Safe Abortion 4



March in Johannesburg on 28 September - International Day for Safe Abortion. Photo: Shamiso Chigorimbo

KEY POINTS

- The SADC SRHR Strategy highlights that 24% of all pregnancies in Southern Africa end in abortion. Among the international instruments, only the Maputo Protocol mentions the right to abortion, in certain circumstances.
- There are only two SADC countries in which abortion is available on demand in the first trimester (South Africa and Mozambique). Abortion is available under certain circumstances in all SADC countries, with varying degrees of restriction.
- Safe and legal abortion is an SRHR right. The ability of a woman or girl to safely decide not to continue a pregnancy may be the key that unlocks numerous opportunities in life, including education, employment, financial security and good health.
- Abortion is almost always the result of an unintended pregnancy. Improving access to contraception to reduce unintended pregnancy is critical to reduce demand for abortion.
- More restrictive legislation does not reduce the abortion rate. Abortion rates are slightly higher in countries with restrictive legislation than in those with less restrictive legislation. More restrictive legislation drives women to clandestine abortion providers and unsafe abortions.
- Provision of good post abortion care reduces the mortality but is costly.
- The GL attitude survey shows that in almost all SADC countries less than half the respondents believe that a woman should be able to choose to terminate a pregnancy in the first three months.
- The SAFAIDS "My choice, our choice" campaign seeks to influence the policy environment on unsafe abortion.

Introduction

Induced abortion is a procedure for terminating an unintended pregnancy. It is considered to be medically *safe* when WHO-recommended methods, appropriate for the pregnancy duration, are used by trained persons, *less safe* when only one of those two criteria is met and *least safe* when neither is met. Induced abortion, safe or unsafe, legal or illegal, is a universal phenomenon and has existed throughout recorded history.[1] Unintended pregnancies are often the result of unmet need for contraception and also result from rape. When faced with an unintended pregnancy many women choose abortion, whether legal or safe. The SADC SRHR Strategy highlights that 24% of all pregnancies in Southern Africa end in abortion. Unsafe abortions contribute an estimated 10 to 13% of maternal mortality.

Deciding whether and when to have children, and being able to act on that decision, is a fundamental human right. The ability of a woman or girl to safely decide not to continue through a full pregnancy may be the key that unlocks numerous opportunities in life, including education, employment, financial security and good health.[2] Further, the psychological impact on both woman and the child of being forced to carry a pregnancy that has resulted from rape is enormous.



Young marchers in Orange Farm, Johannesburg. Photo: Colleen Lowe Morna

[1] Shaha. I, E Åhmana & N Ortaylib, 2014. Background paper # 3, ICPD Beyond 2014 Expert Meeting on Women's Health - rights, empowerment and social determinants 30th September - 2nd October, Mexico City. Access to Safe Abortion: Progress and Challenges since the 1994 International Conference on Population and Development (ICPD). UNFPA Unpublished paper. https://www.unfpa.org/sites/default/files/resource-pdf/Safe_Abortion.pdf Accessed 10 June, 2019

[2] IPPF. 2018. Her in charge: Medical abortion and women's lives - A call for action. London. https://www.ippf.org/herincharge/downloads/IPPF_Her_In_Charge_Report_2018.pdf accessed 10 June, 2019.

A UNFPA briefing paper for the *International Conference on Population Development (ICPD) Beyond 2014* conference estimated that there had been a decline in global abortions between 1995 and 2008 from 46 million to 44 million which corresponded to a decline in overall abortion rate from 35 to 28 per 1000 women in reproductive age 15-44 years. In the same period it was estimated that the decline in unsafe abortion was only from 15 to 14 per 1000 women of reproductive age 15-44 years while the rate of safe abortion dropped from 20 to 14.[3] The report also noted that there was insufficient data on occurrence of abortion and recommended that this needed to improve.

In the twenty five years since the ICPD conference, the number of countries globally which do not permit abortion on any ground declined from 8% to 3%. Countries where abortion is permitted on request increased from 22% to 30%. During this period, 70 countries made grounds for abortion more liberal while 11 increased the restrictions on grounds for abortion. Abortions occur as frequently in countries where abortions are banned outright or allowed only to save the woman's life (37 per 1000 women) as in countries which are least-restrictive (34 per 1,000 women).

In much of the world, 20-24-year-old women have the highest abortion rate of any age-group. Adolescent abortion rates in developed regions are fairly low (e.g., 3-16 per 1,000) but are much higher in developing regions.[4] However, where abortion is highly restricted, the incidence of unsafe abortion and related mortality is high. Legal restrictions also result in major inequity in access to safe providers, as women in urban areas and those who can afford to pay can access physicians or travel abroad to procure abortion. Those that are most likely to access unsafe abortions, with attendant morbidity, disability and even mortality, are poor, rural and young. Though ICPD was clear that access to safe abortion is imperative for public health, organised opposition to abortion has intensified and hampered progress to make safe abortion available.[5]

Health management information systems rarely collect data which is disaggregated by spontaneous abortions (or miscarriages) and induced abortions even in countries where abortion is legal. In countries where abortion is not legal it is very difficult to find data. Rates of abortion are therefore estimated, based on a variety of data such as care for post abortion cases. As a result of data gaps and the lack of reliability of data, there are few graphs or even tables in this chapter. In fact, much of the data that is available is for all of Sub-Saharan Africa or all developing regions. Some is a little dated. One of the calls of this chapter is for more routine collection of data, but this is difficult in an era of an expanded Mexico City Policy (or Gag Rule) blocking any US government funding to organisations that give women access to or even information about, safe abortion.

The Gag Rule will impact many women's' lives negatively

[3] Shaha et al. 2014. Op Cit
[4] Singh, S. et al. Op Cit
[5] Shaha etal Op Cit

Table 4.1: Key facts on abortion in Southern Africa

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
	Penal Code 2014	Penal Code 1991	Penal Code 2004	Penal Code 2005	Penal Code 2010	Penal Code 1998	Penal Code	Criminal Code 2012	Penal Code 2013	Abortion and Sterilisation Act 1975	Termination of Pregnancy Act 1994	Termination of Pregnancy Act 1996	Penal Code	Penal Code 2014	Abortion Law 1977
Laws															
Abortion on demand									Yes			Yes			
Save the Woman's Life	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Economic or Social reasons											Yes	Yes		Yes	
Foetal impairment	Yes	Yes		Yes	Yes			Yes	Yes	Yes		Yes		Yes	
Rape		Yes	Yes	Yes	Yes			Yes	Yes	Yes	Yes	Yes		Yes	Yes
Incest		Yes	Yes	Yes	Yes				Yes	Yes	Yes	Yes		Yes	Yes
Intellectual disability				Yes						Yes	Yes	Yes		Yes	
Mental Health	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes	Yes	Yes		Yes	
Physical Health	Yes	Yes	Yes	Yes	Yes			Yes	Yes	Yes	Yes	Yes			
Response															
Strengthen access to contraceptives		Yes		Yes				Yes							
SRH education	Yes	Yes		Yes			Yes		Yes	Yes		Yes			Yes
Decriminalise abortion					Yes	Yes						Yes			
Safe abortion health			Yes		Yes				Yes		Yes		Yes	Yes	
Comprehensive post abortion care guidelines		Yes				Yes	Yes		Yes			Yes	Yes	Yes	Yes
Attitudes															
% who say a woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy	47%	24%	10%	30%	51%	15%	27%	35%	16%	15%	41%	28%	15%	47%	28%

Source: Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019 and Gender Links Attitude Survey.

Table 4.1 shows that:

- There are only two SADC countries in which abortion is available on demand in the first trimester (South Africa and Mozambique).
- Abortion is available under certain circumstances in all SADC countries, most commonly to save the woman's life; foetal impairment; rape; incest, mental or physical health.
- In some countries (for example Angola, Madagascar, Malawi and Tanzania), the circumstances under which abortion is allowed is extremely limited.
- Only three countries (South Africa, Seychelles and Zambia) allow for abortion for economic and social reasons.
- The response to abortion has been largely reactive. Eight countries (Botswana, Madagascar, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe) have Comprehensive Post Abortion Care Guidelines. All evidence shows that safe abortion procedures would be much cheaper than post abortion care.
- The GL attitude survey shows that in almost all SADC countries less than half the respondents believe that a woman should be able to choose to terminate a pregnancy in the first three months. Even in South Africa, where abortion is legal, only 28% of those polled agree with this statement. However, attitudes on this very emotive subject are changing. For example, in neighbouring Lesotho, 51% of respondents agreed with the statement, as did 47% in Zambia.

Abortion incidence

The Guttmacher Institute has used the best available data to estimate abortion rates per 1000 women aged 15 to 44 for different regions and times (in series of 5 year intervals). It is estimated that abortion rates in Southern Africa increased from 32 in 1990 - 1994 to 35 in 2010 - 2014, compared to a decrease of 40 to 35 globally; a decrease of 39 to 37 in developing countries overall and decrease of 46 to 27 in developed countries.

The Institute estimates that 25% of pregnancies globally, and 24% in Southern Africa, end in termination. In the period 2010-2014, an estimated 8.2 million abortions occurred in Africa every year, an increase from the estimated 4.6 million in the 1990 - 1994 period. The rate of unintended pregnancy in Africa is estimated at 89 per 1000 women aged 15 to 44.[6] It recognizes comprehensive safe abortion care (including post abortion care), as a key element of SRHR.

