# Safe Abortion 4




March for safe abortion outside Parliament in Namibia. Photo: Gender Links

## KEY POINTS

- Africa has the highest rates of unintended pregnancies in the world at 91 per 1000 women aged 15 to 49, as compared to 35 per 1000 women in Europe and North America. This region has the highest pregnancy rate overall (218 per 1,000)[1].
- 89% of unintended pregnancies in Sub-Saharan Africa occur among women with unmet need for contraception: 11% result from failure of a modern method[2].
- The abortion rate in Africa has increased from 27 per 1000 women aged 15 to 49 to 33, representing a 24% increase since 1990[3].
- Unsafe abortions affect mostly poorer, unmarried women and adolescents fuelling high maternal mortality rates in the region.
- US President Joe Biden rescinded the Global Gag Rule, enabling resumption of US government funding for the United Nations Fund for Population Activities (UNFPA).
- Disruptions resulting from the COVID-19 pandemic were not as dire as the UNFPA had initially predicted. But the pandemic led to increases in unwanted pregnancies and demand for safe abortion, while slowing down campaigns for safe abortion.
- There is debate on whether to advocate for decriminalisation of abortion or legislation for safe abortion, a medical procedure that should be available to all women.

[1] Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019 Lancet Glob Health 2020; 8: e1152-61 https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X%2820%2930315-6.pdf, accessed June 12, 2021
[2] Ibid
[3] Ibid

# Introduction

Every woman, irrespective of age, locality, socioeconomic or any other status, should have the inalienable right to decide whether to have a child, when to have a child, how many children to have and with what spacing between those children. And yet many women do not enjoy this right. Often those who are least able to make and act on such decisions are poor, rural and young. Unintended pregnancies result from unplanned and often non-consensual sex or from absence or failure of contraception. The Southern African Development Community (SADC) Sexual and Reproductive Health and Rights (SRHR) Strategy notes that 24% of all pregnancies in Southern Africa end in abortion.

Ironically, abortion is one of the safest medical procedures if done following the World Health Organization's (WHO) guidance[4]. Conversely, unsafe abortion is the cause of at least one in six maternal deaths[5]. The WHO has shown that the broader *the legal grounds for abortion, the fewer deaths there are from unsafe abortions*.[6]

Throughout SADC and beyond many activists have joined forces over many years to build coalitions, conduct workshops, lobby with traditional and religious leaders, march and petition for changes to the legislation on abortion. These vibrant coalitions must regroup after every election as they begin again to develop relationships with new parliamentarians.

They are up against well-funded conservative groups that fuel the opposition to abortion. This is a highly emotive issue with strong opinions, morality and religious fervour brought to the debate. When other crises, such as COVID-19, become more pressing, the abortion issue is pushed to the back burner. Even though abortion is regulated by such a maze of laws, with hefty sentences for both the woman who seeks the abortion as well as providers of abortion, many women still procure abortions.

In reality, abortions occur in virtually every country in the world. Even where the legal framework is extremely restrictive women chose to terminate unintended pregnancies. The major difference is that where abortions are legal women have access to safe abortions. A restrictive legal environment on the other hand drives women to use unsafe and even dangerous abortion options with heavy consequences for their physical and mental health. Many countries which restrict access to legal abortion services provide post abortion care, which is invariably much more expensive.

The World Health Organization (WHO) distinguishes abortions into




**SAFE:** Carried out (1) using a method that is recommended by World Health Organisation (WHO), that is appropriate to the pregnancy duration, and (2) when the person carrying out the abortion has the necessary skills.



**LESS SAFE:** When only one of the criteria above is met.



**UNSAFE:** When carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.



**DANGEROUS** or **LEAST SAFE:** Do not meet either of the criteria and involve ingestion of caustic substances or untrained persons use dangerous methods.[7]

4 World Health Organisation. Safe abortion: Technical and policy guidance for health systems. Geneva: WHO; 2012. [Google Scholar]
5 Kassebaum N. J., Bertozzi-Villa A., Coggeshall M. S., et al. "Global, regional, and national levels and causes of maternal mortality during 1990-2013: A systematic analysis for the Global Burden of Disease Study 2013" Lancet. 2014;384(9947):980-1004. [PMC free article] [PubMed] [Google Scholar]
6 World Health Organization. Primary Health Care: Now More than Ever. World Health Report 2008. Geneva: WHO; 2008. p. 65.http://www.who.int/whr/2008/whr08_en.pdf [Google Scholar]
7 WHO. Preventing Unsafe Abortion. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion;, accessed 30 May, 2021

