Safe Abortion 4



KEY POINTS

- The Guttmacher Institute reports that 24% of all pregnancies in Southern Africa end in abortion.
- The 2019 Nairobi International Conference on Population and Development (ICPD25) conference firmly established that safe abortion services and treatment of complications from unsafe abortion represent one of nine essential elements of comprehensive sexual and reproductive health and rights (SRHR) service.
- ICPD25 resulted in renewed commitments from governments across Africa and the globe to the provision of SRHR to reach three overarching targets: zero maternal deaths, zero unmet need for family planning, and zero gender-based violence (GBV) and harmful practices within the next decade.
- A new study has shown the negative impact of the Global Gag Rule on improving legislation around abortion and provision of SRHR services.
- No SADC country totally bans abortion, but most conditions under which women can obtain abortions remain restrictive.
- Little change has occurred in legislation in the last year, but DRC and Mozambique have made strides to improve their legislative framework for abortion.
- Namibia's First Lady spoke out in favour of legal reforms to improve access to abortion in July 2020 as lawmakers in that country prepared to debate the issue.
- Unsafe abortions affect mostly poorer, unmarried women and adolescents. As this group contributes significantly to high maternal mortality rates in the region, it will be difficult to reach the goal of eliminating maternal mortality without addressing the need for safe abortion. Emerging evidence suggests that the COVID-19 pandemic will increase the need for abortions, reduce the provision of abortion services, restrict access to abortion and SRHR services, and reduce the opportunities for advocacy for legislative reform.



Introduction



Adverts for abortions can be found on street poles throughout South Africa, even though activists warn that most of these services are unsafe.
Photo courtesy of Amandla.mobi

Deciding whether and when to have children, and being able to act on that decision, is a fundamental human right. Men and women should share in the decision to conceive a child. Unplanned pregnancies have repercussions, such as forcing young women to drop out of school, lose employment, or experience delayed progress in their career paths. Women can also experience health challenges, struggles accessing material and emotional resources to care for and feed a child, shame, stigma, and discrimination. Risk factors that affect health and wellbeing increase if a woman is too young or too old to have a child - or having another child too soon after the last. If a woman has been raped and becomes pregnant as a result, she may face enormous psychological trauma if forced to carry the pregnancy to term.

Between 2010 to 2014, Africa's unintended pregnancy rate stood at 89 out of 1000 women aged 15-44. Each year, approximately 38% of unintended pregnancies in Africa end in abortion.[1] While the Southern African Development Community (SADC) Sexual and Reproductive Health and Rights Strategy notes that 24% of all pregnancies in Southern Africa end in abortion, the Guttmacher Institute found that the region's abortion rate per 1000 women stood at 34% between 2010-2014.[2]

Article 26 (a) of the revised SADC Gender Protocol commits all member states to work to eliminate maternal mortality. Though the region's governments have made progress on this around four causes of maternal mortality (severe bleeding, severe infection, blood pressure disorders, and obstructed labour), they have largely neglected unsafe abortion, which represents the only fully preventable cause.[3]

The World Health Organisation (WHO) defines unsafe abortions as pregnancies that get terminated either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Impact of COVID-19 on safe abortion services in SADC

This chapter delves further into this topic, highlighting the high rates of unsafe abortions in SADC and the challenges this presents for the region's development. It also outlines the legal, moral, and religious environment that allows for this situation and the steps that the region's leaders must take to reduce the need for abortion and encourage safe abortion.

While many health practitioners worry that COVID-19 will limit women's options for SRH support, including abortion and post-abortion care, the pandemic has also created some promising innovations linked to telehealth and telemedicine. Both employ telecommunication technologies to deliver health-related information and services. Indeed, some health facilities have offered medication abortion to women during the pandemic via telehealth systems. Despite these advances, activists predict that the sudden global restrictions imposed to curb the spread of COVID-19 will mostly have negative implications on women's health issues, including access

[1] Guttmacher Institute. 2018. Fact Sheet: Abortion in Africa. New York, NY.
[2] https://www.guttmacher.org/fact-sheet/abortion-africa#
[3] Africa: Unsafe Abortion - Neglected Emergency. 4 March 2019.

to safe abortion. These include reduced supply of, and access to, contraception services, which leads to increased unintended pregnancies and demand for abortions, as well as reduced access to safe abortion services.

Reduced supply of contraception: Many reports, from as early as March 2020, point to interruption of the supply chain for contraception commodities. Devex[4] attributes the delays to a few key factors:[5]

- The slowdown of manufacturing in Asian countries, which supply the raw materials, as well as reduction in manufacturing of final products. One example of this included a report from DKT[6], a family planning agency, of a two-month delay in delivery of condoms to Mozambique.



Reports point to interruption of the supply chain for contraception due to COVID-19. Photo: Ntolo Lekau

- Shipping and clearing approval processes and increased attentiveness of oversight bodies with regards to the import and export of goods (including contraceptives) coming from other countries led to delays in the already lengthy processing of paperwork.
- Many countries have stringent regulatory body requirements, particularly about health services. These processes include factory visits and approvals, which regulators will have to revisit given ongoing travel restrictions.

Reduced access to contraception: The United Nations Population Fund (UNFPA) estimates that, due to the pandemic, 47 million women across 114 low- and middle-income countries will not be able to access critical family planning services, resulting in increases in unwanted pregnancies.[7] Drawing on evidence from other pandemics, such as Ebola in West Africa, the Guttmacher Institute and others raised the alarm that the pandemic will dramatically impact SRH service provision. Guttmacher points out that the first step in ensuring continuation of SRH services during various levels of lockdowns means making them essential services, which SADC countries did.[8] However, the pandemic has curtailed access to all health services as providers focus on responding to COVID-19 and clients fear visiting health centres.

In late May, the acting administrator of USAID called on the UN to "stay focused on life-saving interventions" such as food insecurity, essential health care, malnutrition, shelter, and sanitation. In a letter to the UN, John Barsa also wrote, "I ask that you remove references to 'sexual and reproductive health,' and its derivatives from the Global [Humanitarian Response Plan], and drop the provision of abortion as an essential component of the UN's priorities to respond to the Covid-19 pandemic."[9]

The implication of this is an increased demand for abortion services at a time when many remain inaccessible due to curfews and limitations of movement. The hardest hit will be in countries that criminalise abortion, or where it is only legal on limited grounds. The situation will also hurt women who cannot travel to major centres to access termination services and those who cannot access termination of pregnancy medication due to manufacturing delays.

[4] Devex is a social enterprise and media platform for the global development community. Devex aims to connect and inform development, health, humanitarian, and sustainability professionals through news, business intelligence, and funding & career opportunities in international development.
[5] https://www.devex.com/news/opinion-how-will-covid-19-affect-global-access-to-contraceptives-and-what-can-we-do-about-it-96745
[6] DKT International is named after D.K. (Deep) Tyagi, who was assistant commissioner of Family Planning for the Government of India from 1966. He pioneered an extensive communication and behavior change program that introduced modern methods of family planning to hundreds of millions of Indians, successfully bridging the gap between the traditional aspirations of rural Indians and national family planning goals.
[7] https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf
[8] https://www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health
[9] US demands removal of sexual health reference in UN's Covid-19 response https://www.theguardian.com/global-development/2020/may/20/us-demands-removal-of-sexual-health-reference-in-un-covid-19-response accessed 6 June 2020



Reports from **Malawi** note that women have been struggling to access contraceptives from local health centres.[10] This leads to stress as women grapple with the worry of a possible unwanted pregnancy. In an interview with the journalist Penelope Paliani-Kamanga, one woman expressed frustration, noting that responding to COVID-19 seemed to be the Malawian government's only priority at this time.

Reduced access to abortion services: According to *Foreign Policy*, COVID-19 has had a serious negative impact on organisations such as Marie Stopes International (MSI) and DKT, which deliver crucial family planning and other SRH services to many African countries.[11] MSI, which operates in several SADC countries, temporarily reduced many activities in the region. When programmes restarted, however, some challenges remained. In Zimbabwe, for instance, even though the government had deemed post-abortion care and contraception as essential services, reports emerged of women who had been turned back at a roadblock because the police did not view contraception as an acceptable reason for them to travel. In response, and in collaboration with the Swedish International Development Cooperation Agency (SIDA), MSI set up emergency remote services for rural communities to meet the needs of 3500 women.



A safe abortion and COVID-19 flyer by Southern Africa HIV & AIDS Information Dissemination Service (SAfAIDS). Photo courtesy of SAfAIDS

In April 2020, International Planned Parenthood Federation (IPPF) closed 5633 static and mobile clinics and community-based care stations globally, accounting for a total of 14% of IPPF outlets.[12] More than 100 IPPF centres reportedly closed in both Zambia and Zimbabwe. Outcome of this include a scaling down of HIV testing, GBV services, abortion care, and contraceptive services. This will be more pronounced in poorer communities. All national members and partners reported challenges in moving goods within countries, as well as shortages of HIV-related medication and contraceptives.



In **Zimbabwe**, the onset of COVID-19 resulted in border closures that meant many Zimbabwean women could no longer access a safe abortion in South Africa. The alternative is to try to obtain a clandestine abortion in Zimbabwe. The border closures also resulted in a scarcity of the abortion pills misoprostol and mifepristone, driving prices up and making the drugs inaccessible to most Zimbabwean women.[13]

Telehealth options for abortion in South Africa

Medical practitioners have been looking into ways of reaching more people faster through telehealth and telemedicine for some years. The COVID-19 pandemic revived this discussion, along with the topic of self-managed abortion at home. On 3 April 2020, the Health Professions Council of South Africa (HPCSA) amended its telemedicine guidelines during the COVID-19 pandemic to allow telehealth even where an established practitioner-patient relationship does not exist, as long as it is in the best clinical interest of patients.[14] This has eased the conditions under telehealth for safe abortion, leading to more successful terminations. Patients receive a delivery of pills and experts guide them through the procedure over the phone, providing medical advice throughout. Though this is available to women in South Africa who can afford the drugs, many women cannot access these services because of the price tag.[15]

[10] https://genderlinks.org.za/news/109754/
[11] https://foreignpolicy.com/2020/05/04/coronavirus-africa-abortion-access/
[12] https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world
[13] https://genderlinks.org.za/news/lockdowns-may-increase-unsafe-and-illegal-abortions/
[14] https://www.hpcsa-blogs.co.za/notice-to-amend-telemedicine-guidelines-during-covid-19/
[15] https://www.safeabortionwomensright.org/blog/south-africa-a-space-of-many-contradictions-and-now-covid-19/



Table 4.1: Key facts on abortion in Southern Africa

Country	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Laws	Penal Code 2014	Penal Code 1991	Penal Code 1995	Penal Code 2004	Consti-tution 2005	Penal Code 2010	Penal Code 1998, Criminal Procedure Law	Penal Code	Criminal Code 2012	Penal Code 2013	Abortion and Sterilisation Act 1975	Termination of Pregnancy Act 1994	Choice of Termination of Pregnancy Act (92/1996) amended in 2008	Penal Code	Termination of Pregnancy Act 2005 and Penal Code 2014	Abortion Law 1977
Abortion on request	Yes	Not specified	No	No	No	No	No	Not specified	No	Yes	No	Not specified	Yes	Not specified	Not specified	No
Conditions																
Save the woman's life/preserve health	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Economic or social reasons	No	No	No	No	No	No	No	Not specified	No	No	No	Yes	Yes	Not specified	Yes	No
Foetal impairment	Yes	Yes	No	No	Yes	Yes	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Rape	No	Yes	No	Yes	Yes	Yes	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Incest	No	Yes	No	Yes	Yes	Yes	No	Not specified	No	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Intellectual disability	No	Not specified	No	No	Yes	No	No	Not specified	No	No	Yes	Yes	Yes	Not specified	Yes	No
Mental health	Yes	Yes	No	Yes	Yes	Yes	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	No
Physical health	Yes	Yes	No	Yes	Yes	No	No	Not specified	Yes	Yes	Yes	Yes	Yes	Not specified	Yes	Yes
Response																
Improve access to contraceptives		Yes			Yes				Yes							
SRH education		Yes			Yes			Yes		Yes	Yes		Yes			Yes
Decriminalise abortion	Yes					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	48	24		10	31	51	11	37	35	16	14	41	28	15	47	28

Source: Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019 and Gender Links Attitude Survey. WHO, Global Abortion Policies Database: https://abortion-policies.srhr.org/ accessed 15 April 2020.