SAfAIDS has conducted a knowledge, attitudes and practice (KAP) survey among 2993 respondents (2186 young women and 805 young males) across 16 SADC member states. Although there were poor response rates in some countries to some questions, this data collected provide some indication of the state of abortions across SADC.

Table 4.2: SAfAIDS Safe Abortion KAP survey responses

Country	% who knew 1 - 5 friends who had an abortion		% who knew someone that died from an abortion	Person responsible for an abortion	
	Male	Female		Named as	By %
Angola	na	na	19.50	Doctor Self-induced Herbs	60 22 10
Botswana	na	na	47.1	Self-induced Traditional healer Friends	74 13 9
DRC	na	na	16	Doctor	93
Eswatini	60.8		34.8	Self-induced Traditional healer Friend	30.2 5.7 17
Lesotho	90.5		28.5	na	na
Madagascar	56		na	na	na
Malawi	64.4	58.9	45 males 38 females	na	na
Mauritius	na	na	na	na	na
Mozambique	91.2		28.3	na	na
Namibia	89.6		31.5	Self-induced Traditional healer Doctor	64.4 12.9 9.9
Seychelles	na	na	33.3	Self-induced Herbs Doctor	60.9 10.4 13.9
South Africa	na	na	na	na	na
Tanzania	na	na	na	na	na
Zambia	84.9		36.3	Self-induced Doctor/Nurse Pharmacist	46.2 17.5 15.6
Zimbabwe	17.5	63	na	na	na

Source: SAfAIDS. 2019. Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. Final Report.

[6] Singh, S. et al. 2017. Abortion Worldwide 2017. Guttmacher Institute. New York.

Table 4.2 shows that where data was available, a high proportion of those surveyed knew 1-5 friends who had an abortion. This ranged from 17.5% in Zimbabwe to 90% in Lesotho. Of these, anywhere from 19.5% of those surveyed (Angola) to 47% (Botswana) knew of someone that died of an abortion. Self- induced abortions featured highest except in DRC where doctors were said to perform 93% of abortions.



Zimbabwe: Incidence Study shows high rate of abortion[7]



Overall, 40% of pregnancies in Zimbabwe were unintended, and one-quarter of all unintended pregnancies ended in abortion in 2016, according to the Abortion and Posabortion Care study.[8]

The study estimates that here were an estimated 677,277 pregnancies in Zimbabwe in 2016, resulting in a pregnancy rate of 180 per 1,000 women of reproductive age. Even though Zimbabwe has one of the highest contraception prevalence rates in Sub-Saharan Africa, the estimated national unintended pregnancy rate was found to be 71.1 per 1,000 women of reproductive age. Overall, 40% of pregnancies in Zimbabwe were unintended, and one-quarter of all unintended pregnancies ended in abortion.

Among all pregnancies in Zimbabwe, half (50%) ended in intended birth, 24% in unintended birth, 16% in miscarriage, and 10% in abortion.

The study found 25,245 Post Abortion Care (PAC) cases treated in facilities annually, of which 13,138 were estimated to be second trimester miscarriages, resulting in an estimated 12,107 PAC cases as a result of induced abortions. This translated to a 3.2 women per 1,000 women age 15-49 treated with PAC for induced abortions.

The study also identified gaps in the provision of PAC. Thus, though Zimbabwe has a relatively low abortion rate, unsafe abortion may still be contributing to a very high maternal mortality ratio. The study concluded that greater steps must be taken to fully implement the National Guidelines for Comprehensive Abortion Care.

Source: PLOS One, 2018

In 2016, 37,865 women were treated in health facilities for complications of abortion in Kinshasa, **DRC**. Further it was estimated that those that sought treatment were 25% of those that had accessed an abortion. Thus, it was estimated that 146,713 abortions were performed; corresponding to an abortion rate of 56 per 1,000 women aged 15-49. It was also estimated that there were more than 343,000 unintended pregnancies which is in an unintended pregnancy rate of 147 per 1,000 women aged 15-49.[9]

An estimated 53% of pregnancies in **Malawi** are unintended and 30% of unintended pregnancies end in abortion.[10] It is estimated that between 6-18% of abortions outside the health system in Malawi are associated with severe complications while 60% result in complications that require

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6200425/
[8] https://www.guttmacher.org/article/2018/10/severity-and-management-postabortion-complications-among-women-zimbabwe-2016-cross
[9] Chae S, Kayembe PK, Philbin J, Mabika C, Bankole A. The incidence of induced abortion in Kinshasa, Democratic Republic of Congo, 2016. PLoS One. 2017;12(10):e0184389. Published 2017 Oct 2. doi:10.1371/journal.pone.0184389
[10] Polis CB, Mhango C, Philbin J, Chimwaza W, Chipeta E, Msusa A. Incidence of induced abortion in Malawi, 2015. PLoS One. 2017;12(4):e0173639. Published 2017 Apr 3. doi:10.1371/journal.pone.0173639

attention from a health service provider.[11] One third of women in Malawi who had abortions do not receive the required treatment which leaves them in dire circumstances.

The 2012 Reproductive Health Policy[12] states that the number of terminations increased from 443 to 562 between 2006 and 2010. 58,8% of abortions were in women aged 20 to 34. Out of 237 reported teenage pregnancies in Seychelles in 2017, 31.7% ended in termination, according to the Ministry of Health. Traditional healer and friend-induced terminations are the highest cause of abortion related deaths in **Seychelles**[13].

Tanzania experienced an estimated 405,000 induced abortions in 2013, equivalent to a national rate of 36 abortions per 1,000 women age 15-49 or a ratio of 21 abortions per 100 live births. Only one in seven women who underwent an abortion received care.[14]

The 2018 Government of **Botswana** Relationship Study, carried out by Gender Links, offers insight into the nexus between sexual assault, pregnancy and abortion. 4224 women participated in the nationwide survey that included approximately equal numbers of women and men.

Table 4.3: Botswana Relationship Study Key facts on Abortion

Number of women in the study	4224						
Number and % who fell pregnant as a result of rape	72 (1.7% of the sample of women)						
Number and % who sought abortion	40 (56% of those who fell pregnant)						
Number and % who sought a legal abortion	7 (17.5% of those who sought an abortion)						
Age	Below 17	18-20	21-24	25-29	30-39	40-44	Total
	2	20	6	5	5	2	40
Who performed the abortion?	Doctor	Nurse	Mid wife	Self	Other	No one	
	5	18	2	6	9		40
Who examined you after the abortion procedure?	5	21	2			12	40
Where did the abortion take place?	Hospital	Clinic	Private surgery	Home			
	6	12	1	21			40
Views on abortion					Yes		No
Do you think that women who get pregnant as a result of rape or sexual assault should be allowed to have an abortion?					37%		63%
Do you know the circumstances that allow for legal abortion in Botswana?					32%		68%

Source: Botswana Relationship Study 2018.

Table 4.3 shows that:

- 72 or approximately 1.7% of the women interviewed became pregnant as a result of sexual assault.
- Of these 40, or 56% sought an abortion.
- Of the 40 who said they had an abortion, 18 went to a nurse; 6 self- induced and 9 sought "other" means. The latter is a worrying measure of lack of safety.
- The largest number of abortions took place in the home setting, and more than half had no follow up care, again raising concerns regarding safety.
- Only 37% of the women agreed that a woman who gets pregnant as a result of rape or sexual assault should be allowed to have an abortion. Only 32% knew the circumstances under which an abortion can be legally obtained in Botswana.

The rigid abortion laws in Botswana have forced abortion underground spawning a huge black market in 'Abortion Pills' that can be purchased for about $60. Dangers of backyard abortions include a ruptured uterus and uncontrollable bleeding that in most cases is fatal within a few hours.[15]

[11] Ibid
[12] http://www.health.gov.sc/wp-content/uploads/REPRODUCTIVE-HEALTH-POLICY-2012-last-version.pdf Accessed 22 June, 2019
[13] SAfAIDS. 2019. Rapid Assessment on the Adolescent Sexual and Gender Based Violence (SGBV) Related Policy Environment and Unsafe Abortions Seychelles Report Draft
[14] Keogh SC, Kimaro G, Muganyizi P, et al. Incidence of Induced Abortion and Post-Abortion Care in Tanzania. PLoS One. 2015;10(9):e0133933. Published 2015 Sep 11. doi:10.1371/journal.pone.0133933
[15] http://www.sundaystandard.info/botswana-turns-huge-underground-abortion-clinic

Three African countries (Ghana, Gabon and Congo Republic) were among 14 countries with data on the reason for an abortion. In women under the age of 25 the main reasons in all three sub-Saharan countries were: socio economic concerns, too young and partner related, while in women over 25 the major reasons were: socio economic concerns, partner related, wants to postpone or space births and maternal health related.[16]

A small qualitative study with women who received post abortion care in Kenya found that the main reasons for induced abortion were socio-economic stress, a lack of support from the male partner and deviation from family expectations. The male partner was influential in the abortion decision by declining his financial or social responsibilities or by demanding termination. In some cases, the male partner arranged for an unsafe abortion without the woman's consent. Stigma about an abortion resulted in women only confiding in very few people, which made them more vulnerable to complications and delayed seeking of help.[17]

The case study from South Africa illustrates how male partners, family and service providers influence decision-making on abortion.