A review of research on abortions, which found many more studies in the United States than in other countries, found evidence to link legal abortion to advancement of women in education and the labour market. Women who were denied abortion were less likely to be employed full time, more likely to live in poverty and to require state assistance. The review found that children born after the US Roe Vs Wade ruling were more likely to graduate from college and less likely to be on welfare. The review suggested that this may be the case as parents had children that they wanted and that they were able to invest in. The same review found that less restrictive abortion legislation in Sub-Saharan Africa is associated with more investment in girls' education. It is suggested that parents believe that their daughters are more likely to complete their education.[8]

## US: The Global HER Act revokes the Gag Rule

A critical change in the global context since the 2020 #VoiceandChoice Barometer is the rescinding of the universal Gag Rule on the 28th of January 2021, by United States President Joe Biden in one of his first executive orders on assuming office. Biden stated:

> "Section 1. Policy: Women should have access to the healthcare they need. For too many women today, both at home and abroad, that is not possible. Undue restrictions on the use of Federal funds have made it harder for women to obtain necessary healthcare. The Federal Government must take action to ensure that women at home and around the world are able to access complete medical information, including with respect to their reproductive health."

In one move he restored UNFPA (United Nations Population Fund) funding and reinstated the ability of USAID to fund safe abortion, the first steps in reversing the controversial damage that the Donald Trump administration wrought through an expanded Gag rule for exactly four years. Though the impact for many organisations will take some time to be felt the act will free up at least $7.3 billion in United States funding for global health, a much needed injection for global NGOs working in sexual and reproductive health.[9]

Representatives Barbara Lee, Ami Bera, Jan Schakowsky and Senator Jeanne Shaheen and more than 46 co-sponsors introduced the Global Health, Empowerment and Rights Act otherwise known as the (Global HER Act) introduced to Senate on 28 January 2021. If passed, the Global HER Act will permanently repeal the Global Gag Rule, disallowing any future presidents from enacting the Rule again[10].

Originally imposed in 1984 by the Reagan administration, President Bill Clinton rescinded the Gag Rule in 1993. In 2001 President George W. Bush Jr reinstated the rule, only for President Barack Obama to rescind this in 2009. In 2017 Trump reinstituted a new version of the policy, the worst of them all for global health. The yo-yo effect has made it difficult to plan health efforts across the globe. The Trump administration showed that the Gag Rule could go beyond what many imagined. It jeopardised years of hard work into safeguarding women's lives and reclaiming their rights.

The Global Gag Rule struck beyond abortion, removing funding from organisations such as the International Planned Parenthood Federation (IPPF) who refused to sign the clause on abortion. This affected other programmes, particularly contraception and other aspects of SRHR and maternal health. Ironically, an Act intended to curtail abortion is likely to have reduced access to contraception thus increasing unintended pregnancy and need for abortion.

[8] Rodgers, Y. et al. (2021) 'The macroeconomics of abortion: A scoping review and analysis of the costs and outcomes', PLoS ONE, 16, p. e0250692. doi: 10.1371/journal.pone.0250692, accessed 17 June, 2021

[9] The White House. 2021. Memorandum on Protecting Women's Health at Home and Abroad https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/memorandum-on-protecting-womens-health-at-home-and-abroad/, accessed 30 May, 2021

[10] Congresswoman Barbara Lee. 2021 Lee, Bera, Schakowsky and Shaheen Introduce Legislation to Permanently Repeal Harmful Global Gag Rule https://lee.house.gov/news/press-releases/lee-bera-schakowsky-and-shaheen-introduce-legislation-to-permanently-repeal-harmful-global-gag-rule-, accessed 30 May, 2021

Table 4.1 Comparative Global statistics on Unsafe Abortion

| | Unsafe abortions | | Dangerous %age of all abortions | Risk of dying from unsafe abortion per 100,000 abortions |
|---|---|---|---|---|
| | %age of all abortions | Number million per year | | |
| Global | 45 | 35 | 33 | |
| Africa | 77 | 6,2 | 49 | 185 |
| Latin America | | | 17 | 14 |
| Asia | | | 8 | 16 |
| Europe & North America | | | Undetectable | |

*Source: WHO, Factsheet: Preventing Unsafe Abortion.*

As reflected in Table 4.1, Africa has the highest proportion of dangerous or least safe abortions of any region in the world. The risk of dying from an unsafe abortion is much higher in Africa than in any other region. This rate has declined in the last 20 years, likely as a result of expanded access to safer medication abortions and provision of post abortion care. However, Africa still accounts for 62% of the global deaths resulting from abortion. This is about 15,000 preventable maternal deaths each year.