Table 4.1 shows that:

- Abortion is available under certain circumstances in all SADC countries, most commonly to save the woman's life; in cases of foetal impairment, rape, and incest; or for mental or physical health reasons.
- The response to abortion has largely been reactive. Eight countries (Botswana, Madagascar, Malawi, Mozambique, South Africa, Tanzania, Zambia, and Zimbabwe) have comprehensive post-abortion care guidelines.
- The GL attitude survey shows that in almost all SADC countries, fewer 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 controversial topic have been changing, illustrated by the fact that 51% of respondents in Lesotho agreed with the statement, as did 48% in Angola and 47% in Zambia.

Normative frameworks

Beijing Declaration and Platform for Action (BPfA)+25 Africa declaration 9: Accelerating the implementation of Sustainable Development Goal (SDG) 3 on universal health and well-being for all, to reduce the prevalence of disease in women and girls, and to mitigate the disproportionate burden of care affecting women: (b) Ensure universal access to good-quality health care, including testing and treatment for HIV and AIDS, and sexual and reproductive health; (d) Reduce maternal mortality rates and prevent deaths of newborn babies and children under the age of five years.[16]

Nairobi Statement on ICPD25: Accelerating the Promise[17]
2. Zero unmet needs for family planning information and services, and universal availability of quality, accessible, affordable, and safe modern contraceptives.

3. Zero preventable of maternal deaths and maternal morbidities, such as obstetric fistulas, by, inter alia, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national Universal health coverage (UHC) strategies, policies and programmes, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights.[18]

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.

[16] UNECA African Regional Conference on Women Beijing+25 Political Declaration and key messages and priority actions on the implementation of the Beijing Declaration and Platform for Action
[17] https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf
[18] https://www.nairobisummiticpd.org/content/icpd25-commitments
UNFPA, 2020. Accelerating the Promise. The Report on the Nairobi Summit on ICPD25. New York.
https://www.nairobisummiticpd.org/sites/default/files/Nairobi%20Summit%20Report%20on%20ICPD25_0.pdf accessed May 31, 2020.

ICPD25

In November 2019, the world reviewed progress towards attaining the goals of the 1994 International Conference on Population Development at the ICPD25 conference in Nairobi. The UNFPA briefing paper for the conference outlined the following essential SRHR interventions as part of a comprehensive, life course approach to SRHR:

- Comprehensive sexuality education - in and out of schools;
- Counselling and services for a range of modern contraceptives, with a defined minimum number of types of methods;
- Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care;
- Safe abortion services and the treatment of the complications of unsafe abortion;
- Prevention and treatment of HIV infections and other sexually-transmitted infections (STIs);
- Prevention and detection of, and immediate services for sexual and GBV, including referrals for all cases;
- Prevention, detection, and management of reproductive cancers, especially cervical cancer;
- Information, counselling, and services for subfertility and infertility; and
- Information, counselling, and services for sexual health and well-being.

The report points out that low cost options as part of Universal Health Care can provide most of these interventions, including prevention of unwanted pregnancies and provision of safe abortion. The conference emphasised the imperative to commit to three zeros: zero preventable maternal mortality; zero unmet need for family planning; and zero GBV and harmful practices.

All states represented at the conference made commitments to improved SRHR provision and reduction in maternal mortality, including:

- Improved youth-friendly SRH services with a focus on those living with disabilities;
- Improved capacity to deliver comprehensive sexuality education in primary and secondary education;
- Capacity building and allocation of financial and human resources for SRHR;
- Strengthen access to family planning information and services, especially for girls and young women, married and unmarried, in and out of school at all health facilities;
- End child marriage, sexual and GBV, and all forms of discrimination against all women and girls;
- Improve data collection including identifying causes of mortality;
- Support adolescent and youth leadership and participation;
- Improve antenatal care and postnatal services in all heath centres;
- Establish more one-stop centres and review marriage acts;
- Domesticate instruments such as the Convention on the Elimination of all forms of Discrimination against Women and Girls (CEDAW), Maputo Plan of Action, SADC Protocol on Gender and Development, and SADC Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage; and
- Develop comprehensive national SRHR packages and integrate them into the UHC strategies, policies, and programmes.

The Global Declaration on Abortion calls on world leaders to legalise abortion

Global Declaration on Abortion

More than 350 organisations signed on to a joint declaration on abortion for ICPD25 developed by the Asian-Pacific Resource and Research Centre for Women (ARROW), Center for Reproductive Rights, CHOICE for Youth and Sexuality, Ipas, Marie Stopes International, Realising Sexual and Reproductive Justice (RESURJ), Spectra, and Vecinas Feministas.



The Declaration states that the world will not meet the SDGs if governments do not urgently address access to safe abortion, with support from UN agencies, civil society organisations, health providers, the private sector, and the donor community. It notes that this means abortion must be safe, legal, available, accessible, and affordable.

Factors contributing to the demand for abortion

Most abortions occur because of an unintended pregnancy. Some reasons for unintended pregnancies include unmet need for contraception; failure of contraception; coerced or forced sex (rape); and unplanned sex. Contraceptive supply can be limited in areas with poor services, such as rural areas. Some women cannot access it because they cannot afford the ancillary costs like transport. Women with lower levels of education may not have access to information about contraception.

Table 4.2: Contraceptive prevalence rate, unmet need for family planning, and decision-making on SRHR

Country	Contraceptive prevalence rate (CPR) (%)				Unmet need for family planning, women 15-49 (%)	Proportion of demand satisfied, women 15-49 (%)	Decision-making on SRHR (%)
	Women aged 15-49, any method	Women aged 15-49, modern method					
	2019	1970	1994	2019	2019	2019	2007-2008
Angola	17	0	3	16	36	33	62
Botswana	60	3	38	58	14	82	N/A
Comoros	27	1	10	22	30	48	21
DRC	25	2	4	12	27	49	31
Eswatini	66	2	25	65	14	83	49
Lesotho	62	1	22	61	16	79	61
Madagascar	47	0	7	41	18	72	74
Malawi	62	0	11	61	16	79	47
Mauritius	67	17	46	44	10	87	N/A
Mozambique	30	0	5	29	24	56	49
Namibia	60	3	31	59	16	79	71
Seychelles	N/A	N/A	N/A	N/A	N/A	N/A	N/A
South Africa	57	16	52	57	14	80	N/A
Tanzania	43	1	12	37	21	67	47
Zambia	55	1	12	51	18	75	47
Zimbabwe	67	5	43	66	10	87	60

Source: UNFPA, World Population Dashboard: https://www.unfpa.org/data/world-population-dashboard. Accessed 28 May 2020.

Table 4.2 shows the contraceptive prevalence rates (CPRs) in SADC, which represents the percentage of women of reproductive age who use (or their partner uses) a contraceptive method at a particular point in time, usually reported for married women or women in sexual unions. Angola has the lowest rate at 17%, with Mauritius and Zimbabwe sharing the top spot at 67%.

In 2019, the rate of unmet need for family planning - the percentage of married or in-union women aged 15 to 49 who want to stop or delay childbearing but do not use contraception - ranged from 36% in Angola to 10% in Mauritius and Zimbabwe. Meanwhile, the percentage of married or partnered women aged 15-49 years who make their own decisions on three areas - sexual intercourse with their partner, use of contraception, and their healthcare - ranged from a low level of 21% in Comoros to 71% in Namibia and 74% in Madagascar.



In **South Africa**, the 2020 Individual Deprivation Measure study found that 79% of a sample of urban and rural citizens fall under the least deprived group in terms of access to contraception, which means either an individual had no need for contraception or they use a modern method. Meanwhile, 3.3% of the sample fall under the category of somewhat deprived (they did not use a method themselves, but their partner used a modern method); 13.3% use a traditional contraception method, known in the study as the "deprived" group; and 4.3% fall in the grouping of "most deprived," which means they do not use contraception or their partner uses a traditional contraceptive method.[19] However, 90% of respondents categorised as deprived refused to answer questions about their use of contraception to delay or avoid having children. Questions about contraception represented the only series of questions in the broad survey that had a high proportion of refusals to answer (a combined rate across the series of questions of 10.7%).

Similar proportions of men and women fell into the least deprived and most deprived categories. The report notes, "The implications of this unmet need for contraception - of up to around one-fifth of respondents - should not be minimised, particularly for women who may be left to deal with unwanted and unplanned pregnancies alone."



In **Malawi**, as in other SADC countries, overall rates of unmet need for contraception hide marked disparities in access, especially for adolescents and unmarried women. For example, more than half of women in the country use a modern method of contraception, such as injectables, implants, or external condoms. However, the unmet need for family planning for married women is about 19% while it rises to 40% for unmarried, sexually active women.[20] Factors such as stigma, lack of support from family, partners or health providers, and low self-esteem contribute to reduced access to contraception for young and unmarried girls and women.

More than half of women in Malawi use a modern method of contraception

UNFPA reports that African countries represent 24 of the 26 countries in the world with adolescent fertility rates higher than 100 per 1000 girls between the ages of 15 and 19.

[19] Suich, H., Pham, T., Hunt, J., Yap, M., Hasan, M. and Bessell, S. (2020) 'The Individual Deprivation Measure South African Country Study.' Canberra: ANU, Crawford School of Public Policy. https://www.individualdeprivationmeasure.org/wp-content/uploads/IDM-South-Africa-Report_Final.pdf

[20] National Statistical Office (NSO) [Malawi] & ICF, Malawi Demographic and Health Survey 2015-16 94 (2017), available at https://dhsprogram.com/pubs/pdf/FR319/FR319.pdf.

Table 4.3: SADC countries with high adolescent fertility rates

Country	Adolescent fertility rate (births per 1000 girls aged 15-19)
Mozambique	167
Angola	163
Madagascar	152
Zambia	141
DRC	138
Malawi	136
Tanzania	132
Zimbabwe	110

Source: UNFPA, World Population Dashboard https://www.unfpa.org/data/world-population-dashboard, accessed 28 May 2020.