South Africa: Who decides?[18]

When Charmaine, 22, arrived at the social work department accompanied by her boyfriend (Sam) he wanted to her terminate her pregnancy. Charmaine reported that she did not want to as she had an abortion before due to high blood pressure. However, in this case she was planning to keep her pregnancy.

The social worker enquired about whose decision it was. Charmaine was hesitant to answer and she responded it was her boyfriends' decision. At this point the social worker highlighted to the couple that, the decision should be made by the mother- to-be.

Sam is married and he only told Charmaine about wife and kids when he discovered that Charmaine was pregnant. The social worker re-emphasised to Sam that termination of pregnancy cannot be provided to Charmaine based on the fact that he wants her to have it and that he wants to take the easier way out of his responsibilities.

In a different case, Vanessa, a 23 year old young woman discovered that she was pregnant. Although her boyfriend was willing to take care of the baby Vanessa had decided that she could not keep the baby as she has no one to help her with the child and she wants to finish school. When Vanessa went to the hospital she was referred to a social worker for pre-counselling. The social worker asked Vanessa why she wanted to terminate her pregnancy when there were so many people who want to have children? Vanessa had no answer for the social worker as she felt judged. Vanessa was dismissed and told to come back later.

On return she was told by the social worker that she cannot have TOP as she was now 14 weeks pregnant rather than 12 weeks. Vanessa then resolved to private illegal clinic. She was assisted on the same day that she went.

These scenarios bring attention some of the factors that contribute to unsafe Termination of

[16] Chae S et al., Reasons why women have induced abortions: a synthesis of findings from 14 countries, Contraception, 2017, 96(4):233-241
[17] Rehnström Loi et al, Decision-making preceding induced abortion: a qualitative study of women's experiences in Kisumu, Kenya. Reproductive Health (2018) 15:166 https://doi.org/10.1186/s12978-018-0612-6
[18] https://genderlinks.org.za/news/sa-women-must-make-own-choices-on-safe-and-legal-abortion/

Pregnancy (TOP). Many women and girls in South Africa suffer in silence when families and partners infringe on their sexual reproductive health rights when they are pregnant. Thei families or partners feel that the choice is theirs to dictate what happens to a woman's body.

Termination of pregnancy is often forced on these young women and young girls. Families and partners often take them to the hospital to request termination of pregnancy (TOP) on their behalf.

Source: Vuyo Makapela, Gender Links News Service, 2018

Generally, there are still very high levels of stigma associated with abortion and especially abortion for adolescents. Some of this stigma is associated with attitudes to the morality of sex outside of marriage, or socially unaccepted pregnancy.

Other stigma is related to social norms of womanhood which perceive a women's role as being primarily to reproduce and ascribe negative attributes to women who choose not to.

Normative frameworks



BPFA +20 Africa declaration3 (d) Expand the provision of family planning services and contraceptives and access to safe and legal abortion services in accordance with national laws and policies, and protect the reproductive rights of women by authorizing medical abortion in the case of sexual assault, rape, incest, in line with the Maputo Protocol to the African Charter on Human and Peoples' Rights;

ICPD 7.5 (b) to enable and support responsible voluntary decisions about child bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so

8.25: All governments, and relevant intergovernmental and NGOs are urged to strengthen their commitment to women's health to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved Family Planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion.

Maputo Protocol Article 14 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted.

14.2. States Parties shall take all appropriate measures to:

c) Protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

SADC SRHR Strategy 2018-2030. Rates of unplanned pregnancies and unsafe abortion are reduced.

Very few global, regional or continental instruments mention abortion. The adoption of Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa in July of 2003 in Maputo, Mozambique signalled a shift for women's' rights across the African continent. The protocol entered into force after a total of 15 ratifications were obtained in 2005.

The Maputo Protocol covers a wide range of women's rights provisions including political, social, cultural, environmental, economic, civil and health and promises to eliminate discrimination against women. Most prominent and highly contemplated, discussed and critiqued is Article 14: Health and Reproductive Health Rights. The article empowers women to control their fertility, decide whether to have children or not and the number thereof, provides the right to choose their preferred contraception, the right to self-protection and to be protected from STI's.

Additionally, women have the right to be informed on one's health status and that of their partner and the right to family planning education. Women are further afforded the right to affordable and accessible health services, pre and post- natal as well as for delivery and nutritional services. Finally, women are granted the right to medical abortions in cases of sexual assault, rape, incest, in the event that the pregnancy endangers the mental and physical health of the mother, or the life of the mother or unborn child.



GL Staff marching on the the Global Day of Action for Safe and Legal abortion.
Photo: Gender Links

Article 14; 2C has been debated all over Africa, even in the case of states who already have similar provisions through different policies (even if these are not included in penal codes). Though countries have signed the Protocol, there is no obligation for countries to make the protocol legally binding. This remains an expectation, or a best practice.

The **Democratic Republic of Congo** signed the Protocol in 2003 and ratified it in 2008. After months of advocacy initiatives by civil society groups in conjunction with the Ministry of Gender the DRC finally ensured access to abortion for women by publishing the ratified Maputo Protocol in the Gazette on March 14, 2018. Abortions are now obtainable in cases of rape, incest, assault, and mental and physical endangerment of the woman and/or her child.

> The adoption of Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa entered into force after a total of 15 ratifications were obtained in 2005

The revised Maputo Plan of Action 2016 - 2030 (which follows the original Maputo Plan of Action, 2007 - 2015) is a continental framework for universal access to comprehensive Sexual and Reproductive Health Rights and Services. The African Commission on Human and Peoples' Rights adopted General Comment No 2 to interpret provisions of Article 14 of the Protocol to the African Charter on the Rights Women in 2014 in Luanda, Angola. The provisions relate to women's rights to fertility control, contraception, family planning, information and education, and abortion. Civil society and human rights advocates can use the General Comment to hold states accountable for implementation of treaty obligations.[19]

The current deadline for all states to ratify the Maputo Protocol is 2020. If this is achieved, there will be more reason for abortion and post abortion services to be available for all women and girls who need them.To date, Botswana has not signed nor ratified the Protocol. Madagascar has not ratified, even though it has signed and South Africa, Mauritius and Namibia have ratified the Protocol with reservations.[20]

Legal and policy provisions for abortion in SADC

As times change, there remains hope that SADC countries can all legalise abortion in less restrictive ways. The table details the legal provisions in SADC regarding abortion.

Table 4.4 below shows that most SADC countries provide for abortion in some circumstances. This ranges from South Africa and Mozambique, where abortion is available on demand, to Zambia where abortion is legal in some circumstances, to Seychelles where the law appears very restrictive but regulations in the Reproductive Health Policy of 2012 enable abortion and even include statistics of safe abortions conducted, to Zimbabwe, Botswana, Lesotho, Mauritius and Namibia, where abortion is illegal except in certain circumstances; to Tanzania, Eswatini, Malawi, Angola and DRC where abortion is only available in extremely limited circumstances, to Madagascar, where abortion is totally outlawed. Penalties vary. In four countries (Zambia, Botswana, Tanzania and Malawi) the penalties apply to both those who have an abortion and those who aid the process. Penalties range from three years in prison (or fine) to life imprisonment.

[19] Ngwena, C. E Brookman-Amissah, P. Skuster, "Human rights advances in women's reproductive health in Africa". International Journal of Gynecology and Obstetrics 129 (2015) 184-187

[20] https://au.int/en/newsevents/20180129/high-level-consultation-ratification-maputo-protocolhttps://www.howtouseabortionpill.org/blog/maputo-protocol-DRC-howtouse/ http://www.achpr.org/instruments/women-protocol/#14 https://reproductiverights.org/worldabortionlaws https://www.ipas.org/news/2018/July/legal-access-to-abortion-expands-in-democratic-republic-of-congo

Table 4.4: Legal provisions regarding abortion in SADC[21]

Country	Law	Abortion on demand (yes/no)	Conditions under which an abortion may be granted			Childs life	Time frame	Consent	Penalties
			Rape/incest	Mothers life	Mothers Mental state				
ABORTION AVAILABLE ON DEMAND									
South Africa	Choice on Termination of Pregnancy Amendment Act No. 1 of 2008[22]	Yes - specifies available to any woman who wants to terminate out of choice, including counselling					Within the first trimester	Right to terminate without consent of other parties apart from medical practitioners	No punishment as abortion is legal
Mozambique	Amended Penal Code	Yes					On demand up to 12 weeks; incest, up to 16 weeks; foetal anomalies, up to 24 weeks	A certified practitioner must perform the termination at designated facilities[23]	No punishment - abortion is legal
ABORTION AVAILABLE IN CERTAIN CIRCUMSTANCES									
Zimbabwe	Termination of Pregnancy Act of 1977, Chapter 15: 10[24]	No	If conception is deemed unlawful (instances of rape)	Only under circumstances where the life of the mother is in danger		Where the child will suffer from complications after birth		A magistrate must grant permission	Five years in prison and or fine not exceeding $5000
Zambia	Termination of Pregnancy Act, 13 October 1972 Amended 2005 (ToP)	No		If the pregnancy will cause death	Mental or physical damage to the woman.	Child at risk of mental and physical deformities		Once three medical practitioners have agreed	7 years for person who administers; 7 years for woman who administers own abortion
Botswana	Penal Code (Amendment) Act, 1991 - Section 160	No	Rape or incest	If the mother's life is at risk or may cause harm to her mentally	✓	If the unborn child will suffer or later develop physical or mental abnormality	Termination has to be performed before 16 weeks[25]		3 years for procurement; 7 years for aiding