The costs of abortion care, including ancillary costs such as transport, prevent many women from accessing safe and timely care. Delayed access may result in less safe options. There is little evidence about how adolescents navigate the costs of abortion care.

Traditional unsafe abortion methods used in Sub-Saharan Africa include:[11]

- Substances ingested/inserted
  - Plants/plant-based infusions: Aloe vera/burnt bean ashes/cassava leaves/garlic/gourd/



honey/lime tree root/mango tree seeds/ plectranthus (spurflower)/ papaya-leaf poultice/boiled henna root/ sisal leaves.

- Store-bought non-pharmaceutical items, usually consumed in large quantities: Ammonia-based cleaning products (Handy Andy, Jeyes Fluid)/baking soda/ beer/ blood tonics/brandy/chalk/ Coca-Cola/Maggi cube (concentrated bouillon)/fish poison/ Nescafé/steel wool mixed with Oros-Crush (soft-drink syrup)/ toothpaste.
- Combinations of store-bought and plant-based substances: Bark steeped in alcohol/ lemon juice on a vaginal suppository/plants soaked in alcohol/strong black tea plus chloroquine (antimalarial).

• Pharmaceuticals
  - Over-the-counter, usually in large quantities: Aspirin/Cafemol (caffeine plus paracetamol)/ folic acid/laxatives (castor oil and Epsom salt)/paracetamol/ potassium permanganate (wound cleaner)/snake antidote.
  - Antibiotics; Antimalarials; Deworming agents; Vasodilators Uterotonics Hormonal contraception.
  - Objects inserted into cervix: Cassava sticks, metal rods or wires, scissors, tree roots.

As abortion-related deaths contribute to high maternal mortality across SADC, it is not possible to achieve the SADC Gender Protocol ambition of eliminating maternal mortality.

[11] Bankole, A. et al From Unsafe to Safe Abortion in Sub Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute 2020

Table 4.2: 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** | | | | | | | | | | | | | | | | |
| Abortion on request | Yes | Not specified | No | No | No | No | No | Not specified | No | Yes | No | Not specified | Yes | Not specified | Not specified | No |
| | Penal Code 2017 | Penal Code 1991 | Penal Code 1995 | Penal Code 2004 | Constitution 2005 | Penal Code 2010 | Penal Code 1998, Criminal Procedure Law | Penal Code | Criminal Code Act 2012 | Penal Code 2015 | 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 |
| **Unmet Need for Modern method of Contraception** | | | | | | | | | | | | | | | | |
| % of unmarried sexually active women 25 - 49 with unmet need | 45 | | 58 | 64 | 30 | 22 | 51 | 41 | | 41 | 15 | | 24 | 33 | 43 | 21 |
| % of married women 15 - 49 with unmet need | 39 | | 38 | 40 | 28 | 19 | 29 | 20 | | 24 | 18 | | 15 | 29 | 22 | 11 |
| **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 | 40 | 36 | | 24 | 20 | 26 | 18 | 28 | 41 | 24 | 16 | 33 | 35 | 25 | 47 | 22 |

*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 4.2 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 reasons are very restrictive in most countries, with only South Africa, Mozambique and Zambia having less restrictive legislation.
- 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 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 35% of those polled agree with this statement. However, attitudes on this controversial topic are beginning to change.

This chapter highlights the high rates of unsafe abortions in SADC and the challenges this presents for the region's development against the backdrop of the COVID-19 pandemic and the roll out of vaccinations. The chapter examines the root causes of safe abortion - unwanted pregnancies and unmet contraception needs - that need to remain a primary focus. It presents the international, African and regional normative frameworks relevant to safe abortion, underscoring the many gaps that have resulted in restrictive legislation.

The chapter details ongoing advocacy efforts and gradual changes taking place despite the odds, notably the *My Choice, Our Choice* campaign led by SAfAIDS, the SRHR cluster lead of the Southern African Gender Protocol Alliance. As consensus is built around the need for a model law or guidelines for the region, the chapter introduces an important debate as to what the best legal approach should be: decriminalisation of abortion or introduction of pro-abortion legislation or a combination of the two. In the meanwhile, expanded access to medication abortion is playing a crucial role in providing access to safe, effective, and acceptable abortion care in many regions of the world. Post abortion care, while skirting the real issue, shows that this is a matter that the region ignores at its peril.