Table 4.3 shows the eight countries in SADC with extremely high adolescent fertility rates, ranging from 110 in Zimbabwe to 167 per 1000 girls in Mozambique.



Zimbabwean youth learn about safe abortion at a Marie Stopes International clinic in 2020. Photo: Tapiwa Zvaraya

Women seek abortions because of socio-economic concerns linked to the ability to care for a child, or an additional child; lack of support from the male partner; and, particularly for unmarried women, when the pregnancy deviates from the expectations their family has for them. Stigma about abortion traces back to religious attitudes about the sanctity of life, attitudes about the morality of sex outside of marriage, and social norms of womanhood which perceive a women's role as being primarily to reproduce. Stigma can result in women confiding in very few people about an abortion, which leaves them more vulnerable to complications especially in cases where they do not immediately seek help.



The pope's visit to **Madagascar** in 2019 provided the backdrop for a story about illegal and unsafe abortions.[21] One woman, a mother of six, told journalists how she had aborted up to eight foetuses, highlighting the need for contraception in the country. The story noted that the woman's husband did not support the abortions and expected her to have sexual intercourse every time he wanted it. Because the woman works as a domestic helper, she could not afford contraception. Nifin'Akanga, an abortion rights group whose name derives from a powerful blue-flowered herb used as part of unsafe traditional abortions, estimates that one in four women in Madagascar have terminated between two and eight pregnancies. Illegal abortionists - locally known as angel makers - use a variety of infusions and medications. MSI provides post-abortion care to 200 000 women a year in the country and estimates that three women die per day as a result of abortions or miscarriages. Parliament has delayed an attempt to decriminalise abortion first put forward in 2017.



The government of **Angola** has a programme of integrated healthcare for adolescents for the years 2016-2021. Half of girls have already been pregnant by the time they turn 18, which restricts their education and opportunities. The risk of maternal death from pregnancy complications in girls younger than 20 is four times greater than in adult women in Angola.[22] A study of 715 patients with post-abortion complications in a hospital in Huambo found 75% did not use

[21] https://www.news24.com/Africa/News/madagascars-angel-makers-flourish-in-ban-on-abortion-20190906
[22] Angola - integrated health care programme for adolescents launched. https://www.safeabortionwomensright.org/angola-integrated-health-care-programme-for-adolescents-launched/ accessed 27 April 2010.

contraception even though 79% had previously undergone an abortion. In the study, 30% of women were aged 20-24; 46% had a primary education; 41% were single; and 27% were employed in the informal sales sector. First sexual intercourse had occurred as early as 13-15 years for 40% of respondents and 8% had experienced serious complications, with six maternal deaths (0.8%).[23]



In **Botswana**, the Ministry of Local Government and Rural Development has acknowledged that GBV causes many unplanned pregnancies in the country, resulting in women opting for unsafe abortions, which endangers their lives. Minister Botlogile Tshireletso said she prefers a situation that allows women to terminate pregnancies legally and safely, noting this would also help women who face desperation stress and anxiety due to unplanned pregnancies.[24]



Researchers estimated in 2016 that unintended pregnancies account for 71 out of 1000 pregnancies in **Zimbabwe** in women ages 15-49. During that same year, an estimated 25 245 women received post-abortion care. Activists have lauded Zimbabwe as having one of the highest contraceptive prevalence rates in the region. The Zimbabwe National Family Planning Strategy 2016-2020 shows that the country has almost achieved universal knowledge of family planning, but it accepts that gaps still exist in delivering family planning methods to some segments of the population. These gaps continue to leave many unmarried women and adolescents at risk of unwanted pregnancies, with little recourse from the law or the medical system.[25]

Unintended pregnancies account for 71 out of 1000 pregnancies in Zimbabwe

Legal and policy provisions for abortion in SADC

In most SADC countries, penal codes cover abortion, often in ways that date back to the region's colonial past. Most legislation is very conservative, though most member states have some exceptions that allow abortion. It is important to note that when a woman or girl is determined to end her pregnancy she will do so, even in instances when the only option is a risky, unsafe, or illegal procedure. Abortions occur as frequently in countries that ban abortion or allow it only to save a woman's life (37 per 1000 women) as in countries that have legalised it (34 per 1,000 women). Where abortions remain illegal, many women risk their lives to have unsafe abortions. Thus, the proportion of unsafe and dangerous abortions (defined by the WHO as involving ingestion of caustic substances or untrained persons using dangerous methods such as insertion of foreign bodies, or traditional concoctions) remain high in the region.[26]

[23] Natércia de Almeida, Andreia Teixeira, Alberto Capoco Sachiteque, José R. Molina, Hamilton dos Prazeres Tavares & Carla Ramalho (2020) Characterisation of induced abortion and consequences to women's health at Hospital Central do Huambo - Angola, Journal of Obstetrics and Gynaecology, 40:4, 558-563, DOI: 10.1080/01443615.2019.1635096
[24] Unsafe abortion worries Ministry http://www.dailynews.gov.bw/news-details.php?nid=35333 accessed 26 April 2020.
[25] https://www.afro.who.int/news/enhancing-capacity-zimbabwes-health-system-reduce-abortion-related-maternal-deaths
[26] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0205239 and http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/12/Zimbabwe-National-FP-Strategy-2016-2020_9.12.16.pdf

Table 4.4: Legal provisions regarding abortion in SADC[27]

Country	Law	Abortion on demand (yes/no)	Conditions under which an abortion may be granted					Gestational limits	Consent	Provided by	Penalties for an illegal abortion
			Rape/ incest	Mothers life at risk	Mothers mental state compro-mised	Child's life at risk	Other				
ABORTION AVAILABLE ON DEMAND											
South Africa	Choice of Termination of pregnancy Act (92/1996) amended in 2008[28]	Yes - specifies available to any woman who wants to terminate out of choice, including counselling						Within the first trimester	Right to termi-nate without consent of other parties apart from medical practitioners		Yes, for the woman, provider, and person who helps a woman obtain abortion
Mozambique	Amended Penal Code	Yes						On demand to 12 weeks; in the case of incest, 16 weeks; in the case of foetal anomalies, 24 weeks	Parental consent for minors; a health unit committee determines legal grounds[29]	A certified practitioner must perform termination at designated facilities[30]	Yes, for the woman, provider, and person who helps a woman obtain abortion
ABORTION AVAILABLE IN CERTAIN CIRCUMSTANCES											
DRC	Penal Code 2004, super-seded by Maputo Protocol, 2018	No	Yes	Yes	Yes	Yes	Sexual assault		Parental consent for minors		Yes, for the woman, provider, and person who helps a woman obtain abortion
Zimbabwe	Termination of Pregnancy Act of 1977, Chapter 15: 10[31]	No	In cases of incest or rape, but not marital rape	Only under circumstances where the life of the mother is in danger		If 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,	No		If the preg-nancy will	If the pregnancy will	If the child is at risk of mental			Once three medical		Seven years for person who

	13 October 1972, amended in 2005 and Penal Code			cause death	cause mental or physical damage to the woman	and physical deformities			practitioners have agreed		administers; seven 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 the pregnancy may cause mental harm	Yes	If unborn child will suffer or later develop physical or mental abnormality	Yes, in cases of defilement	Termination must be performed before 16 weeks[32]	Consent of parent or next of kin for minors; two doctors	Licensed facility	Three years for procurement; seven years for aiding
Lesotho	The Penal Code (2012)[33]	No	If pregnant due to incest or rape	To save the life of a pregnant woman		To prevent 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-M10 000 or imprisonment of up to three years
Mauritius	Penal Code 1983; Criminal Code Amendment Act 2012[34]			To save the life of a pregnant woman; or prevent permanent physical damage		If the foetus may suffer severe malformation or abnormalities	Woman younger than 16	If a pregnancy is within 14 weeks and the girl is younger than 16	Parental consent for minors		Imprisonment of up to ten years
Namibia	Abortion and Sterilisation Act 2 of 1975	No	When two other medical practitioners confirm that the woman has been raped or is a victim of incest	If the pregnancy poses a threat to the physical and mental health of the pregnant woman	If the woman is deemed to be an idiot or imbecile as per the Immorality Act 1957, which criminalises sex with her[35]	If 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	Licensed facility	A fine not exceeding N$5000 or imprisonment not exceeding five years, or both

Country	Law	Abortion on demand (yes/no)	Conditions under which an abortion may be granted					Gestational limits	Consent	Provided by	Penalties for an illegal abortion
			Rape/ incest	Mothers life at risk	Mothers mental state compro-mised	Child's life at risk	Other				
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	No		If the woman's life is deemed to be in dan-ger or 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[36]			If three medical practitioners agree in good faith, termination can be under-taken at Victoria Hospital in Mahe		Imprisonment up to 14 years
Tanzania	Penal Code 1981[37]			If a woman is at risk of death, or the pregnancy threatens her mental and physical wellbeing	If a pregnancy threatens the mental and physical wellbeing of the pregnant woman						Seven years for procurement; three years for suppliers
Eswatini	The Consti-tution			Only if the life of the woman is in danger[38]			Unlawful intercourse with mentally retarded female		One doctor		Life imprisonment
Malawi	Penal Code	No		Only to save a woman's life							14 years for having an abortion; three years for supplying instruments to conduct an abortion

Angola	Penal Code 2017[39]			Yes, to save the life of a woman		If there are strong reasons to believe the foetus is unfeasible	If the pregnancy is the result of a crime against freedom and sexual self-determination	16 weeks to preserve health, foetal impairment no limit specified	Parental consent for minors	Licensed facility and one doctor	Four to ten years in prison
Comoros	Comoros-Penal-Code-1995	No	Yes		Yes	Yes	For a very serious medical reason	Not specified	Two doctors	One doctor	Penalties for the woman and provider
Madagascar	Reproductive Health and Family Planning Law 2017			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.

Activists worry that SADC could see higher rates of unplanned pregnancy because of COVID-19, increasing the demand for abortions

[27] This table is reproduced from Gender Links 2019 Abortion Fact Sheet, with some additions from WHO Global Abortion Policies Database https://abortion-policies.srhr.org/ accessed 15 April 2020.
[28] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[29] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[30] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[31] http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
[32] 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
[33] https://lesotholii.org/ls/legislation/num-act/6
[34] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[35] https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
[36] https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
[37] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
[38] http://srhr.org/abortion-policies/country/swaziland/
[39] http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf

In detailing the current legal provisions in SADC regarding abortion, Table 4.4 illustrates that legal change, especially for an issue as emotive and contentious as abortion, remains slow and varied across the region. However, most SADC countries now provide for abortion in some circumstances. This ranges from South Africa and Mozambique, where abortion is available on demand, to Angola, Eswatini, Malawi, and Tanzania, where abortion is only available in extremely limited circumstances. Penalties for an illegal abortion also vary widely.



Activists in Malawi take part in the launch of a music album to mobilise support for law reform on abortion in Mangochi in 2015. Photo courtesy of Luke Tembo

Many factors mediate the relationship between legislation, policy, and practice, including moral and religious contestations, patriarchal attitudes, control of policy and legal processes and, in some cases, pragmatism. Foreign aid restrictions, such as the Global Gag Rule, also known as the Mexico City Policy, block funding for organisations that provide abortion counselling or referrals, or lobby to decriminalise it. The Trump administration in the United States has reinvigorated this approach in its distribution of USAID and the President's Emergency Plan for AIDS Relief (PEPFAR) funds. SADC also has instances of progressive legislation around abortion that lawmakers do not fully implement and other cases where seemingly conservative legislation does not prevent many women from seeking abortions.