[21] This table is reproduced from Gender Links 2019 Abortion Fact Sheet
[22] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[23] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[24] http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
[25] http://www.gov.bw/en/Citizens/Sub-Audiences/Women/Unsafe-Abortions/ https://www.hsph.harvard.edu/population/abortion/BOTSWANA.abo.htm http://www.wipo.int/wipolex/en/text.jsp?file_id=238601

Lesotho	The Penal Code (2012)[26]	No	If pregnant due to incest or rape	To save the life of a pregnant woman		To prevent the birth of a child who will be seriously physically or mentally handicapped		Performed by a registered medical professional, with the written opinion of another registered medical professional	A fine of M5000-M10000 or imprisonment of up to three years
Mauritius	Penal Code 1983 Criminal Code Amendment Act 2012[27]			To save the life of a pregnant woman; or from permanent physical damage		If the foetus may suffer severe malformation or abnormalities	The pregnancy is within 14 weeks and the girl is younger than the age of 16		Imprisonment of up to ten years
Namibia	Abortion and Sterilization Act 2 of 1975	No	Where two other medical practitioners confirm that the woman has been raped or is a victim of incest	The pregnancy poses a threat to the physical and mental health of the pregnant	Where a woman has been deemed to be an idiot or an imbecile as per the Immorality Act of 1957, which makes sex with her illegal[28]	The unborn child is at risk of a serious mental or physical deformity and handicap		Two medical practitioners must approve in writing that the pregnancy is a risk	A fine not exceeding N$5000 or imprisonment not exceeding five years, or both
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	No		When a woman's life is deemed to be in danger or if the cost of carrying the foetus is greater than the pregnant woman's physical and mental health		Termination can be carried out if the child is at risk of serious mental and physical deformities[29]		If three medical practitioners agree in good faith, termination can be undertaken at Victoria Hospital, Mahe	Imprisonment of 3-14 years
Tanzania	Penal Code 1981[30]			Woman is at risk of death, pregnancy threatens the mental and physical wellbeing of the woman	Pregnancy threatens the mental and physical wellbeing of the pregnant woman				7 years for procurement; 3 years for suppliers

[26] https://lesotholii.org/ls/legislation/num-act/6
[27] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[28] https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
[29] https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
[30] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf

ESwatini	The Constitution			Only possible where the life of the pregnant woman is in danger[31]					Life imprisonment
Malawi	Penal Code and The Law Commission of Malawi has drafted the Termination of Pregnancy Bill to legalise safe abortion in the event of incest, rape or severe foetal abnormalities[32]	No		Currently, Malawi only allows abortion to save a woman's life					14 years for having an abortion; 3 years for supplying instruments to conduct an abortion
Angola	Penal Code 2017[33]			Termination only permissible to save the life of a woman					4-10 years' imprisonment
DRC	Penal Code 2004			Abortion is illegal except in cases where a woman's life is in danger[34]					5-15 years' imprisonment
Madagascar	Reproductive Health and Family Planning Law 2017		Abortion under any circumstance remains illegal	In Criminal Procedure law, an abortion can be performed to save the life of a woman					Not explicit, but death, forced labour or life are most severe punishment

Source: Gender Links, with data from UNAIDS 2019.

[31] http://srhr.org/abortion-policies/country/swaziland/
[32] http://www.satregional.org/wp-content/uploads/2018/05/Age-of-consent-Malawi.pdf
[33] http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf
[34] https://www.google.co.za/#safe=off&q=abortion+bill+1991+democratic+republic+of+Congo (UN Publication)



South Africa: Why the backstreet abortions?[35]

An estimated 260,000 abortions take place in South Africa yearly. In a country where this is legal, more than half of these abortions are illegal. There has, however, been over 90% decline in abortion- related mortality in South Africa between 1994 and 1998 - 2001.[36]

One factor that contributes to the high level of illegal abortions is poor or no access to services. In 2017, Amnesty International found that less than 7% of South Africa's 3,880 public health care facilities actually perform pregnancy terminations.

Knowledge plays a vital role in women's access to safe abortion, simply because women need to know where to access a safe abortion up to 12 weeks. Many women remain uneducated on abortion. What are easily accessible however are the innumerable flyers offering back-door abortion. Many women are also unable to tell the difference between a safe and unsafe abortion provider. These can be seen advertised on every street corner in many towns and cities. When women do have information, they have to travel far and wide to seek a legal abortion from their remote areas or areas where their local clinics do not offer termination.

Furthermore, the majority of those needing the services are young women between the ages



15 to 19[37]: mostly school going girls who do not have access to youth friendly facilities that would afford them a safe abortion.

Even with the progressive law, there is still stigma, taboo and myth surrounding the topic of abortion. Stories of spiritual punishment are told to girls in numerous communities, to deter them from having sex, and in the event that they fall pregnant, to deter them from terminating. Refusal by health care professionals is unregulated in South Africa and therefore a choice based on cultural, religious or moral grounds, which further jeopardises the chances of girls and women accessing the termination they opt for. Health care professionals who offer services in their areas therefore face the reality of becoming overwhelmed with the number of patients that need to acquire an abortion. Although the South African Constitution guarantees the right to freedom of conscience,[38] this applies only to the direct provision of services, and not to pre - or post-abortion care. It also does not apply in circumstances where a woman's life or health is at immediate risk.

The many gaps around abortion in South Africa sparked the *#My Body, My Choice* campaign led by Global Health Strategies in which the SADC Gender Protocol Alliance is a partner. The first march took place on September 28, 2018 on the Global Day of Action for Safe and Legal abortion. The campaign has surfaced devastating stories of women turned away to rethink getting an abortion even where the pregnancy is a result of rape. The *My Body, My Choice* campaign aims to inform and educate by "providing values clarification and training to all healthcare providers to help them critically reflect on and challenge their deeply-held beliefs and attitudes regarding abortion."

Source: Amnesty International, 2018

[35] Shaha et al Op Cit
[36] Shaha et al Op Cit
[37] https://www.who.int/gho/women_and_health/diseases_risk_factors/situation_trends_unsafe_abortion/en/
[38] Abortion Fact Sheet My Body, My Choice: https://www.mybodymychoicesouthafrica.org/

Mozambique amended the Penal Code decriminalising abortion in 2015 as part of a comprehensive review of the code. Women can now terminate their pregnancies during the first 12 weeks, except in the case of rape, which would extend the legal period to 16 weeks. The amended law also stipulates that abortions would have to be carried out in approved health centres by qualified practitioners. Abortion is available as a free service.

Women over the age of 16 provide consent for themselves. Anyone below the age of 16 requires consent from someone over 21 (age of majority in Mozambique) to have an abortion. The person may be a parent or trusted adult. There is a 48-hour waiting period before a woman receives an abortion. The 2015 Penal Code criminalises unsafe abortion. The Code stipulates that the provider, person requesting and anyone forcing the person to do an unsafe abortion will be prosecuted.

A small qualitative study with women aged 15 - 24 who had accessed abortion in Mozambique (Maputo and Quelimane) found poor knowledge of the law on abortion as well as poor access to safe abortion in health facilities. Factors which influenced the decision to have an abortion included partner rejecting responsibility, parental refusal to help with the child, wanting to pursue studies, poverty and inability to care for a child. Young women had little autonomy in the decision to have the abortion or the decision on what form of abortion to have. They had little counselling and poor support in accessing post abortion contraception. Consequently, some of the 14 participants in the study had had more than one abortion.[39] Uptake by health providers and women and girls themselves is minimal. Reassurance, training, trust and action are needed in a country where abortion has been illegal for longer than it has been legal.

The lack of information and awareness raising has resulted in a lack of uptake of the service. Boane Health Centre, sees about 20 patients per month who are admitted after unsafe abortions. Nurses are refusing to do abortions on religious or cultural grounds. If this occurs the nurse is moved to her another department because the Ministry is upholding the right to freedom of choice and association. This is creating shortages in the number of health professional available to do abortions in health centres.

The health centres are currently not administratively equipped to do abortions. There are no consent forms. Nurses write a form of words on a piece of paper that the patient signs. This is a legal risk and requires an urgent intervention. This links with issues confidentiality. The better resourced health centres have stand-alone facilities that guarantee confidentiality. Others require patients to come through a common reception making them vulnerable to identification.