## Impact of COVID-19 on unintended pregnancy and abortions

On March 11 2021, the first anniversary of the declaration of COVID-19 as a pandemic, the United Nations Population Fund (UNFPA) released an assessment of the impact of COVID-19 on supplies and distribution of contraceptives compiled with Avenir Health using modelling technology with available data. UNFPA projected at the start of the pandemic that restrictions on movement, disruptions in supply and delivery of contraceptives would overwhelm health facilities. UNFPA also predicted that fear of going to health facilities for routine care would have a drastic impact on women's access to, and use of contraception.

**UNFPA estimates COVID related disruptions resulted in 1,4 million unwanted pregnancies in 2020**

So far, the impact has proved less drastic than feared, occurring mostly from March to May 2020. Thereafter, governments, UNFPA and partners such as Marie Stopes International (MSI), International Planned Parenthood Foundation (IPPF) and DKT International re-established

supplies using swift and innovative approaches. Overall, UNFPA estimates the pandemic disrupted contraceptive use for about 12 million women resulting in about 1.4 million unintended pregnancies during 2020 across 115 low- and middle-income countries[12]. The data is not disaggregated by country, thus it is unclear how many Southern African countries are included in this data. Anecdotal evidence gathered through the Southern Africa Gender Protocol Alliance points to some of the challenges and innovative solutions.



**Madagascar**: When travel restrictions and closures of markets meant that women were not able to move freely and thus to access services MSI Reproductive Choices (formerly Marie Stopes International), got permits for their buses to deliver services to women at their homes and to transport women to receive services at health facilities. This enabled women to continue receiving services safely.[13]



In **Malawi**[14], COVID-19 has seen authorities divert financial, infrastructural and human resources from SRHR. Women have struggled to access family planning services as they would usually receive these at points which are currently inaccessible. This has led to an increase in unwanted pregnancies and an increase in the numbers of women seeking unsafe abortions.

Malawi has one of the highest maternal mortality rates in the world with 18 % attributed to unsafe abortions- an estimated 23 women per 1,000 induced abortions. Clandestine abortions are widespread due to the restrictive nature of the law as and lack of access to safe abortion services, adequate family planning and youth friendly services. Stigmatization is common, leading to delay in seeking post abortion care, increasing mortality.

The National Sexual and Reproductive Health and Rights policy (2017-2022) is the overarching SRHR policy which addresses: family planning, maternal, neonatal and postnatal health, sexually transmitted infections and HIV, reproductive cancers, infertility, young people in reproductive health, obstetric fistula, harmful practices and male involvement in reproductive health.

## COVID lockdowns resulted in increased violence and adolescent pregnancy

Abortion is only allowed in circumstances where the woman's life is in danger by the Malawian penal code (sections 149-151), which also stipulates imprisonment of between 7 to 14 years for abortion related offences.

School going youth have been affected by the school closures, leaving more idle time where they participate in sexual activity that cn result in unwanted pregnancy. The youth were also affected by a lack of peer to peer education having been reduced by the amount of face-time they experience. COVID-19 has created gaps in outreach activities and created fear amongst communities of accessing healthcare as they fear contracting COVID-19. There are also fears that even less money will be directed to SRHR in the next fiscal year, with the pandemic continuing.

In its review of the NGO Gender Coordinating Network, the Malawi focal network of the Southern Africa Gender Protocol Alliance, urged that family planning service providers be trained to provide services to the youth during the pandemic. The network also advocated for strengthening meaningful youth engagement, especially through social media and USSD (Unstructured Supplementary Service Data) platforms and community engagement. "This

[12] UNFPA COVID Impact: What we know 1 year into the pandemic https://www.unfpa.org/sites/default/files/resource-pdf/COVID_Impact_FP_V5.pdf
[13] MSI Reproductive Choices. Stories from the frontline: in the shadow of the COVID-19 pandemic. https://www.msichoices.org/covid-19/stories-from-the-frontline, accessed 20 June, 2021
[14] Gender Links 2021. Malawi Report for the Analysis of SRHR Campaigns - Unsafe Abortions (Impact of COVID-19)

will provide a platform for the youth to assist in structuring the scope, direction and activation of SRHR initiatives. Further, we must leverage innovation and self-administration of SRHR interventions where possible," NGOCC stated.

Stakeholders agreed to:

- Message the campaign through established traditional institutions which are readily available in communities such as chiefs and *anamkungwi* (older women and instructors).
- Develop hotspots in communities for the youth and service providers to interact.
- Advocate for a decentralisation of abortion care services.