Lawmakers in the region adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, often referred to as the Maputo Protocol, in July 2003 in Mozambique. It entered into force after 15 countries ratified it in 2005. The Maputo Protocol covers a wide range of women's rights provisions. Article 14 on health and reproductive health rights empowers women to control their fertility, decide whether to have children or not and the number thereof, to choose their preferred contraception, and to be protected from STIs. Additionally, women have the right to know their own and their partner's health status; to family planning education; affordable and accessible health services; and pre- and post- natal, delivery and nutritional services. Finally, it granted women the right to medical abortions in cases of sexual assault, rape, incest, and in the event that the pregnancy endangers the mental and physical health of the mother, or the life of the mother or unborn child.



The **Democratic Republic of the Congo (DRC)** signed the Maputo 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 published the ratified Maputo Protocol in the nation's legal gazette on 14 March 2018. According to the DRC's monist legal system, international and domestic law form part of one integrated system. Thus, gazetting the Protocol means that its provisions become legally binding. Abortion is now legal in cases of rape, incest, assault, and mental and physical endangerment of the woman and/or her child and all medical facilities must provide termination of pregnancy.

The DRC has high rates of unintended pregnancy because of both poor access to contraception and high levels of sexual assault, especially in the eastern parts of the country. In 2016, researchers estimated that 61% of all pregnancies in Kinshasa were unintended. Approximately 43%, or 147 000, of those pregnancies led to induced abortions and nearly 38 000 women sought treatment for abortion complications. Meanwhile, 27% of women in the DRC report experiences of sexual assault; many of these result in pregnancy. Due to fear of death or

complications, 47% of women who became pregnant because of assault did not attempt to abort.[40] Gazetting of the Maputo Protocol was the first step in making abortions more available to women who need them. However, many women still struggle to access abortion because:

- Many Congolese legal experts and medical providers do not know about the change or choose not to follow the law;
- The legal establishment and law enforcement's inconsistent understanding and application of the law;
- Slow integration of Maputo Protocol language into national laws; and
- Crippling stigma against women who seek or have had abortions.

Several NGO programmes now support government efforts to train health professionals to provide safe abortions, especially in regions of the DRC where men use rape and sexual assault on women as weapons of war in the ongoing unrest. One of these is Si Jeunesse Savait (SJS, "If Young Women Knew" in French), which has organised online communication as well as face-to-face workshops to sensitise healthcare providers on the need to provide quality care without stigmatisation of women. SJS has also educated young women about their rights, how to exercise them, and the means available to them. The association estimates that it reached more than 5000 people in one year. It also offers referral services to appropriate health structures.

Many factors mediate the relationship between abortion legislation, policy, and practice in SADC

[40] Se Jeunesse Savait, Safe Engage & Population Reference Bureau. 2018. Fact Sheet: Expanding Access to Safe Abortion in DRC. https://www.prb.org/wp-content/uploads/2019/04/SAFE-ENGAGE-DRC_Medical-Fact-Sheet.pdf Accessed 2 May 2020.

[41] Blystad et al. International Journal for Equity in Health (2019) 18:126, The access paradox: abortion law, policy and practice in Ethiopia, Tanzania and Zambia. https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1024-0 accessed 23 April 2020.



Mozambique amended its Penal Code in 2015, decriminalising abortion as part of a comprehensive legal review. The revisions allow women to terminate their pregnancies during the first 12 weeks or, in the case of rape, up to 16 weeks. The amended law stipulates that qualified practitioners must conduct abortions in approved health centres as a free service. Girls younger than 16 require consent from someone 21 (age of majority in Mozambique) or older to have an abortion - either a parent or trusted adult. There is a 48-hour waiting period before a woman receives an abortion.

However, several bottlenecks to full implementation of these new rules exist, including delays in defining clinical standards for safe abortion, institutional opposition, resistance from health workers, and gaps in the knowledge of decision-makers. Consequently, many women still cannot, or do not know how to, access abortion services.

NGOs such as Associação Moçambicana de Obstetras e Ginecologistas (AMOG), the country's association for gynaecologists, has tried to improve the situation, including by:

- Sensitising girls and women on the provisions of the law, especially time limits for an abortion, and where they can receive them;
- Sensitising communities to reduce the high levels of stigma that may prevent a woman from seeking an abortion;
- Sensitising doctors and health providers on the provisions of the law and their responsibility to provide abortions; and
- Training qualified health providers on safe abortion in line with the law.

A study of the interplay between legislation, attitudes, policy and practice in Zambia and Tanzania found that many factors besides the actual legislation influence access to safe abortion.[41] The study also assessed Ethiopia and noted that all three countries have high fertility rates (the average number of children a woman gives birth to in her childbearing years), and high maternal mortality ratios: 224 per 100 000 live births in Zambia and 398 in Tanzania. Meanwhile, the contraceptive prevalence rate at the time researchers conducted the study stood at 41% in Zambia and 25% in Tanzania - and 28% among

teenage girls in Zambia and 15% among Tanzanian teens.

The study, conducted between 2016 and 2018 and published in 2019, also examined implementation of abortion legislation in Zambia, which appears to allow abortion on many grounds, but remains hampered by a requirement for three doctors to authorise any abortion in the country. This provision has stymied implementation of the law, especially in rural areas where it is almost impossible to find the three doctors in any one community. Lack of coherent implementation guidelines has exacerbated the situation. In Tanzania, on the other hand, quite conservative legislation includes an explicit exemption of providers from punishment if they perform an abortion to save a woman's life. The law allows a single health practitioner - a doctor or a midwife - to make this determination.

Records from five major hospitals across Zambia between 2003 and 2008 suggest that almost one-third of all women admitted for gynaecological reasons came in due to complications of unsafe abortions, and researchers estimate that six in every 1000 of these women died as a result of complications. In Tanzania, where abortion is highly restrictive, researchers struggle to estimate incidences of unsafe abortions. However, a 2013 study found that clandestine abortions represent a major contributor to maternal death and injury in the country.



Despite much consultation and a critical need for abortion review in **Malawi**, progress has been very slow. A CHANGE fact-finding mission found that one contributing factor for this is the Protecting Life in Global Health Assistance (PLGHA) policy in all USAID health assistance, also known as the Global Gag Rule, which blocks aid for organisations that provide abortion counselling or referrals.[42] Malawi depends on foreign aid from a range of bilateral and multilateral donors. In 2017, US$1.5 billion in aid to the country accounted for more than one quarter of its gross national income (GNI).

USAID disbursed more than US$215 million in global health assistance for programming in Malawi from 2017-2019. In comparison, the UK's Department for International Development (DFID), disbursed about US$84 million during the same period. The CHANGE study found that the Malawi government could not afford to directly contradict the USAID policy, resulting in delays in the passage of the Termination of Pregnancy Bill.



Malawi: coalition that includes faith leaders pushes for abortion reform



Chisale Mhango, a gynaecologist with the College of Medicine, writes a column about safe abortion in The Daily Times. Photo courtesy of Nyasa Times

An advocacy network called Coalition for the Prevention of Unsafe Abortion (COPUA) has brought together leaders from various sectors including media, health, legal, gender and women's rights, academia, students, faith communities, and traditional leaders to push for law reform on abortion.

Many Malawians, including faith and traditional leaders, now openly talk about the danger of unsafe abortion and the need for a modernised termination of pregnancy policy and legal framework.

[42] CHANGE, op cit.

Since 2015, Malawi's lawmakers have avoided debate of a draft bill from the Malawi Law Commission that would expand the grounds under which women can access abortion.

These include: when the continued pregnancy will endanger the life of the pregnant woman; when termination is necessary to prevent injury to the physical or mental health of the pregnant woman; when there is a severe malformation of the foetus, which will affect its viability or compatibility with life; and when the pregnancy occurred because of rape, incest, or defilement.

Maternal health statistics indicate the critical need for abortion reform in Malawi. Unintended pregnancies represent more than half of all pregnancies, with 30% of these ending in unsafe abortion. Indeed, research has found that more than 78 000 Malawian women undergo unsafe abortions annually, with more than 50 000 experiencing complications that necessitate post-abortion care (PAC).[43] Complications from unsafe abortion rank among the top five direct causes of maternal deaths in the country, which has one of the highest global maternal mortality rates, estimated to be 439 maternal deaths per 100 000 live births in 2019.[44]

Malawi's Centre for Solutions Journalism (CSJ) has been disseminating research from the College of Medicine at the University of Malawi on maternal and sexual and reproductive health that highlights the gravity of unsafe abortion. Through a multimedia programme, CSJ hopes to reach a million people. A local radio show in Chichewa, *Uchembere ndi Ufulu* ("motherhood and rights"), engages experts to raise awareness on issues of safe abortion.

Chisale Mhango, a gynaecologist with the College of Medicine, writes a column about safe abortion in *The Daily Times*. Mhango covers topics such as the proposed bill, whether abortion is a religious or a health issue, and the health system's capacity to deliver safe abortion. Faith-based leaders also play a role in the discussion. Pastor Esitedi Chikopa wrote of how his interest in unsafe abortion stems from the death of two members of his congregation. "As master condemners, we have no compassion for many women who induce abortion in Malawi," he wrote. "We have no concern for women who die due to unsafe abortions because we are disciples of Biblical literalism instead of being experts in practical hermeneutics (or interpretation)."

Political turbulence in Malawi following the nullification of the May 2019 elections created a hostile environment for the enactment of the draft bill, as MPs worried about discussing abortion issues in fear of losing their political support bases. The COVID-19 pandemic also resulted in a reduction of awareness campaigns as social distancing measures and restrictions prohibited mass gatherings.

Source: Extract from Luke Tembo, "Malawi: Moving the Needle on Comprehensive abortion Care," entry into the SADC Gender Protocol @ Work Summit 2019 and Gender Links, Malawi: Political Discourse, Safe Abortion Care.

Abortion incidence

The Guttmacher Institute uses the best available data to estimate abortion rates per 1000 women aged 15 to 44 for different regions and times (in a series of five-year intervals). It estimates that 58 million women in Africa have an unmet need for contraception, which results in 21.8 million unwanted pregnancies per year and 8.2 million abortions. This is an increase from 4.6 million in 1990-1994, mainly because of the increased number of women of reproductive age.[45]

[43] CHANGE. 2020. A Powerful Force: U.S. Global Health Assistance and Sexual and Reproductive Health and Rights in Malawi. https://srhrforall.org/a-powerful-force-u-s-global-health-assistance-and-sexual-and-reproductive-health-and-rights-in-malawi/
[44] USAID: Maternal, neonatal and child health. Accessed 2 July 2020 https://www.usaid.gov/malawi/global-health/maternal-neonatal-and-child-health#:~:text=Malawi%20has%20one%20of%20the,and%2015%25%20of%20maternal%20deaths.
[45] Guttmacher Institute, 2018. Fact Sheet: Abortion in Africa. Guttmacher Institute. New York, NY.