Lack of knowledge of the law impacts women's access to safe abortion

[39] Frederico, M. K Michielsen , C Arnaldo P Decat "Factors Influencing Abortion Decision-Making Processes among Young Women", Int. J. Environ. Res. Public Health 2018, 15, 329

Advancing Abortion Rights[40]

By Rita Badiani


Rita Badiani

As the country representative for Pathfinder in Mozambique, I know first-hand how challenging it can be to advance abortion access and rights in settings with restrictive laws. Until 2014, abortion was permitted in Mozambique only to save the life of the woman and to preserve her physical health (and even those criteria were not widely known or acknowledged by civil society or most in positions of authority).

Recognising the shortcomings of this law, in 2011, we formed a coalition with other likeminded organisations to advocate for broader abortion rights. Pathfinder firmly believes that a woman's right to terminate a pregnancy is fundamental to her right to choose whether and when to have a child.

To achieve this goal, the coalition developed a strategy that spanned several fronts. We held awareness raising and opinion-changing events with government bodies, we developed and submitted inputs to parliament for a revised penal code, and we implemented a comprehensive media engagement strategy that recruited and trained journalists in sexual and reproductive health and rights.

A revised penal code with a less restrictive abortion law was approved and signed into law in 2014. Efforts from various stakeholders in the country including many civil society stakeholders, as well as the Ministries of Finance, Education, Planning, Youth, Gender and Health are underway to raise awareness of the provisions of the Protocol. This needs to continue, and intensify, to save lives of women and improve the choices women can make. The Coalition for Sexual and Reproductive Rights which mounted a sustained campaign to review the Penal Code and decriminalise abortion from 2011 continues the advocacy for access.

Source: Pathfinder, 2016

In **Lesotho**, government acknowledges the devastating effects of unsafe abortions on girls and women. Rather than make safe abortions available, women are often advised to go across the border into South Africa where abortion is legal. The irony is not lost on human rights lawyer Lineo Tsikoane, who has said of the Ministry of Health: "They know abortion is illegal, but they're telling us to advise girls to go elsewhere, and [yet] won't change our own law."

[40] https://www.pathfinder.org/advancing-abortion-rights-lessons-from-mozambique/



Lesotho: Unsafe abortion next door to a country with safe abortion laws[41]

"I woke up this morning and a nurse told me that I have been I a coma since I came in," says Ntsoaki* from her bed in Lesotho's only referral hospital. "I don't know where I will go when I leave the hospital. I do not have money to pay and I do not have any clothes with me. I was not trying to abort the baby, I was trying to commit suicide using rat poison because my boyfriend did not want the baby and my mother said she could not support us. Unfortunately for me I survived and only my baby died."

In September 2018 Lesotho Minister of Health Nkaku Kabi announced that the hospital is bursting at the seams with 15 young women admitted each week following abortion complications. According to the World Health Organisation (WHO), 35 out of 1000 pregnancies in Southern Africa end in abortions; one of the highest rates in the world. Almost all of these are backstreet. Abortion is the third highest cause of already high rates of maternal mortality. Yet, according to WHO, safe abortion is one of the simplest and most effective procedures to administer.

South Africa and Mozambique are the only Southern African Development Community (SADC) countries in which abortion is available on demand. Madagascar outlaws abortion under all circumstances.



Looking for SRHR solutions in Lesotho. Photo: Ntolo Lekau

In the other 13 SADC countries, abortion is only legal in limited circumstances including rape, incest, or danger to the life of the mother or child. In Namibia, which generally has a strong human rights record, the pre-independence Abortion and Sterilization Act 2 of 1975 (still in place) gives as one of the few grounds for abortion "if a woman has been deemed to be an idiot or an imbecile... which makes sex with her illegal." Zimbabwe has a policy on post abortion care even though abortion is illegal: a de facto recognition of the reality on the ground.

Explaining why she sought an abortion despite it being illegal in Lesotho, Matumelo*, 23, says: "I already know that the police are going to arrest me as soon as I leave the hospital. The reason I underwent a backstreet abortion using pills I got from a Facebook acquaintance is because when I told my boyfriend of six years that I was pregnant, he told me he does not want the baby as my pregnancy will negatively affect his family. I never knew that he had a wife and children. As such I could not raise a child alone as I am not working."

Itumeleng*, a 15 year old rape victim, should have been able to have a safe abortion in Lesotho based on her circumstances, but the system failed her. "My case was referred to the children's court where the magistrate ordered some tests to be done on me," she recalls. "All the other tests came back negative except for the pregnancy test that indicated that I was six weeks pregnant. The magistrate gave an order for a termination of such pregnancy. At the hospital where I was supposed to be assisted with the abortion as dictated by the Penal Code, I was thrown from pillar to post. At one time I was told the order should not be hand written but typed. When I came back with a typed order I was told the stamp was too vague. When that was corrected, I was told the signature did not

[41] https://mg.co.za/article/2018-09-28-00-abortion-sa-must-speak-up

seem legitimate. This continued until I was six months pregnant and was no longer eligible for abortion. Today I have to raise a child I did not choose to have. I am raising a child when I am also a child myself. If abortion were legal in Lesotho, I would not have suffered like this." Rather than fix the system and change the laws, Lesotho officials are known to surreptitiously advise women to go across the border for safe abortions in South Africa. Few women can afford that; South Africa is not coping; and exporting the problem sidesteps the central issue of the right of women to make choices about their bodies and lives, not only when they are violated, but always. Lesotho, a deeply Catholic country, could learn from the recent referendum on abortion in that most Catholic of countries - Ireland - that resoundingly put rights above religion or morality.

South Africa needs to learn that choice without the services to make the choices is a violation of the Constitution. And rather than become a place of refuge for women seeking abortion from the region, South Africa has a duty to speak up and speak out for women's rights, at home and in the region.

*Pseudonyms have been used for survivors of abortion to protect their identity.
Source: Colleen Lowe Morna and Manteboleng Mabetha, Gender Links News Service, 2019

The most common circumstances in which abortion is provided for are incest and rape; related to that, threat to the mother's life and mental well- being. Evidence of possible child deformities may also be grounds for abortion.

While allowing for abortion in limited circumstances, **Zimbabwe** passed a law in 2012 that allows for post-abortion care. A much more cost- effective option would be to provide for safe abortion.



Zimbabwe: Stepping up campaign for access to safe abortion services[42]

Abortion in Zimbabwe has been taboo due to social stigma and the restrictive law governing provision of safe abortion services. Research done in 2016 revealed that 66,800 abortions took place in Zimbabwe.

Zimbabwean legislation on abortion is restrictive. Abortion is allowed when the continuation of pregnancy endangers the life of the woman, cases where the foetus was conceived as a result of unlawful intercourse, including rape, incest. Obtaining a legal abortion is a long and fraught process in Zimbabwe. If a woman is raped, she must obtain a certificate to terminate from a magistrate in that area. Communities and health workers are not aware of this law.

Abortion contributes to high maternal mortality rate in Zimbabwe. Furthermore, getting a legal abortion in Zimbabwe is a costly process which requires one to go through several medical examinations and approvals by physicians.

The Women's Action Group (WAG) implemented a project whose ultimate goal is to empower women and girls to utilise the law for access to safe abortion services without stigma, to reduce unsafe abortion related deaths and morbidity in Zimbabwe. The project sought to raise awareness on the Termination of Pregnancy Act (1977) through community dialogues. A national survey on abortion attitudes, knowledge and practice was conducted. A coalition of all organi-

[42] https://genderlinks.org.za/casestudies/zimbabwe-stepping-up-campaign-for-access-to-safe-abortion-services/

sations working on abortion was formed and meets twice a year. Dialogues with Parliamentarians were conducted. Health workers have been trained on the TOP Act and post abortion care. These strategies were used to reduce abortion stigma, as well as bring the issue for discussion at policy level. Awareness on the fact that abortion is already allowed by law in specific circumstances was raised.

The initial activity was a survey to understand attitudes on stigma and practices on abortion. Community dialogues on abortion were held targeting women and traditional leaders. Values clarification exercises were used. Discussions focused on the current situation with regards to abortion, myths about abortion, abortion stigma and the current shortcomings of the law. The broad aim was to address negative attitudes and stigma related to abortion.

Positive media attention has been received on abortion through Radio programmes and print media. This was done to bring visibility to abortion as a reproductive justice issue in Zimbabwe and influencing public and decision-making opinion. WAG has also made presentations on abortion at regional and international conferences.

WAG has partnered with Population Reference Bureau (PRB) to develop a multimedia communication tool that will be used by the abortion coalition for advocacy. Another approach is sensitization of members of parliament on the impact of unsafe abortion and how this is contributing to maternal mortality in Zimbabwe. WAG offered psychosocial support and financial support for those who require legal termination after unlawful sexual intercourse.



Zimbabwe SRHR Strategy workshop led by the Women's Action Group.
Photo: Tapiwa Zvaraya

WAG partnered with several organisations. Some members of the Women's Coalition are part of the abortion Coalition. Ministry of Health and Child Care have assisted with information on the situation in the health institutions. Health workers are feeding in information on the challenges faced by women and girls as they try to access abortion services. The Swedish Embassy has also provided space and some technical expertise to the group that meets at the embassy. Zimbabwe Women Lawyers Association has continued to offer technical expertise in the analysis of the law and identifying gaps.

Research institutions such as Guttmacher Institute have provided data on abortion incidence and morbidity in Zimbabwe. WAG has started lobbying parliamentarians so that they support access to safe abortion. Lobbying has included supporting members of parliament to support the SADC sexual and reproductive health strategy which has access to safe abortion as one of the indicators.