In countries and areas that have good Internet and telephone coverage there has been a great expansion of **telemedicine**. Unfortunately, such determined and resilient adaptations underscore the digital divide in which many women and girls are being left behind. For every instance of innovations there are several of girls and women who have not had access to technology and have experienced early, and unintended pregnancy, without recourse. Across the world governments and donors have continued to prioritise delivery of contraceptives to women and this has enabled services to rebound when there are lulls in the COVID-19 waves.

A WHO Pulse Survey on continuity of essential health services conducted in 105 countries released in August, 2020[15] found the most severe disruption of all health services in the Eastern Mediterranean region, followed by Africa and South East Asia, with the least disruption in Europe and West Pacific. The highest levels of disruption in reproductive, maternal, newborn, child, adolescent and nutrition services were in outreach for routine immunisation (18% severe disruption, 53% partial disruption) followed by family planning and contraception (9% severe disruption, 59% partial disruption). The lowest level of disruption was facility based births.

The most recent UNICEF dashboard (March 2021)[16] shows that:

- Three of the 18 countries[17] in East and Southern Africa reported new family planning services compared to pre COVID-19;
- Seven countries reported disruption in family planning services of up to 10%;
- Two countries reported disruption of 25% to 49%; and
- One country reported reduction in services of 50% to 74%.

Although data is not readily available, it is likely that young, unmarried, poor and rural girls and women, those who struggle the most to access contraception in "normal" times due to stigma, attitudes of providers, lack of confidentiality, distance to services and other barriers, suffered more severe disruption of access during COVID-19 than did married, urban and more wealthy women and girls.

A Rutgers report on services for adolescents conducted with partners in two global initiatives (Right Here, Right Now and Get Up, Speak Out for Youth Rights!) in Ghana, Indonesia, Kenya, Nepal, Uganda and **Zimbabwe**, found that almost all adolescents were impacted by extended school closures. While some children, particularly in urban areas, and those from higher socio-economic groups continued learning through Internet, TV and radio based approaches, poor and rural adolescents often did not have this luxury. Further, what lessons were available focused on the "hard core" subjects and comprehensive sexuality education was not often part of this.

Adolescents were also not able to participate in school clubs and other groups through which they access accurate information. The study found that telephone hot lines, the Internet and Whats app provided the most available source of information. Even NGO sensitisation services have migrated to online formats which are

[15] WHO. August 2020. Pulse Survey on Continuity of Essential Health Services during the COVID-19 pandemic. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1, accessed 18 June, 2021
[16] UNICEF. 2021. Tracking the situation of children during COVID-19. Dashboard. https://data.unicef.org/resources/rapid-situation-tracking-covid-19-socioeconomic-impacts-data-viz/, accessed 17 June, 2021
[17] Does not include two SADC countries; Angola and DRC; does include four East African countries: Kenya, Uganda, South Sudan, Ethiopia, Somalia

available to some but not all young people. Although some contraceptives, especially condoms and injectables are still available to young people, there are limitations such as: condoms which were previously available for free must now be bought from a pharmacy, during the day due to curfews.



Junior councillors in Zimbabwe, who provide peer support, have had to scale down their SRHR campaigns during the pandemic. Photo: Colleen Lowe Morna

Many young people reported that it was now more difficult to obtain contraception. Overall, one young Zimbabwean woman said, "I feel that things are out of control and out of my hands, because I had plans at the beginning of the year. I would have done something in June, but then COVID-19 broke out and now, due to the restrictions, I cannot travel to South Africa, which is what I planned to do. I also wanted to travel to Harare, but have had to put that on hold as well. I don't know any more when COVID-19 will end, and this leaves me with so much uncertainty about the future."[18]

Due to lack of peer groups, young people reported less information about and less access to safe abortion services, leading to greater dependence on unsafe methods. Twenty nine percent of young men[19] and 35% of young women in Zimbabwe perceived themselves as being at risk of physical, emotional or sexual abuse. The survey found that gender based violence, including forced sex increased during the lockdowns. There has been marked increase in adolescent pregnancy reported across the region, as young girls were at home, without the protection afforded by being at school.