Table 4.5: Abortion rates in Africa

Region	Abortion rate per 1000 women of reproductive age (15-44)		% of all pregnancies that end in abortion
	1990-1994	2010-2014	2010-2014
Africa	33	34	15
Southern Africa	32	34	24
Eastern Africa	32	34	14
Central Africa	32	35	13
West Africa	28	31	12
North Africa	41	38	23

Source: Derived from Guttmacher Institute, 2018. Fact Sheet: Abortion in Africa. Guttmacher Institute. New York, NY.

Table 4.5 shows that estimated abortion rates in Southern Africa increased from 32 per 1000 women in the 1990s to 34 between 2010 and 2014. This compares to a decrease of 40 to 35 globally, a decrease of 39 to 37 in developing countries, and a decrease from 46 to 27 in developed countries over the same period. The SADC region has the highest percentage of pregnancies that end in abortion compared to other African regions (24%). Globally, the institute estimates that 25% of pregnancies end in termination.[46] It recognises comprehensive safe abortion care (including post-abortion care), as a key element of SRHR.

In 2019, MSI conducted a survey with 1929 of its clients across Latin America, Africa, and Asia.[47] The organisation wanted to ascertain whether their abortion services were meeting the needs of their clients.

Table 4.6: Age of women seeking abortions

Percentage	Age
9.5	33
25.9	32
28.5	32
19.8	32
12.5	28
3.9	41

Source: Marie Stopes International, 2019.

Table 4.6 illustrates that MSI found that most women seeking abortions fall into the 25-29 age group and the 20-24 age group. However, the study also found that teenagers account for almost 10% of those seeking abortions.

Table 4.7: Marital status of those seeking abortion

Percentage	Status
28.7	Single (not living with a partner) and do not have children
23.8	Single (not living with a partner) and have children
8.2	Married or living with a partner and do not have children
39.3	Married or living with a partner and have children

Source: Marie Stopes International, 2019.

Table 4.7 shows that married and partnered women with children comprise a majority of those seeking abortions. This points to a need for better family planning services to assist women who already have children, so they do not have to deal with unwanted pregnancies.

Table 4.8: Employment status of those seeking abortion

Percentage	Employment status
18.4	Students
45.4	Employed
33.5	In paid work

Source: Marie Stopes International, 2019.

Table 4.8 illustrates that most women seeking abortions have paid work. However, at 18.4%, students account for one in five abortions.

[46] Singh, S. et al. 2017. Abortion Worldwide 2017. Guttmacher Institute. New York.
[47] Marie Stopes International. 2019. My Body, My Voice: Women's views on abortion care. www.mariestopes.org accessed 2 May 2020.

Overall, 23% of women reported that they faced some stigma in choosing to have abortions: from a partner, their community, and even from providers. MSI found single women five times likelier to experience stigma than married women. The study also noted that safe abortion services remain difficult for most women to access. Women travelled further and found it more difficult to gather funds to access safe abortion care than they did for contraceptive services.

MSI concluded that there is a need to deliver safe abortion through a variety of channels, such as those that reach low-income women in rural settings, including via outreach teams. It also found that knowledge of safe services remains limited: 54.7% of women who visited MSI did not know of an alternative abortion provider and 28.9% accessed information on safe abortion care via the internet and social media.

> It is important that programmes offer integrated safe abortion care, including access to a wide range SRHR services

Half of clients planned to receive a contraceptive method with MSI as part of abortion care. It is important that programmes offer integrated safe abortion care, including access to a wider range of SRH services, such as cervical cancer screening and counselling on post-abortion contraception, if desired.

Finally, 31.2% of women found out about MSI from a government or private facility, underscoring the importance of creating partnerships with the public and private sectors.



The **Seychelles** Penal Code criminalises abortion, except in cases of foetal impairment, rape, incest, intellectual disability and to preserve a woman's mental and physical health. In 2018 Seychelles reported 473 abortions, the equivalent of 22% of pregnancies.



In 2016, Guttmacher Institute reported that 60% of women in **Tanzania** who suffer post-abortion complications do not receive medical care. Researchers conducted the most recent study of abortion in Tanzania in 2013, finding that, of one million pregnancies reported, women underwent 405 000 abortions, the vast majority considered unsafe by WHO standards. Of these, only about 66 600 women received post-abortion care.[48]

Safe abortion

Overall, as this chapter has illustrated, most legal frameworks in Africa do not accept abortion, which drives women to unsafe methods and providers. Of all abortions:[49]

- Experts consider only 55% to be safe (i.e. conducted using a recommended method and by an appropriately trained provider);
- 31% are less safe. This means they meet one of either the method or provider criterion, or are conducted using outdated methods like sharp curettage even if the provider has been trained, or if women use tablets but do not have access to proper information or to a trained person if they need help;
- 14% are least safe, which means employing neither a recommended method nor a trained provider, or they involve ingestion of caustic substances, or untrained persons use dange-

[48] https://www.guttmacher.org/news-release/2016/unsafe-abortion-common-tanzania-and-major-cause-maternal-death
[49] World Health Organisation, https://www.who.int/health-topics/abortion#tab=tab_1

rous methods such as insertion of foreign bodies or use of traditional concoctions.



In terms of actual numbers, experts believe an estimated 25 million unsafe abortions take place each year worldwide, of which eight million fall in the category of least safe.[50] In Africa, three of every four abortions fall into the unsafe group. In 2008, women in the 15-24 age group comprised 51% of those accessing the least unsafe abortions in Africa. The more restrictive the legal setting, the higher the proportion of unsafe abortions. Less than 1% of the least safe abortions occur in the least restrictive countries while 31% occur in the most restrictive countries. While unsafe abortion declined between 1990 and 2008 in most regions, it remained constant in Africa at a rate of 28 per 1000 women in reproductive age years (15-44). Africa accounts for 29% of global unsafe abortion but suffers 62% of unsafe abortion-related mortality.[51]

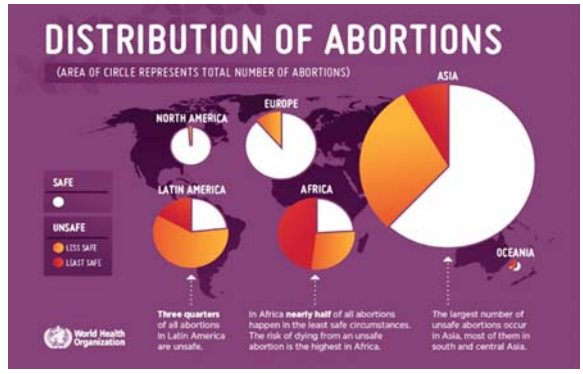
In developing countries, where unsafe abortion remains prevalent, up to 40% of women who have an abortion develop complications, including severe bleeding, uterine perforation, tearing of the cervix, severe damage to the genitals and abdomen, internal infection of the abdomen, and blood poisoning. Long-term complications include increased risks of infertility and ectopic pregnancies, as well as miscarriages or premature deliveries in subsequent pregnancies. Some of the least safe methods of abortion include inserting dangerous objects such as knitting needles, or even glass, into the vagina. Globally, unsafe abortion ranks as the third major cause of maternal death after haemorrhage and sepsis in childbirth.

The WHO has developed guidance to support countries to provide safe services. Its recommendations for safe abortion can be found in the following publications:

- Safe abortion: technical and policy guidance for health systems;
- Clinical practice handbook for safe abortion; and
- Health worker roles in providing safe abortion care and post-abortion contraception (2015).

Impact of the Mexico City Policy

A review of the implications of the Mexico City Policy (MCP), which US Republican administrations since Nixon have enacted - and every subsequent Democrat president has rescinded - found many unintended consequences.[52] The policy aims to reduce abortions by limiting US funding to organisations that provide information, counselling, abortions, or advocacy for abortion. However, some organisations that suffered funding cuts because of this policy also provide SRH services, including access to contraception. Thus, these organisations also lose funding for other SRH services.



Researchers conducted the review for the period from 1991 to 2019, covering the Clinton, Bush, and Obama administrations, which made the policy inactive, then active and then inactive

[50] WHO, 2018: Preventing unsafe abortion. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion. Accessed 10 June 2019.
[51] https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion, 19 February 2018. Accessed 10 June, 2019.
[52] Brooks N, E Bendavid, G Miller, USA aid policy and induced abortion in sub-Saharan Africa: an analysis of the Mexico City Policy. Lancet Global Health. 2019; 7: 1046-1053. https://doi.org/10.1016/S2214-109X(19)30267-0 accessed 30 May 2020.

again. It looked at 13 African countries classified as having high exposure to the MCP as they receive above average annual per-capita development assistance for family planning and reproductive health from USAID (in SADC, this included Madagascar, Malawi, Tanzania, and Zambia) and 13 classified as having low exposure to the MCP (including Eswatini, Lesotho, Mozambique, Namibia, and Zimbabwe in SADC).

The study found a reduction in modern contraceptive use (14% less), an increase in pregnancies (12%), and an increase in abortions (40%) among women living in countries highly affected by the policy during periods when administrations enacted the MCP. It is highly likely that these increased abortions would rank as unsafe. The review also showed that these outcomes reversed after the policy's repeal (2009-14).



Namibia: Unsafe abortion and baby-dumping



Namibia police investigate a case of unsafe abortion in Arandis, Namibia, in June 2019. Photo courtesy of Monalisa Hoaes

Namibia inherited its Abortion and Sterilisation Act from South Africa in 1975. Since then, abortion has been illegal in Namibia for women and girls (except in cases of rape, incest, or endangerment of the mother's or child's life).

Almost 50 years on, however, terminations by other means continue. "It is naive to assume that abortions are not already taking place in Namibia," said Andrea Thompson, communications lead at Marie Stopes in South Africa. "They are, and they are happening through backstreet means."

In 2013, the Namibia Press Agency (NAMPA) published a report stating that Namibians dump or flush 40 babies and foetuses down the toilet every month. A 2010 UNICEF report likewise found that "13 dead babies are found every month at the sewage works in Windhoek."

Shaun Whittaker, a clinical psychologist in Windhoek who counsels post-abortion women, says these stories may be hard to stomach, but women in Namibia have few other options. "When someone is confronted with an unwanted pregnancy, they are in a state of panic. Usually these are young women, from a working-class background, with little or no financial means. They are desperate," he said.

Sacky Shangala, of the Law Reform and Development Commission, agrees, noting it is time for the country's leaders to address the issue. "There have been many baby dumping incidents in Namibia to warrant a discussion on whether or not abortion should be legalised," he said.

Namibian women who choose "backstreet" solutions break the law in doing so and face risk of complications, including haemorrhage, septicaemia, internal organ damage, tetanus, sterility, and even death. Failed procedures remain common.

"The current situation allows people with means to go to another country, such as South Africa, to access safe, legal abortions," said Dianne Hubbard, coordinator of Gender Research and Advocacy at the Legal Assistance Centre. "While our restrictive laws expose the poorest and most vulnerable members of society." Crossing the border to visit a clinic in South Africa is an expensive trip for most Namibians.

Private doctors regularly charge more than R10 000, whilst non-profit organisation prices start at R3 000. This does not include travel, accommodation, and other expenses.