Source: Ednah Masiyiwa, Women's Action Group, SADC Protocol@Work case study

It is clear that many of the laws governing abortion in SADC are inherited from the colonial era and are out of sync with modern rights-based laws. For example, the Abortion and Sterilization Act 2 of 1975 in **Namibia** dates back to 1975. One of the few grounds for abortion is where "a woman has been deemed to be an idiot or an imbecile as per the Immorality Act of 1957, which makes sex with her illegal."

On 24 February 2018, **Angola**'s parliament approved an amendment to the abortion law, making all abortions, without exception, illegal and punishable by between four to ten years' imprisonment. This is part of the process of replacing Angola's 1886 penal code. Parliamentary debate on the amendment stalled following a public outcry over it, leading to the ruling party proposing a revised version of the legal amendment. The revised version retained the legality of abortion in cases of rape or maternal health risk.

Unsafe abortion

Overall, the legal frameworks for abortion in Africa are unaccepting, which drives the majority of abortions to unsafe methods and providers. Of all abortions:

- An estimated 55% are safe (i.e., done using a recommended method and by an appropriately trained provider);
- 31% are less safe (meet either method or provider criterion, or done using outdated methods like sharp curettage even if the provider is trained, or if women using tablets do not have access to proper information or to a trained person if they need help)
- 14% are least safe (neither a recommended method nor a trained provider, or when they involve ingestion of caustic substances or untrained persons use dangerous methods such as insertion of foreign bodies, or use of traditional concoctions).

This is a staggering 25 million unsafe abortions globally, of which 8 million are least safe, every year.[43] It is estimated that 3 of every 4 abortions in Africa were unsafe. In 2008, 51% of all unsafe abortions in Africa were among young women aged 15-24 years. The more restrictive the legal setting, the higher the proportion of abortions that are least safe- ranging from less than 1% in the least-restrictive countries to 31% in the most-restrictive countries. The report for ICPD beyond 2014 found that, while unsafe abortion rate declined between 1990 and 2008 in all regions, it remained constant in Africa at a rate of 28 per 1000 women in reproductive age 15-44 years.

In developing countries where unsafe abortion is prevalent, up to 40% of women who have an abortion develop complications. Complications of unsafe abortion include haemorrhage, infection, peritonitis, and trauma to the cervix, vagina, uterus (including perforation), and abdominal organs. Some of the least safe methods of abortion include inserting dangerous objects such as knitting needles, or even glass, into the vagina. Worldwide, unsafe abortion mortality is the third major cause of maternal death after haemorrhage and sepsis in childbirth.

The risk of death as a result of an abortion is highest in Africa

The burden of mortality from unsafe abortion is much higher in Africa than in other parts of the world. It is estimated that there are 30 deaths for each 100 000 unsafe abortions in developed regions, 220 deaths per 100 000 unsafe abortions in all developing regions, but 520 deaths per 100 000 unsafe abortions in Sub Saharan Africa. Africa accounts for 29% of global unsafe abortion

[43] WHO. 2018. Preventing unsafe abortion. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion. Accessed 10 June, 2019.

but suffers 62% of unsafe abortion related mortality.[44]

According to the SAFAIDS Situation Analysis[45], there are five barriers that inhibit access to safe abortions:

- ***Policy and legislative restrictions*** that prevent women from accessing abortion, even in cases where they want to abortion. In the case of countries which have legalized or made concessions for circumstances that may lead to abortion, or make an abortion acceptable, uptake by service providers is often slow.
- ***Lack of information and knowledge:*** The Analysis has found that in countries where abortion is less restrictive, information does not reach those who could legally access abortions. In addition to this, healthcare providers do not always know when they are legally permitted to administer an abortion.
- ***Health workers are sometimes judgmental and negative*** regarding abortion, they are reported to refuse to administer abortions. In some rural areas health workers have even been reported to violate privacy of patients. This leads to restrictions of access to abortion, especially for adolescent girls and young women.
- ***A prevalent view that "Abortion is sin".*** This means that conversations about abortion are in many cases completely out of bounds, let alone even considering or administering one.
- ***Gender norms in SADC*** are restrictive, which results in women being marginalized. This marginalization further means that men are in control of women's bodies. Abortion is seen as a threat to men's power, and therefore, abortion is restricted.

The SADC SRHR Strategy reports that deaths related to unsafe abortion contribute significantly to maternal mortality in SADC. The highest abortion-related deaths globally are in Africa, where an estimated 3.9 million unsafe abortions take place annually among girls aged 15-19 years, leading to death and enduring health problems. 24 per cent all pregnancies in Southern Africa end in abortion. In Botswana, complications relating to post-abortion care were the third leading cause of maternal deaths.[46]

There are safer methods of abortion, such as manual vacuum aspiration and medical abortion consisting of mifepristone and misoprostol, which are both on the WHO essential medicines list which are being used even for illegal abortions. Misoprostol is widely available and inexpensive but only results in a complete first trimester abortion 75-90% of the time if used correctly. When combined with mifepristone, which is less widely available and more expensive effectiveness for complete abortion at nine weeks of pregnancy is between 95-98% when used correctly.[47]

Further, 140 countries have approved emergency contraception. This has resulted in lower morbidity, disability and mortality from unsafe abortions. The number of deaths globally due to unsafe abortion declined from 69 000 in 1990 to 47 000 in 2008; which is an annual decline in unsafe abortion-related mortality ratio of 1% in Africa, 4% in Asia and over 6% in Latin America. The case-fatality rate of unsafe abortion declined globally at about 3% annually.

However, mortality due to unsafe abortions in developing countries is still much higher than mortality as a result of safe abortions in developed countries. The risk of death as a result of an abortion is highest in Africa. Sub Saharan Africa accounted for 61% of all deaths resulting from unsafe abortions in 2008, with a case fatality rate of 520 per 100 000 unsafe abortions.[48]

A USAID funded programme in **Botswana** which sought to support government initiatives to reduce maternal mortality identified the top three causes of maternal mortality as: postpartum haemorrhage, severe pre-eclampsia/eclampsia, and post-abortion complications. The project found the abortion ratio was 209 per 1,000 live births which is higher

[44] https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion, 19 February 2018. Accessed 10 June, 2019
[45] Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019 and Gender Links Attitude Survey
[46] Melese T, Habte D, Tsima BM, Mogobe KD, Nassali MN (2018) Management of post abortion complications in Botswana -The need for a standardized approach. PLoS ONE 13(2): e0192438. https://doi.org/10.1371/journal.pone.0192438
[47] IPPF. Op cit.
[48] Shaha et al 2014. Op Cit

than the global abortion ratio of 148 per 1000 live births estimated in the World Health Report 2005. This is despite the incidence of abortion being based only on data of complicated abortions that needed medical attention, which is not including abortions that did not receive emergency management. Francistown and Gaborone had the highest levels, with an abortion ratio of 555 and 361 per 1,000 live births respectively.[49]

Madagascar: According to the 2018 Statement of the Minister of Public Health, unsafe abortion induced deaths are the second highest cause of maternal death registered in the health system after complications from antenatal and post-partum haemorrhage. In the same year, studies in hospitals indicated that adolescent girls and young women aged between 15 and 24 years are the most affected by complications from unsafe abortions. A study in 2016 found that though abortion is completely illegal in Madagascar, misoprostol is widely and relatively easily available. However, the dosages and regimens that the 19 women in the study used were extremely variable and none were in accordance with WHO guidelines. This resulted in failed or incomplete abortion, heavy bleeding and even sepsis[50]. None of the women, family members or friends, formal or informal health care providers that were consulted had accurate information which led to many complications.

A study in five major hospitals in **Zambia** in 2008 found that the number of women treated in these hospitals for complications following an unsafe abortion was 85 times more than those that accessed safe abortions at the same hospitals. Those that accessed safe abortions were more likely to be older, with children, while those treated for unsafe abortion complications were younger and less likely to be married. There were high levels of stigma in health providers against adolescents accessing abortion.[51]

The SAfAIDS[52] study found that there are short term, medium term and long term impacts of unsafe abortion:

- Stigma associated with abortion: Women who had an abortion faced stigma from family and friends. This contributed significantly to misinformation surrounding women's sexual and reproductive rights.
- Contribute to high maternal mortality ratios.
- Immediate complications included severe bleeding, uterine perforation, tearing of the cervix, severe damage to the genitals and abdomen, internal infection of the abdomen and blood poisoning.
- Medium-term complications range from reproductive tract infections and pelvic inflammatory disease to chronic pain.
- Long-term complications include increased risks of infertility and ectopic pregnancies, and miscarriages or premature deliveries in subsequent pregnancies.



Promoting SRHR Services through the MobiSAfAIDs Social Accountability Monitoring for young People. Photo: SAFAIDS

The study also found six enabling factors that increase access to safe abortion:

- Human rights protocols such as the Maputo Protocol, are recognized and ratified in the region. Ratifying protocols provides justification to calls for abortion legislation to mirror abortion delivery or services.