Using data about increases in teenage pregnancies in Sierra Leone during school closures from the Ebola crisis, World Vision has estimated that up to one million girls in Sub-Saharan Africa will fall pregnant during the COVID-19 related school closures.[20] This is corroborated by a news report in Namibia in November 2020, in which the Ministry of Education, Arts and Culture confirmed that at least 3 323 girls were impregnated during the lockdown from March to July. As 25,235 children did not return to school when schools re-opened, the number that failed to do so due to pregnancy could be much higher.[21]

## Unintended pregnancy - the root cause of abortion

The root cause of abortions is unintended pregnancy. This may be the result of unprotected sex between two consenting people. Lack of protection may be from lack of adequate knowledge, or preparation or unavailable or inaccessible protection. It may also be the result of coerced sex (rape), in exchange for money or other favours. The consequences of an unintended pregnancy, particularly for a young, unmarried adolescent girl or woman include: being rejected by school or other educational/ training institutions and forced to withdraw, being

[18] Both, R. et al. 2021. I feel that things are out of my hands. Utrecht, the Netherlands. Rutgers. Rutgers SRHR & COVID 19 Report_International Study.pdf, accessed 21 June, 2021
[19] Studies on Violence against Children show that boys are at higher risk of physical violence (bullying, beating, fighting) than girls, and at risk of verbal / emotional abuse. They also suffer sexual abuse but at much lower rates - or at least lower reported rates - than girls.
[20] World Vision. 2020. COVID-19 Aftershocks: Access Denied. Teenage Pregnancy threatens to block a million girls from Sub-Saharan Africa from returning to school. www.wvi.org/sites/default/files/2020- 08/Covid19%20Aftershocks_Access%20Denied_small.pdf.
[21] The Namibian. 2021. 3 300 schoolgirls pregnant after Covid lockdown https://www.namibian.com.na/206504/archive-read/3-300-schoolgirls-pregnant-after-Covid-lockdown, accessed 16 July, 2021

rejected by family, friends and faith community and losing opportunities for improved livelihood possibilities.

Even where laws allow girls who have been pregnant to return to school, this may not be possible without support in raising and caring for the child. Stigma and unwelcoming attitudes in the schools or educational institutions may also make return to school difficult. Adolescent mothers are prone to higher rates of maternal depression than older women; experience higher rates of HIV transmission and are also more likely to experience obstetric problems such as fistula. Pregnancy in adolescents is often a precursor of child marriage. Older women may not be able to care for another child or feed another mouth. The result is that even where abortion is illegal many women - adolescents, young women and older women still make the choice to access abortion. Addressing abortion must therefore be accompanied by efforts to reduce the rates of unintended pregnancy. Thus, Chapter Three which focuses on adolescent SRHR and Chapter Two on SRH in general must be considered with this chapter.

Rates of unintended pregnancy and unmet need for contraception are derived from Demographic Health Survey (DHS) survey data. MSI estimates that globally 218 million women want to access contraception but are not able to[22] and Guttmacher institute estimates that this contributes to 121 million unintended pregnancies annually, which is equivalent to a rate of 64 per 1000 women aged 15 to 49 between 2015 and 2019[23].

Increasing access to contraceptives reduces unintended pregnancy, decreasing demand for abortion

Table 4.3 Selected Data on Fertility, Age first sex and first marriage from available DHS data

| Country and year | Total fertility rate (lifetime births per woman*) | Total wanted fertility rate (lifetime births per woman)† | Difference total fertility rate and total wanted fertility rate | % of recent births unplanned | Median age at first sex | Median age at first marriage | Difference of median age at first sex and first marriage |
|---|---|---|---|---|---|---|---|
| Mozambique, 2011 | 5,9 | 5,2 | 0,7 | 16 | 16,1 | 18 | 1,9 |
| Madagascar 2008-9 | 4,8 | 4,2 | 0,6 | 13 | 17,1 | 18,2 | 1,1 |
| Malawi 2015-16 | 4,4 | 3,4 | 1 | 43 | 17,4 | 18,6 | 1,2 |
| Zimbabwe, 2015 | 4 | 3,6 | 0,4 | 35 | 18,6 | 19 | 0,4 |
| DRC, 2013-2014 | 6,6 | 5,7 | 0,9 | 32 | 17 | 19,3 | 2,3 |
| Tanzania 2015-16 | 5,2 | 4,5 | 0,7 | 34 | 17,5 | 19,7 | 2,2 |
| Zambia, 2018 | 4,7 | 4 | 0,7 | 38 | 16,9 | 19,8 | 2,9 |
| Angola 2015-16 | 6,2 | 5,2 | 1 | 35 | 16,7 | 20,4 | 3,7 |
| Lesotho, 2014 | 3,3 | 2,3 | 1 | 52 | 18,5 | 21 | 2,5 |
| Comoros, 2012 | 4,3 | 3,8 | 0,5 | 33 | 21,1 | 21,1 | 0 |
| Eswatini, 2006-7 | 3,8 | 2,1 | 1,7 | 67 | 18,2 | 25,6 | 7,4 |
| Namibia, 2013 | 3,6 | 2,9 | 0,7 | 53 | 19,2 | 30,4 | 11,2 |
| South Africa 2016 | 2,6 | 2 | 0,6 | 55 | 18 | 31 | 13 |