Even some religious leaders in Namibia say they are open to talking about the current laws. "In the light of ongoing gender-based violence, teenage pregnancies and baby dumping, these tragic events necessitate a fresh discussion," said Ernst//Gamxamub, deputy bishop of the Evangelical Lutheran Church in the Republic Namibia.

Any change in policy could have a profound positive effect on women's health, as occurred in South Africa. In 1997, South Africa legalised abortion, and the same year the annual number of abortion-related deaths fell by 91%.

Source: Monalisa Hoaes from Arandis Namibia as part of SADC Gender Protocol Summit @ Work application 2019.

Access to post-abortion care services

Some countries have begun to develop guidelines for post-abortion care, a key part of comprehensive abortion care that has 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 they receive on site or via referrals to other accessible facilities; and
- Community and service provider partnerships to prevent unintended pregnancies and unsafe abortions, to mobilise resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs.[53]

Table 4.9: Policies and guidelines on post-abortion care

Country	Policies and 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.

[53] IPPF. Op Cit

Table 4.9 outlines available guidelines on post-abortion care in seven SADC countries. Many countries have explicit guidelines that lawmakers have recently updated, while others look to standards set out in lists of essential medicines or standard treatments. To reduce maternal mortality, it is essential that all countries provide easily accessible post-abortion care. There is an urgent need therefore for comprehensive post-abortion care guidelines in all countries. However, activists note that provision of post-abortion care in cases of unsafe abortion is much costlier than providing legal access to safe abortion.



Zimbabwe's 2gether4SRH programme combines interventions from UNAIDS, UNFPA, UNICEF, and WHO to combat maternal mortality due to abortion and take more direct action to achieve SDGs 3 and 5. Zimbabwe's Ministry of Health and Child Care partners with these groups, implementing the initiative in 12 districts.[54] All 18 health facilities assessed provide post-abortion care to women through manual vacuum aspiration, dilation and curettage, medical abortion and electric vacuum aspiration, with dilation and curettage, a procedure to remove tissue from inside the uterus, most common. However, researchers found that 79% of these centres do not provide counselling to their clients, which illustrates a gap if the aim is to deliver a complete package of post-abortion services.

Other gaps identified include too few professionals trained in post-abortion care, as well as limited post-abortion care courses for health care workers, such as pre-service medical professionals and midwives. Zimbabwe also has a shortage of supplies such as sterile water, manual vacuum kits, and aspirin, which limits the quality of services rendered to clients.[55] A study conducted by Guttmacher Institute found that staff at 55% of health facilities in 2016 said they had run out of misoprostol[56] within the last three months at the time of the study, and no central hospitals had the drug at that time. The research also found that 93% of primary health care centres, 75% of all provincial hospitals, and 50% of all district hospitals did not have misoprostol. Hospital staff also reported they did not have blood transfusion services, IV antibiotics, and MVA kits.

Increasing access to post-abortion care saves lives

Regardless of Zimbabwe's stringent laws on abortion, many women still risk their lives to terminate unwanted pregnancies. Government leaders knows abortions occur daily and, even though it is illegal, they know they have a duty to preserve life and treat women when they arrive in health facilities. While there is nationwide awareness of family planning, access to it remains spotty. Legislators need to do more to make it available to all women in the country.

Access to safe abortion services

Safe abortion care is a package of essential health services: safe termination of pregnancy, management of post-abortion complications, and provision of contraceptives. The services must be timely, reliable, confidential, compassionate, and provided by well-trained professionals.

Termination of pregnancy is a safe and effective medical act, carried out using tablets, known as "medical" or "medication" abortion, or through a minor procedure using local anaesthesia, known as manual vacuum aspiration (MVA). Medical abortion involves five tablets of two drugs, mifepristone and misoprostol - both listed

[54] https://www.afro.who.int/news/enhancing-capacity-zimbabwes-health-system-reduce-abortion-related-maternal-death
[55] https://www.afro.who.int/news/enhancing-capacity-zimbabwes-health-system-reduce-abortion-related-maternal-deaths
[56] https://journals.plos.org/plosone/article/file?type=printable&id=10.1371/journal.pone.0205239

as WHO essential medicines. 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 improves: between 95-98% when used correctly.[57] Women usually prefer medical abortion as it is less invasive and can be started as an outpatient and completed in the privacy of one's home. Skilled midwives and nurses can provide both methods in hospitals and health centres.[58] Abortion is safe when service providers use safe methods.



Activists gather for a safe abortion roundtable meeting in Namibia in 2019.
Photo: Kaino Kamweka

Southern Africa Gender Protocol Alliance

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

- Ensuring that all adolescents can access people-centred integrated SRHR services, including HIV services (testing, counselling, accessing treatment), information, contraceptives, and safe abortion.
- Building 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 a 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.

Contraception and safe abortion care are critical components of any strategy to reduce unwanted pregnancies, unsafe abortions, and maternal deaths. Increasing access to modern contraception is essential to reduce unintended or unwanted pregnancies and abortions or unplanned births. However, contraception alone is not enough.

Provision of safe abortion services is a powerful indicator of relative gender equality. Countries that score high on the UN Gender and Develop-



[57] 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.
[58] Africa: Unsafe Abortion Neglected Emergency, MSF Opinion https://allafrica.com/stories/201903040646.html

ment Index (GDI) tend to provide good access to safe abortion services, while countries with low GDI scores often have higher levels of unsafe abortion. Further, safe abortion services are part of a package of improved SRHR services, including good access to contraception and sex education. Thus, countries with more liberal abortion legislation do not have increased demand for abortion as they also have reduced rates of unintended pregnancy.



In **Lesotho**, CNN spoke with nine women between age 17 and 30 who had contacted people on social media who claimed to be doctors for the purpose of an abortion. All nine women told the journalists they felt they had undergone an unsafe procedure. They all experienced extensive bleeding and faintness following use of the pills provided. None of the women sought medical attention.[59]



In providing safe and legal abortion for its citizens, South Africa has also seen an increase in women arriving for abortions from neighbouring countries, including Botswana, Eswatini, Lesotho, Namibia, and Zimbabwe. Although these countries all have conservative legislation around abortion within their own borders, a quick Google search in any of them highlights providers with South African numbers. Unfortunately, even though abortion is legal and can be safe in South Africa, searching for providers via social media, such as WhatsApp or Facebook, puts women at risk of finding unsafe and unscrupulous providers.

Safe abortion campaigns

Gender Links (GL) has collaborated with SAfAIDS to champion campaigns across the SADC region and raise awareness of available services for abortion and post-abortion care. Many women, especially young, poor, and rural women, do not always know about availability of safe services and therefore do not access them. The campaigns also highlight the need for legislation, policy, and provision of services that support women.

Voice and Choice campaign

GL launched the #VoiceAndChoice campaign in 2018 with the aim of campaigning for the increase of abortion services in Mozambique and South Africa. The campaign also advocates for decriminalisation of abortion in the SADC region. Because abortion laws differ from one country to the next, each country's campaign highlights different priorities and gaps within policies.

There is need to align as a region and ensure that all women have access to safe abortions. Women take different risks across the region, contributing to high maternal mortality across Southern Africa every year. Angola and Madagascar receive particular attention because abortion remains illegal in both countries under most circumstances and both have extreme punishments for those who undergo abortions. The campaign aims to amplify the voices of women across the region who seek to take ownership of their bodies and exercise their rights to safe SRH, including abortion. GL's campaign looks to ensure that leaders hear all voices in the region.

The #VoiceAndChoice campaign also connects global policy to those on the ground through tangible activities to share contextualised information for local communities. On 28 September 2019, Gender Links, through the Southern African Gender Protocol Alliance, joined SafAIDS and dozens of organisations across the globe in observing the International Safe Abortion Day.

[59] https://edition.cnn.com/2018/03/07/health/lesotho-abortions-asequals-intl/index.html

Through simultaneous round tables hosted in Angola, Botswana, DRC, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe, organisations set out to understand the ramifications of the Global GAG Rule while advocating for its reversal. They also undertook to increase national and regional advocacy to reduce stigma, remove policy restrictions, and increase access to safe and legal abortions. The Alliance undertook seven national and 17 local campaigns on safe abortion with support from Amplify Change. The case study that follows is an example of a local-level campaign led by a male councillor.



Anushka Virahsawmy, Gender Links' country manager in Mauritius, speaks about abortion at an International Women's Day event in 2020.
Photo: Sheistah Bundhoo



Lesotho: Councillor campaigns for safe abortion



The Gender Hub at Tanzania's Antakae primary school in Antakae village in 2018.
Photo: Gender Links

"Our girls' future, health, and safe life is in our hands and knowledge is power," says Mohlomi Setlaba.

The Mamants'o councillor and member of the social services committee wants Lesotho's councils to work together with traditional and community leaders to campaign for safe abortion.

In 2018, Setlaba participated in an SRHR action planning workshop with a focus on safe abortion for councillors from ten councils. He was the first person in the meeting to support safe abortion.

Afterwards, he held public gatherings in his village, at which he talked to teenage girls about safe abortion and tried to gather evidence to support legalisation in Lesotho.

He organised a big public gathering during the 16 Days of Activism campaign, themed "Safe abortion." He has also promised to encourage all councillors to get involved and campaign for safe abortion.

Abortion in Lesotho remains criminalised under Section 45 of the Penal Code Act of 2010. However, illegal sales of misoprostol for abortion is a lucrative business. Black market dealers have found a way to smuggle the pills out of hospital pharmacies and clinics to sell them at a street value of M400 for three pills.

"Most of the customers now are from referrals of friends who have accessed our services," says one seller. "For each abortion, a female

client is given three pills, two which she swallows while the third one she places inside the vagina. It succeeds mostly when the foetus is less than two months but can still work up to five months although the risks are high at the time. However, it is not our problem if something goes wrong, I always tell customers that they do it at their own risk."

Desperate young women in rural areas often do not have access to these pills so they resort to using traditional practices including herb mixtures to abort the foetus. One woman from Tlhanyaku, a rural village, said although she eventually lost the baby, she also nearly died in hospital. "I got pregnant in 2016... by my teacher. We could not risk people finding out. He gave me money to go and see a lady who was popular for abortions in the area. She gave me a bitter concoction to drink and gave me three pads, one to put on three hours later and others to change."

The young woman discovered serious bleeding from her vagina in the middle of the night and her neighbour then rushed her to the hospital three hours away. "I was bleeding heavily when I got to the hospital and the last thing I remember were nurses shouting at me asking what I had consumed. I could not respond but was only focusing on the unbearable pain in the stomach. I passed out and only woke up the following day when I was told by a nurse I had lost a baby."

Although statistics are not readily available, Mothepane Thahane, public relations officer at Lesotho's Queen Mamohato Memorial Hospital, said most maternal deaths there occur because of failed abortions.

Source: Adapted from Lesotho SRHR summit case study and Gender Links news services accessed from: https://genderlinks.org.za/casestudies/lesotho-male-councillor-campaigns-for-safe-abortion/ and https://genderlinks.org.za/news/lesotho-unsafe-abortions-leading-to-high-maternal-mortality/

Safe abortion campaign Zimbabwe[60]

Zimbabwe's Safe Abortion Coalition has developed an advocacy tool named Safe Engage to collect data, package evidence and summaries, and provide facts on abortion. Nationally, and despite restrictive laws in Zimbabwe regarding the termination of pregnancy, the coalition remains determined to engage women and girls about their rights. This includes letting them know when they can access abortion services and empowering them to use this right free of stigma. The coalition also aims to empower women and girls with knowledge on the right to post-abortion care and equip them with necessary information on how to access these services.

