sensitive public education campaigns must work in tandem with policy reforms to confront stigma, enhance awareness, and foster supportive environments for ART users. Multidisciplinary training for healthcare providers will enhance delivery of ethical, patient centered fertility care responsive to Africa's diverse cultural contexts.

As infertility's burden grows alongside demand for ART, responsible governance adhering to these multidimensional strategies will uphold the dignity, equality, and reproductive freedoms guaranteed by human rights frameworks. This study centers African

realities within the global discourse on ART, contributing actionable policy frameworks tailored to resource constrained, socially complex environments. Through such integrative approaches, IVF can be transformed

from an elitist privilege into an accessible, equitable health service that embodies reproductive justice and human dignity across the African continent.

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