*Source GL adapted from Unsafe to Safe Abortion in Sub Saharan Africa: Slow but steady progress.*[24]

[22] MSI Reproductive Choices. Making Choice Possible. https://www.msichoices.org/, accessed June 14, 2021
[23] Bearak et al, 2020. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019 Lancet Glob Health 2020; 8: e1152-61 https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X%2820%2930315-6.pdf, accessed June 12, 2021
[24] Ibid

Table 4.3 shows a growing gap between median age of sexual debut and median age of marriage. This is lowest in Comoros where there is no gap and Zimbabwe where the gap is 0.4 years and highest in Namibia and South Africa with gaps of 11,2 and 13 years respectively. This gap is consistent with an increase in the median age of first marriage which is lowest at 18 in Mozambique and highest at 31 in South Africa. Table 4.3 also illustrates a shift in total wanted fertility rate which is highest at 5,7 in DRC and 5,2 in Angola and Mozambique and lowest in South Africa (2), Eswatini (2,1) and Lesotho (2,3). There is also a gap between wanted fertility rate and actual fertility rate which is highest in Eswatini (1,7) and lowest in Zimbabwe (0,4). This is reflective of an intersection between what women want and how they are able to act on those choices which is partly a result of access to contraception and is also mediated by other factors.

The growing gap between age of sexual debut and of marriage increases need for contraception in unmarried women

## Abortion around the world, in Africa and in SADC

Similar to the variations found in SADC, globally legislation on abortion varies from very liberal to highly restrictive. Many abortions are procured in secret to avoid the penalties which range in SADC from three years imprisonment in Botswana and Lesotho to fourteen in Seychelles and Malawi. Little accurate information on abortions is available which makes collection of data on abortions very difficult. The Guttmacher Institute has developed modelling approaches to estimate the number of abortions in any country or region and has been refining these as new information becomes available. Estimates tend to be available in five year time bands. A 2020 report published in the Lancet provides information on both unintended pregnancies and abortion rates from a database that covers 166 countries (previous estimates were made on the basis of information from 92 and 105 countries). This report estimated that 73,3 million unintended pregnancies per year ended in abortion which is a rate of 39 abortions per 1000 women aged 15 to 49. The report examined abortions and abortion rates across geographic regions and World Bank economic bands.

Legal abortion is linked to advancement of women

[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: Comparative data on abortion1990-4 and 2015 - 19

| Region | Unintended Pregnancy Rate per 1000 women aged 15 - 49 | | | Abortion rate per 1000 women aged 15 - 49 | | | Unintended pregnancies ending in abortion | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1990 - 4 | 2015-19 | Change | 1990 - 4 | 2015-19 | Change | 1990 - 4 | 2015-19 | Change |
| World | 79 | 64 | -18% | 40 | 39 | -3% | 52 | 61 | 18% |
| Sub-Saharan Africa | 103 | 91 | -12% | 27 | 33 | 24% | 26 | 37 | 41% |
| W Asia & N Africa | 126 | 86 | -31% | 61 | 53 | -14% | 48 | 61 | 25% |
| Central & South Asia | 89 | 64 | -28% | 40 | 46 | 15% | 45 | 72 | 59% |
| East & South East Asia | 60 | 58 | -4% | 38 | 43 | 13% | 63 | 74 | 16% |
| Latin America | 94 | 69 | -27% | 35 | 32 | -8% | 37 | 47 | 26% |
| Europe & N America | 67 | 35 | -47% | 46 | 17 | -63% | 69 | 49 | -29% |
| Australia & New Zealand | 42 | 38 | -9% | 19 | 25 | -19% | 45 | 41 | -11% |
| Rest of Oceania | 82 | 78 | -4% | 22 | 34 | 51% | 28 | 44 | 54% |

*Source: Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019.*[25]

Table 4.4 shows that Africa has the highest rates of unintended pregnancies in the world at 91 per 1000 women aged 15 to 49, as compared to 35 per 1000 women in Europe and North America. The region also has the highest pregnancy rate overall (218 per 1,000) which represents a decline of 12% since 1990. The proportion of pregnancies reported as unintended is actually lowest in Sub-Saharan Africa, at 42%. But 89% of unintended pregnancies in Sub-Saharan Africa occur among women with unmet need for contraception, with 11% resulting from failure of a modern method. The abortion rate in Africa has increased from 27 per 1000 women aged 15 to 49 to 33: a 24% increase. Oceania (without Australia and New Zealand) experienced the highest rate of increase while the highest rate of decrease occurred in Europe and North America. With abortion rates of 17 per 1000 among women aged 15 to 49, these regions now have the lowest abortion rates in the world.