[49] Sinvula M, Insua M. 2015. Botswana Maternal Mortality Reduction Initiative. Final Report. Published by the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project. Bethesda, MD: University Research Co., LLC (URC).
[50] Pourette, D, C. Mattern, R Ratovasan, P. Raharimalala. "Complications with use of misoprostol for abortion in Madagascar: between ease of access and lack of information". Contraception 97, 2. 2018. 116-121. https://doi.org/10.1016/j.contraception.2017.12.005
[51] Likwa RN, Biddlecom AE and Ball H, Unsafe abortion in Zambia, In Brief, New York: Guttmacher Institute, 2009, No. 3.
[52] SAfAIDS, op cit

- Though certain policy makers may be against the notion of abortion, the same policy makers can also be receptive to related issues, such as economic and human costs of post abortion complications and high maternal mortality rates.
- Younger men are less conservative than their older counterparts and their views on abortions are not as restrictive as older men.
- Discussions around abortion increasingly include discourse on the services that are required for survivors of rape resulting from conflict. This has resulted in a moral shift that is opening up discussions to the public.
- As women become more educated on their rights, particularly regarding SRHR, they are able to exercise more agency over their own bodies and their reproductive health rights.
- Countries which have less restrictive abortion laws provide an opportunity for girls and women from bordering countries with restrictive laws to travel across the border to access abortion and post abortion services.

Access to safe abortion services



To increase access to safe abortion the SADC SRHR Strategy encourages Member States to advance the SRHR of adolescents through:

- Ensuring that all adolescents are able to access people-centred integrated SRHR services, including HIV services (testing, counselling, accessing treatment), information, contraceptives, safe abortion, build the capacity of health-care providers to provide services with respect to privacy and confidentiality.
- Engaging with the need for safe abortion services as a human right for women and exploring ways in which the policy and legal environment can protect the health, lives, and rights of women and girls is an important area, while ensuring that policies facilitate the provision of comprehensive post-abortion care in all contexts.
- Improved realisation of quality, comprehensive, integrated SRHR, GBV and HIV and AIDS package that meets the needs of all women, men, adolescents, youth and key populations in SADC.
- Providing safe abortion services and treatment of complications of unsafe abortion.

From a gender perspective, lack of access to safe abortion promotes stigma around abortion. Stigma itself is directly related to gender inequality. In addition, lack of access to safe abortion limits women and girls' reproductive rights, and significantly contributes to maternal mortality in the region. Further, outcome five of the strategy seeks to achieve the reduction in the rates of unplanned pregnancies and unsafe abortions. However, the question that needs to be understood is how is this possible when abortion is illegal in most countries? Legalising abortion is seen as an important step in providing safe and accessible services.

Research has shown that there is much disparity in quality of abortion services, both in countries where abortion is legal and where it is illegal. If a country provides safe abortion services, this is a powerful indicator of relative gender equality. Countries which score highly on the UN Gender and Development Index (GDI) tend to provide

good access to safe abortion services, whereas countries with low GDI scores are likely to have higher levels of abortion-related mortality. However, it is important to note that, once abortion is legal, abortion services need to be provided as part of a quality-assured SRHR package and reviewed regularly from different perspectives (community, client, and health provider), to see how they can be better improved or addressed. A number of civil society organizations are expanding their work to include outreach and advocacy for fewer restrictions to abortion and access to quality services.

SAfAIDS *My Choice, Our Choice* a campaign to End Unsafe Abortion in SADC

The "Transforming Lives" programme will be implemented by SAfAIDS and its partners until 2021, and seeks to influence the policy environment in three important areas of SRHR: sexual gender-based violence (SGBV), adolescent unintended pregnancy, and unsafe abortion. The programme seeks to contribute towards a more conducive policy environment that enables positive SRHR outcomes among adolescent girls and young women. SAfAIDS is following a four-step approach that brings together key stakeholders in the region to plan, analyse data, build consensus and advocate for action.

1. **Evidence-Based Planning:** Outline unsafe abortion problem, agree methodologies for systematically analysing data.
2. **Analysis:** Commission research, compile findings and share with national and regional stakeholders.
3. **Building Concensus:** Convene stakeholders to discuss findings, agree positions, develop action plans and guidelines.
4. **Support Action:** Advocate for policy shift, service delivery and harmonisation; monitor progress.

Access to post abortion care services

Only 7 countries provide post-abortion care

Some countries are beginning to at least make post abortion care available. Post-abortion care which is an important component of comprehensive abortion care is comprised of five essential elements:

- Treatment of incomplete and unsafe abortion as well as complications.
- Counselling to identify and respond to women's emotional and physical health needs.

- Contraceptive and family planning services to help women prevent future unintended pregnancies.
- Reproductive and other health services that are preferably provided on site or via referrals to other accessible facilities.
- Community and service provider partnerships to prevent unintended pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs.[53]

Table 4.5: Policies and Guidelines on Post Abortion Care

Country	Policies or Guidelines on Post Abortion Care
Botswana	Comprehensive Post Abortion Care Reference Manual, Ministry of Health; Botswana Essential Drug List 2012; Botswana Sexual and Reproductive Health Policy Guidelines
Malawi	Malawi Standard Treatment Guidelines 2015; Post-Abortion Care Strategy, Ministry of Health
Mozambique	Clinical guidelines on abortion and post abortion care, 2017; Ministerial Decree on abortion, 2017; National Medicines Form 2007
South Africa	Standard Treatment Guidelines and Essential Medicines List for South Africa, May 2017; Regulations related to Choice of Termination of Pregnancy Act; Medicines and Related Substances Control Act No.101 of 1965 as amended by inter alia
Tanzania	Comprehensive Post-Abortion Care Guideline Training Manual 2016; Standard Treatment Guidelines and Essential Medicines List
Zambia	Register of Marketing Authorisations, 2015; Essential Medicines List, 2013; Standard Treatment Guidelines, Essential Medicines List and Essential Laboratory Supplies; Zambia Standards and Guidelines for Comprehensive Abortion Care 2017
Zimbabwe	National Guidelines for Post-Abortion Care May 2018; Essential Medicines List and Standard Treatment Guidelines for Zimbabwe, 2011; Register for Approved Human Medicines, 2015

Source: SAfAIDS. 2019. Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. Final Report.

Post-abortion care is very expensive in the case of unsafe abortions

Table 4.5 outlines the guidelines which are available on post-abortion care. UN human rights standards call on countries to provide immediate and unconditional treatment to anyone seeking emergency medical care. There is an urgent need therefore for all countries to develop PAC guidelines and to offer this service. Post abortion care has a huge burden on the national fiscus. The case study from Zambia estimates that the country is spending up to $1,5 million a year more on treating consequences of unsafe abortion than it would if it were to provide safe abortions to those that need them.

[53] IPPF. Op Cit

The Cost of unsafe abortion to the Zambian health system[54]

A woman should receive post abortion care (PAC) following either a safe or an unsafe abortion In instances in which all the products of a pregnancy have been expelled, such care may be simply a physical check up with counselling for and access to contraception. Where the abortion has been incomplete, PAC ranges from evacuation of the uterus through complicated care for internal damage, haemorrhage, infection and shock.

The Government of Zambia estimated in 2009 that unsafe abortion contributed as much as 30% of maternal mortality. A study conducted in 2015 at the University Teaching Hospital (UTH) in Lusaka, Zambia, compared the costs for providing safe abortion with the costs of PAC from the medical records of 107 women who received either of these between July 2012 and June 2013. UTH is the largest gynaecological and obstetrics training hospital in the country and, thus, the largest provider of both safe abortion and PAC. UTH provided medical abortion using mifepristone and misoprostol from 5 to 9 weeks gestation; and using manual vacuum aspiration (MVA) from 10 to 14 weeks gestation. PAC for induced abortion ranged from treating incomplete abortion to treating life threatening sepsis and shock.

The Government of Zambia estimated in 2009 that unsafe abortion contributed as much as 30% of maternal mortality

Between July 2012 and June 2013 223 safe abortions were performed and 4246 women were treated for PAC, which is not disaggregated according to spontaneous and induced or as a result of a safe abortion. A previous study had found 231 safe abortions and 4794 PAC cases in 2010. The study conducted key informant interviews with key staff from which it was estimated that 50% of PAC cases were for unsafe abortion. Further, it was found that all unsafe abortion cases had incomplete abortion. 18% had sepsis and 3% were treated for shock.

The study found that the total cost of a medical abortion using mifepristone and misoprostol in 2013 at UTH was $33 and using MVA was $39. The cost of treating incomplete abortion was $33. However, the costs for more critical problems rose steeply to $98 for sepsis and $162 for a case of shock. Thus, the average cost for a safe abortion is between $37 and $39. The average cost of treatment for the consequences of an unsafe abortion is $47 to $56. These figures were extrapolated to national costs, using best available estimates of the number of safe and unsafe abortions. These concluded that the annual cost of safe abortion is between $221 000 and $701 000, while the annual cost of PAC for unsafe abortion is between $403 000 and $3.5 million.

The savings if all abortions were safe is therefore between $660,000 and $1.5 million. This is a substantial portion of the Zambia health budget and does not include the costs associated with women's wellbeing which are also significant.

Source: Parmer, D., Leone, T., Coast. E., Murray. S.F., Hukin, E. & Vwalika, Global Public Health, 2015.