Women in Zimbabwe worry that the law does not refer to marital rape or statutory rape, which means they cannot be grounds for termination.

After meetings with multiple stakeholders, the coalition determined that many women in Zimbabwe want access to safe abortion, specifically to reduce the number of deaths that result from clandestine abortions. Thus, they have called on the authorities to broaden the circumstances that allow for it.

Government has made strides in protecting women through legal post-abortion care. The Ministry of Health and Child Care conducted training on MVA and added misoprostol to the essential drugs list in 2011. They introduced training on the use of misoprostol for post-abortion care in 2013 and amended the National Guidelines for Comprehensive Abortion Care in Zimbabwe in 2014 to ensure that primary care and public facilities provide post-abortion care.

[60] https://genderlinks.sharepoint.com/:w:/r/programmes/alliance/_layouts/15/Doc.aspx?sourcedoc=%7B3AB23149-A6F2-4DD9-94E7-4F2E28FF6FB2%7D&file=Zimbabwe%20Safe%20abortion%20campaign%20report.docx&action=default&mobileredirect=true

Statement on International Safe Abortion Day (ISAD) by SAfAIDS

On 1 October 2019, SAfAIDS released the following statement on ISAD:
"As we commemorate ISAD 2019, SAfAIDS urges policy makers to exercise their obligation of ensuring policy spaces facilitate access to safe abortion by ALL women. Policy makers have an enshrined duty to enable adolescent girls and young women to enjoy their fundamental right to freedom of choice, autonomy, and physical and psycho-social wellbeing. Beyond moralization and judgement; denial of access to safe, legal and unrestricted abortion services is a direct contradiction to the pursuit of Saving Lives, Preserving Dignity and the Human Development agenda of all States. A win-win is enjoyed by both States and their communities and populace, where safe abortion access, and contraceptive access, is effected. More girls and young women completing their education, less women dying due to unsafe abortion related complications, lowered burden on health economies, and increase in young women contributing to socioeconomic development of their communities - are among the bigger picture wins, pivotal to this SRHR advocacy agenda.

A regional rapid assessment conducted by SAfAIDS (2019) in 16 SADC Member States illustrates that 14 out of 16 States have restricted laws for provision of safe abortion, and in the same States maternal deaths due to unsafe abortion are as high as 30%. This year's ISAD theme, "Abortion is Healthcare," is timely and fitting, to emphasise and reaffirm the global sexual and reproductive health and broader public health sector's commitment to effectively addressing consequences of unsafe abortion including high incidence of maternal mortality, morbidity and disability. This year's theme is relevant to the global efforts aimed at advancing SRH rights though Universal Health Coverage, Sustainable Development Goals, and ICPD25. At the SADC level, the theme



Rouzeh Eghtessadi is the executive director of SAfAIDS.
Photo courtesy of Twitter

aligns with the SRHR Strategy (2019-2030). Providing access to safe abortion has a direct benefit of keeping the girls in schools and achieving SDG4, reducing inequality and contributing to national development. Provision of safe unrestricted abortion services has proven to contribute to macro-economic development.

SAfAIDS joins like-minded stakeholders in commemorating ISAD 2019, by calling on SADC Member States to address restrictive policies for provision of safe abortion services. SAfAIDS has amplified this advocacy agenda for adolescent girls and young women, through a Regional "My Choice: Our Choice" Campaign on Ending Unsafe Abortions. To commemorate ISAD 2019, SAfAIDS is collaborating with Gender Links under the banner of the SADC Gender Protocol Alliance to amplify and increase national and regional deliberative advocacy for removal of policy restrictions to access safe and legal abortion SADC.

Source: Rouzeh Eghtessadi, Acting Executive Director, SAfAIDS, 2019

My Body My Choice campaign

In 2018, activists launched phase one of the My Body My Choice campaign in South Africa to advocate for abortion rights.[61] Despite the fact that South Africa has one of the most liberal abortion laws in the world, more than 50% of the 260 000 abortions performed every year remain illegal and probably unsafe. Activists designed the campaign to raise mass awareness about issues facing women and girls who seek abortion, such as stigma, poor infrastructure, and refusal of health care professionals to perform abortions.

Together with partners - including Gender Links, Marie Stopes SA, Section 27, Sonke Gender Justice, Amnesty International South Africa, the South African Human Right Commission, Health-e News, Ibis Reproductive Health, Ipas, Médecins Sans Frontières, Nalane for Reproductive Justice, Sexual and Reproductive Justice Coalition, and Treatment Action Campaign - the campaign mobilised experts in the industry to raise their voices, spread the word on abortion practices, and call for reforms and an end to abortion stigma.

Employing a multimedia approach, the campaign made use of the voices of influencers, subject matter experts, and the public to generate mass awareness. In the first phase, the campaign reached 1.4 million people through a short documentary aired on eNCA. The campaign then reached more than 36 million people through messaging across numerous social media platforms. The first phase also included the production of radio, TV and print media spots, including ads, a docu-drama series, and talk show appearances on community radio.

On International Safe Abortion Day, the campaign ran activities such as a youth panel discussion, a theatre production, and a solidarity march to raise awareness of abortion and reproductive health justice with 600 participants. In a major development, South Africa's health department developed comprehensive guidelines on abortion care.



Women enjoy the artwork at the My Body My Choice Safe Abortion Exhibition in South Africa in 2019. Photo: Thato Phakela

The campaign also took off in Botswana, where youth mostly connect and interact using Facebook, Twitter, and WhatsApp. National and local level administrators run the campaign in collaboration with local councils. The activists hope that with increased youth involvement they can explore peer education as a sustainable way to create change.



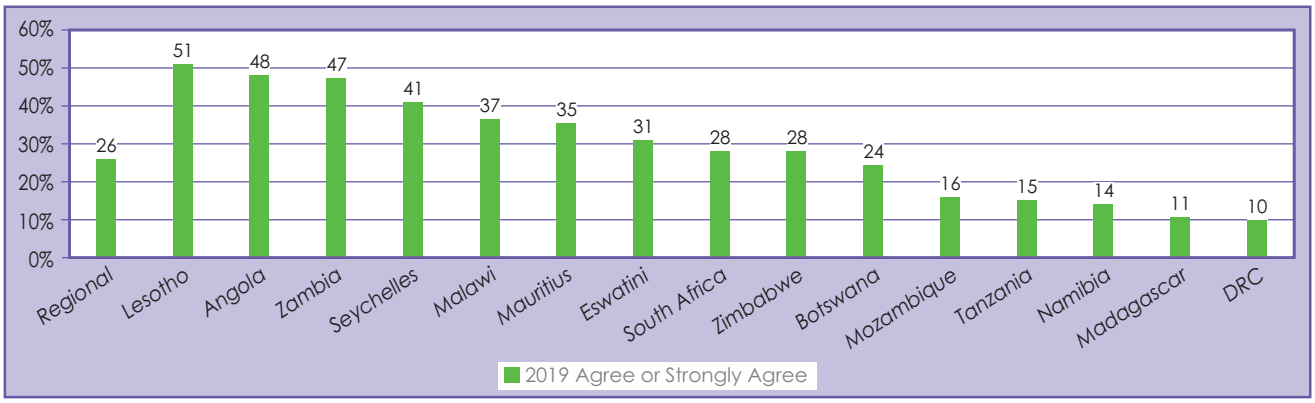
In **Madagascar**, the National Human Rights Commission hosted a conference on the theme "safe abortion in healthcare" at the University of Antananarivo. Other NGOs, such as the Institut Pasteur, joined in coordinating it. Even though abortion remains illegal and tightly restricted in the country, the university often uses its platform to host debates on contentious topics. The conference emphasised that the ultimate aim is to see Madagascar reach zero abortions: that is, all pregnancies would be wanted, and all children born desired by their parents. In the meantime, it remains necessary to draw attention to the high number of unsafe abortions in the country and the high cost in women losing their lives.[62]

[61] https://globalhealthstrategies.com/blog/impact/my-body-my-choice-campaign/
[62] https://www.safeabortionwomensright.org/madagascar-national-debate-on-abortion-law-reform-has-resumed/ accessed 26 April 2020.

Changing attitudes

SADC Gender Protocol Alliance partners regularly conduct attitude surveys to gauge, and measure changes in, public opinion on relevant issues. Some questions help guide advocacy efforts. For example, the findings on the statement, "A woman should be able to choose to terminate a pregnancy in the first three months of her pregnancy" suggest that there is need for continued discussion and debate on this issue to raise awareness about women's sexual and reproductive rights.

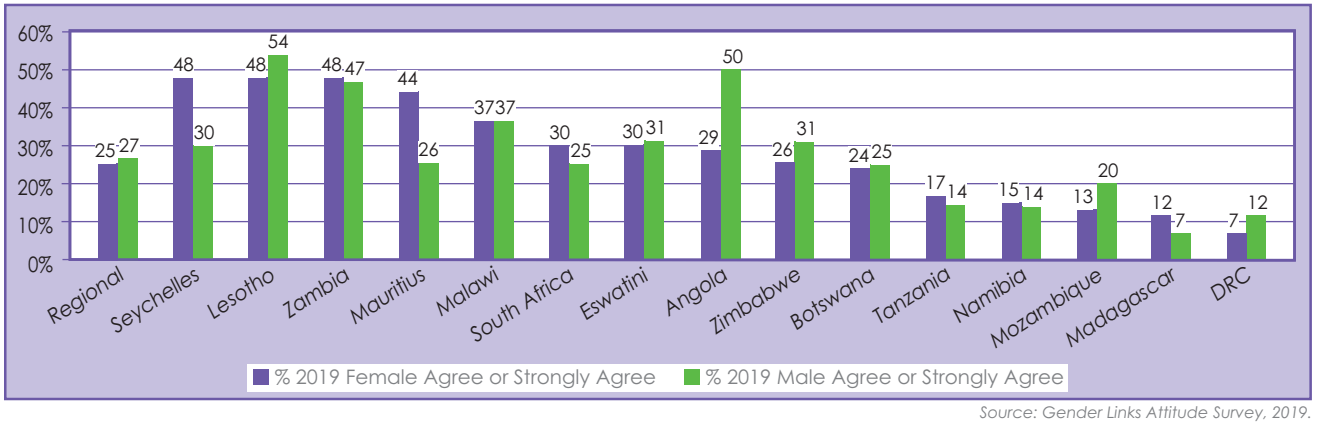
Figure 4.1: A woman should be able to choose to terminate a pregnancy



Source: Gender Links Attitudes survey, 2019.

Figure 4.1 shows that the 2019 regional average of those who agree or strongly agree that a woman should be able to choose to terminate a pregnancy in the first three months sits at just 26%. This ranges from highs encompassing half of people in Lesotho (51%), Angola (48%), and 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 still exist in relation to abortion.