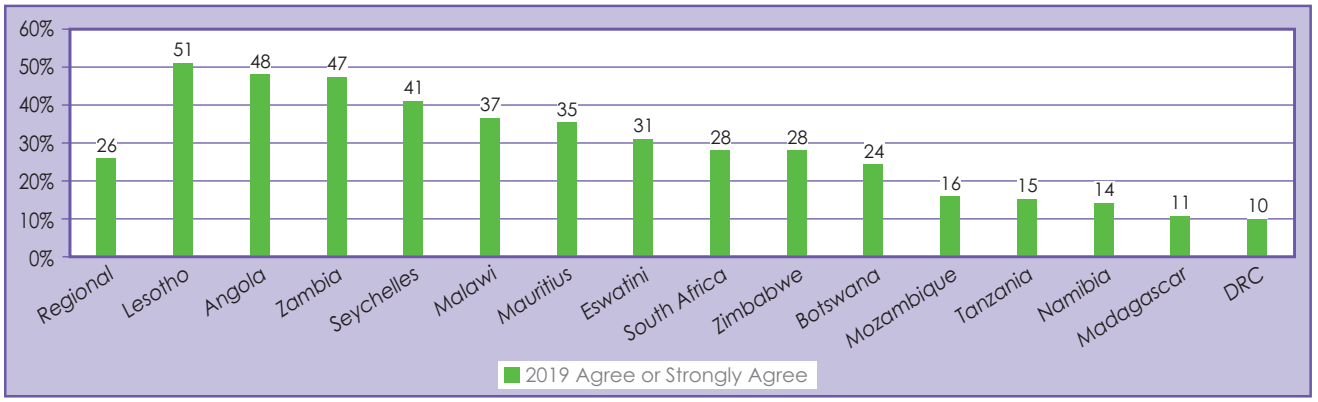
[54] Derived from: Parmer, D, T. Leone, E. Coast. S. Murray. E. Hukin, and B. Vwalika. 2015. Costs of abortion in Zambia: comparison of safe abortion and post abortion care for unsafe abortion. Global Public Health, 10.1080/17441692.2015.1123747.

Public education and awareness

Findings from the Gender Progress Score or attitude survey administered by Alliance partners points to some progress, but still many gaps in advocacy on safe abortion.

There is still too much stigma surrounding abortion

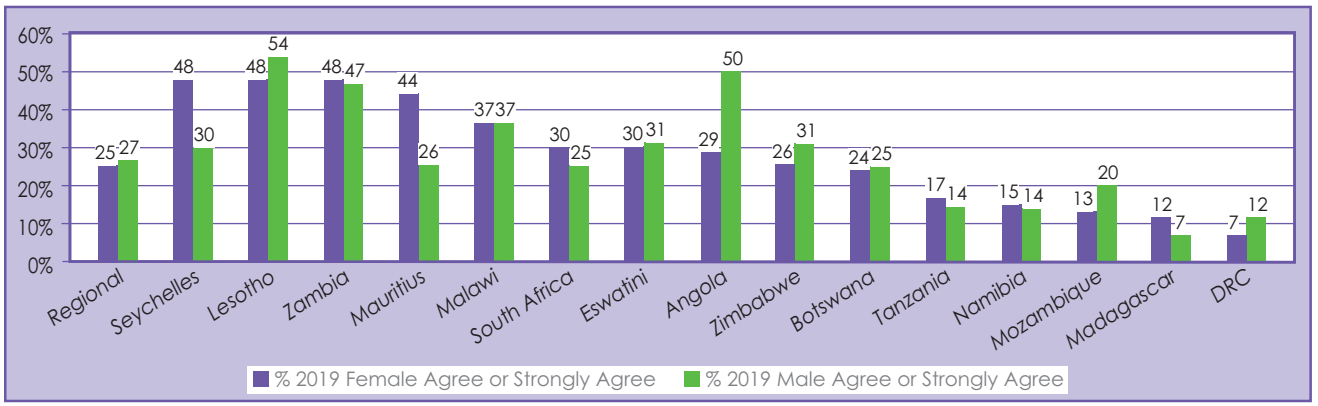
Figure 4.1: A woman should be able to choose to terminate a pregnancy



Source: Gender Links Attitudes survey, 2019.

Figure 4.1 shows that the regional average of those that agree or strongly agree that a woman should be able to choose to terminate a pregnancy in the first three months of the pregnancy is 26%, ranging from upper levels in Lesotho (51%), Angola (48%), Zambia (47%) to lows of 14% in Namibia, 11% in Madagascar and 10% in DRC. This is a strong indication of the high levels of stigma that exist in relation to abortion.

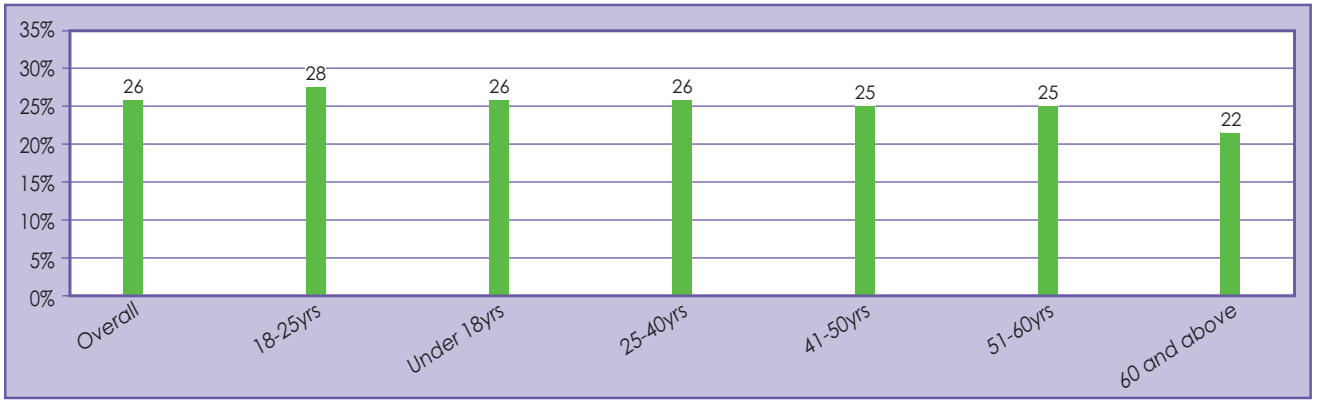
Figure 4.2: Women and men's attitudes on abortion



Source: Gender Links Attitude Survey, 2019.

Figure 4.2 shows the differences in attitudes between men and women in 2019 in relation to the same question. The attitudes of men and women are quite similar in Zambia, Malawi, Eswatini, Botswana and Namibia. Women are much more likely to agree or strongly agree that a woman has a right to terminate a pregnancy in the first three months in Seychelles and to a lesser extent in Tanzania and Madagascar. Interestingly, more men agreed or strongly agreed, particularly in Angola, and to a lesser extent in Lesotho, Zimbabwe, Mozambique and DRC.

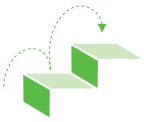
Figure 4.3: Safe Abortion Score 2019



Source: Gender Links Attitudes survey, 2019.

Figure 4.3 shows the difference in responses to this question, disaggregated by age. There is little distinction between age bands with the lowest agreement being in the 60 and over group at 22% and the highest being 18 - 25 year old group at 28%. The table shows that generally across the age groups there are conservative views to the question, "*A woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy*". This is comes through as is evident in all the statistical research in the SADC region, abortion stigma is marred by conservative cultural barriers.





Next steps

Key recommendations and next steps to ensure governments legalise abortion are:

- Governments in SADC need to pay attention to the high levels of unsafe abortion, particularly amongst younger women, including through:
  - Reducing unintended pregnancy and thus the demand for abortion.
  - Reviewing legislation and provision of services to make safe abortions more readily available.
- All SADC Member States, particularly those with low contraceptive rates of less than 50%, Angola (17%), DRC (25%), Comoros (27%), Mozambique (30%), and Tanzania (43%), need to urgently consider making contraception accessible to all women of reproductive age, and particularly those that are not usually reached such as younger women, sex workers, women living with disability and women in rural areas. This would reduce unintended pregnancies and the subsequent backyard abortions.
- All SADC Member States should prioritise comprehensive sexuality education for all adolescents to reduce early and unintended pregnancy.
- All SADC Member States should consider making conditions for accessing safe medical abortion easier by relaxing the required number of doctors from 3 to 1 when trying to access safe abortion and ensuring that women who report having been raped have access safe abortion without the difficulty of proving the rape.
- SADC Member States should consider harmonising the legal ages of sexual consent with the legal ages of access to contraceptives to reduce rates of unwanted pregnancies.
- To save lives, all SADC Member States should provide post-abortion care to all women with abortion complications.
- All SADC Member States should increase the number of health facilities that offer Safe Abortion facilities including building the capacity of health personnel to change attitudes to women seeking safe abortion services.
- There is an urgent need for much better data to inform decision making on the emotive issue of abortion. The data needs include: access to contraception by all who need it (not only women and men in marriage), rate of legal abortions performed, demand for abortion and reason for the demand; rate of illegal abortions performed; rate of unsafe abortions.