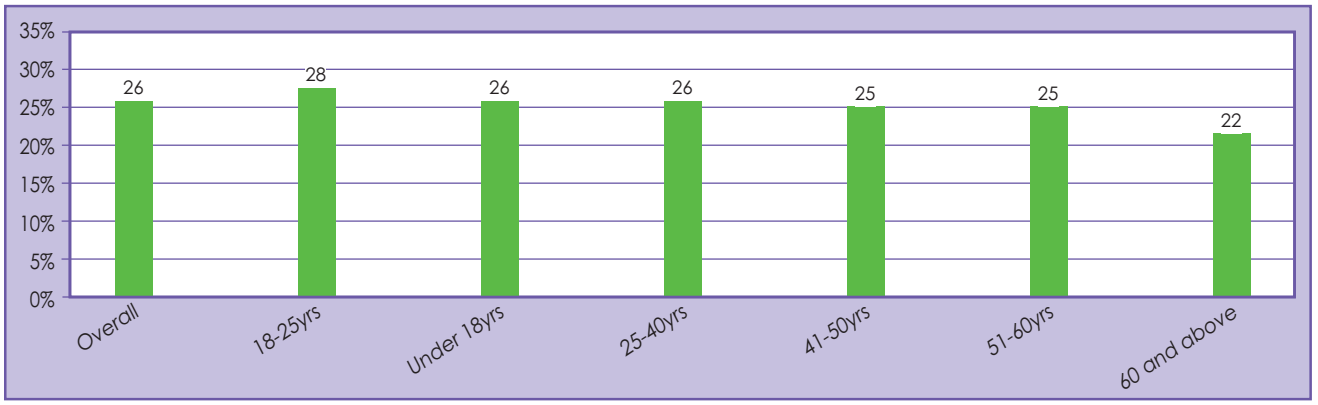
Figure 4.2: Attitudes on abortion by sex



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. Women are more likely to agree or strongly agree that a woman has a right to terminate a pregnancy in the first three months in Madagascar, Mauritius, Namibia, Seychelles, South Africa, and Tanzania. In other countries more men agreed or strongly agreed, particularly in Angola, DRC, Mozambique and to a lesser extent in Lesotho and Zimbabwe.

Figure 4.3: Safe Abortion Score 2019



Source: Gender Links Attitudes survey, 2019.

Figure 4.3 shows the regional responses to the same question on abortion, disaggregated by age. Interestingly, little distinction exists between age bands, with the highest agreement being in the 18-25 age group at 28% and the lowest in the 60 and older group at 22%. This underscores the point that conservative views remain entrenched in all age groups. Research in the SADC region consistently shows that conservative cultural, moral, and religious attitudes continue to fuel abortion stigma.

SADC: Thawing of attitudes on safe abortion in political discourse

There is however growing evidence of changing political discourse on safe abortion. Social media has aided this process, expanding access to information, and providing new opportunities for civil society engagement and campaigning that advocates for SRHR and legalised abortion.

Women Members of Parliament held the first Women's Parliament in the Seychelles in July 2017. The Mahe Declaration made strong recommendations for greater parliamentary involvement in the ratification and domestication of relevant international and continental instruments relating to women, girls, HIV and SRHR. Parliamentarians committed to review, revise, amend or repeal all laws, regulations and policies including cultural and religious practises and customs that have a discriminatory impact on youths, especially girls and young women. In November 2018 SADC Health ministers adopted a ground-breaking SRHR Strategy and Scorecard 2019-2030. The outcomes include maternal and neonatal mortality; GBV; safe abortion; teenage pregnancy; universal access to SRHR; strengthened health

service; enabling environment for adolescent and youth access to SRHR; and removing all policy, cultural, social and economic barriers.

Programmes such as the SADC Parliamentary Forum SRHR project encourage increased political discourse on SRHR, although this remains largely driven by a genuine commitment to reducing maternal mortality. Often, instead of tackling the topic of abortion, discourse tends to focus on addressing unintended pregnancy, particularly for adolescent girls and young women, by expanding access to SRHR information and contraception.

But examples from several countries show that an increasing number of SADC leaders have come out in favour of reform to the region's existing abortion laws. This gives activists hope that consensus may be building for real change on this issue across the region.



Competing petitions from advocates for and against abortion stoked debate in **Namibia** in July 2020. The issue has divided lawmakers, forcing discussion on the issue in a country long known for its conservative views on abortion.

Parliamentarians in Namibia debated the issue in July 2020 after receiving petitions from both pro- and anti-abortion advocates. Activist Beauty Boois submitted an open letter to the government on 29 June 2020 in support of legalising abortion signed by 35 000 Namibians. Boois called on the government to take the issue forward by focusing on facts and human rights. Namibia's First Lady, Monica Geingos, also tweeted out her support, noting that "this discussion needs evidence-based arguments."



Namibia's First Lady, Monica Geingos, joined the debate on Twitter, writing: "Sexual activity, whether by choice or coercion, without the use of effective contraceptives, is the 'root cause' of unintended pregnancy. The decision to remain pregnant, or not, is about reproductive autonomy. Saying women seek an abortion 'for fun' is gaslighting." *Geingos is UNAIDS Special Advocate for Young Women and Adolescent Girls; a qualified lawyer and a businesswoman.*

Meanwhile, parliamentarian Mandela Kapere used Facebook to air his thoughts, noting in June that "access to safe abortion should be an option available for any woman in this day and age, not only the wealthy." Esther Muinjangue, Namibia's deputy health minister, said she wants to see parliament have a debate on the issue and "make informed decisions." Parliament planned to debate her motion in mid-July, even as the country's gender minister, Doreen Sioka, came out against legalisation.[63]



In **Botswana**[64], groups have been advocating for policy and legal reforms for the decriminalisation of abortion to curb the avoidable death toll resulting from these illegal abortions. A 2018 *Sunday Standard* article attempted to sensitise policymakers on this issue and the need for safe abortion facilities. The article noted that women seeking abortions have often been swindled; sold placebos and vitamins under the pretext that they are buying antibiotics. The article targeted ministry of health officials, eager that they understand the urgent need for safe abortion in public health institutions.

Botswana law currently specifies that women can only terminate pregnancies deemed harmful to the mother, or those that result from rape, defilement, or incest. The health ministry has said it will launch an inquest on how to approach the abortion issue as well as run a national referendum to find out what the public wants and needs. Alfred Madigele, minister of health and wellness, stated "The Ministry is

[63] https://www.we.com.na/news/focus-abortion-debate-on-rights-not-religion2020-06-30
[64] Excerpt from a submission for the SADC Protocol @Work Summit 2019 by Ruth Kedikilwe a Journalist who writes for Sunday Standard Botswana.

considering having a conversation around legalising selective abortions. This is because we record a number of unsafe abortions and we will have to turn that around."



Abortion pills on display in Botswana. Photo: Keletso Serowe



In response to high maternal mortality due to unsafe abortion in **Lesotho**, the government has been consulting with schools, religious leaders, communities, and civil society involved in health. These discussions led to a partnership with UNFPA to teach rural women to administer their own injectable contraceptives. The government is also advocating for the free distribution of contraceptives in high schools and sex education for students. Activists have pushed the government to go further, however, noting that these steps will reduce the demand for abortion but not eliminate it. In September 2018, the Lesotho Times reported that the government had been consulting religious leaders since 2007 to get their support in relaxing Penal Code specifications on abortion. This dialogue led to the 2010 amendment allowing a woman to terminate a pregnancy to save her life. Since then, the government has continued to push religious leaders to accept further amendments to the code. The article quoted a minister who noted that legalising abortion remains "tricky because of resistance" from the country's churches.



In **Zimbabwe**, several parliamentarians have spoken in favour of relaxing abortion regulations and addressing the negative effects of current laws on the country's women and girls. This includes Jessie Majome, who advocates for reform, noting to Reuters that "I am concerned about the practical difficulty which often makes it impossible to access termination on legal grounds, especially for low-income victims."[65] The head of the parliamentary committee on women and youth, Priscilla Misihairabwi-Mushonga, has also toured the country to hear first-hand accounts from teenagers who wanted an abortion but could not access it. Though this is not conclusive, it illustrates that lawmakers have been looking into the matter and understand that there is a need to reassess the existing laws, with particular emphasis on preventing teenage maternal mortality.

Advocacy and campaigns during COVID-19

Advocacy and campaigns during COVID-19 The advent of COVID-19 has meant that governments and organisations have diverted resources usually used for SRHR to tackle the pandemic. The Alliance had to postpone all 2020 #VoiceAndChoice summits due to COVID-19. This is especially problematic because of fears that more women than ever will have no choice but to access unsafe abortions during the pandemic due to closures of other health facilities and safe abortion clinics in many parts of the region.

[65] https://www.reuters.com/article/us-zimbabwe-abortion-law/as-teenagers-die-zimbabwean-lawmakers-call-for-abortion-reform-idUSKBN1IA00J

Next steps

Urgently addressing the factors that continue to fuel demand for abortion is the only way to reduce maternal mortality linked to it. This includes increasing access to safe abortion. Especially during the COVID-19 pandemic, this means ensuring that governments define access to comprehensive SRH services as an essential service for all, irrespective of age, socio-economic status, or any other factor.

Key recommendations and next steps include:

- SADC governments must acknowledge the high levels of unsafe abortion and implement urgent measures to reduce the need for abortion, particularly amongst younger women, including through:
  - Finding innovative ways to ensure that comprehensive sex education is always available for both boys and girls, including during COVID-19.
  - Expanding access to modern contraception for all, especially women in groups that governments often overlook, such as sex workers, those in remote communities, the disabled, and poorest.
- Community leaders and health care professionals need to pay attention to the high levels of stigma that prevent young people and other marginalised women from accessing SRH services. These groups must find better ways of engaging with those who need services, including by reviewing legislation and provision of services to make safe abortions more readily available.
- All SADC member states should ensure they have adequate guidelines for health practitioners that clearly outline the conditions under which safe abortions can occur.
- SADC governments should make conditions for accessing safe medical abortion easier by, for instance, relaxing the required number of doctors for sign-off from three to one and ensuring that women who report having been raped can access safe abortion without needing to prove they have been raped.
- To save lives, SADC member states should provide post-abortion care to all women with abortion complications.
- All SADC governments should increase the number of health facilities that offer safe abortion.
- Activists and political leaders need to work together to address negative attitudes about abortion in the region, especially among health personnel, whose role legally obliges them to provide abortion or post-abortion care services.
- There is an urgent need for much better data to inform decision-making on the issue of abortion. Data needs to include: access (or lack of 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; and rate of unsafe abortions.

Alliance networks met virtually throughout April and May 2020 to discuss SRHR in the context of the COVID-19 pandemic. Due to social distancing, it is imperative that they continue to find new measures to keep youth engaged and educated. This includes looking into training service providers to interact with youth, investigating self-administration of contraceptives, and migrating advocacy campaigns online and to social media where youth interact.

Longer term actions could include:

- Utilising established traditional institutions in communities such as chiefs and *anamkungwi* (older women and instructors) to convey campaign messages;
- Develop hotspots in communities for youth and service providers to interact to reduce hospital visits and public transport use during the pandemic; and
- Advocate for decentralisation of abortion care services, which many systems currently only provide in district hospitals.