Africa has the highest rates of unintended pregnancies in the world

Table 4.5 Abortion 1990-4 and 2015 - 19 by legality of abortion

| | Unintended Pregnancy Rate per 1000 women aged 15 - 49 | | | Abortion rate per 1000 women aged 15 - 49 | | | Unintended pregnancies ending in abortion | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1990 - 4 | 2015-19 | Change | 1990 - 4 | 2015-19 | Change | 1990 - 4 | 2015-19 | Change |
| Abortion broadly legal (excluding India & China) | 76 | 50 | -34% | 46 | 26 | -41% | 61 | 53 | -13% |
| Abortion restricted | 91 | 73 | -20% | 33 | 36 | 12% | 36 | 50 | 39% |
| Abortion prohibited | 110 | 80 | -27% | 35 | 40 | 11% | 32 | 50 | 52% |

*Source: Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019.*[26]

The data in table 4.5 suggests that countries in which abortion is broadly legal also have more available and accessible sexual and reproductive health services overall, reducing the rates of unintended pregnancy. Conversely countries where abortion is restricted and even

[25] Bearak, J. et al Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990-2019 Lancet Glob Health 2020; 8: e1152-61 https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X%2820%2930315-6.pdf, accessed June 12, 2021
[26] Ibid

prohibited have fewer and less accessible SRHR services, resulting in higher rates of unintended pregnancy. This converts to higher rates of abortion, despite the legal restrictions, and similar proportions of unintended pregnancy ending in abortion regardless of whether abortion is legal or not.

In the period 2015-2019, the abortion rate in Sub-Saharan Africa is estimated as 33 per 1,000 women aged 15-49, with little variation across the continent. *This rate has been relatively stable over the past 25 years.* However, the total number of abortions has increased significantly as the total population has grown over the same period. The annual number of abortions is estimated to have increased from 4.3 million to 8 million between 1995-1999 and 2015-2019. Abortion rates are higher in urban than rural areas, in younger women than older women and in more wealthy than poorer women. This may indicate that urban and more wealthy women have greater access to those abortion services that are available.






## Better dead than mocked

In eastern DRC, most unwanted pregnancies are a result of sexual violence. Rape is seen as dishonourable and women are blamed for the sexual violence. Husbands whose wives have been raped often abandon their wives. Wives would rather avoid this by having a clandestine abortion. Young unmarried women who fall pregnant as a result of sexual violence are referred to as "goats". Goats are perceived to not know who the "owner" of their pregnancies are, and therefore the women are the same, where the common phrase is that they "picked up the pregnancy in the street".

In Eastern DRC, most unwanted pregnancies are a result of sexual violence

Living with this shame is an enormous burden for women, who therefore opt for a clandestine abortion. Children born out of these pregnancies suffer similar fates. In the DRC, a child's identity is formed after the father, not knowing who the father is means the child has no identity. Often times the child is even nicknamed after the armed group that was active at the time of the mother's rape, continuing the cycle of shame.

A second cause of unwanted pregnancy is transactional sex. Women and girls with no viable financial options or support from family, spouses or their own work have sex for food, money or gifts. Even women who are married are reduced to serving cohabitation and sexual roles. They are sometimes not cared for financially, pushing them into transactional sex to make financial ends meet. Women are mainly seen as tools to service the physical needs of men. There are abortion practitioners who demand sex from women who cannot afford to pay for their clandestine abortions.

The plight of women in transactional sexual relationships could be eased by improved access to contraceptives and better health education.

The local proverb "better dead than being mocked" illustrates how women and girls would rather risk death than face stigma if they continue with an unwanted pregnancy. Young girls for instance are abandoned by their families and face homelessness. Young girls are de-valued, mocked and shunned by members of society. If a woman falls pregnant while breast-feeding, she would rather terminate than face the shame of the pregnancy. In these situations however, abortion is seen as necessary for the protection of the child who is still feeding.

*Source: "Better dead than being mocked": an anthropological study on perceptions and attitudes towards unwanted pregnancy and abortion in the Democratic Republic of Congo*[27]

# Normative frameworks

**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 dispro-portionate 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.[28]

**Nairobi Statement on ICPD25: Accelerating the Promise**[29]
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.[30]

**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 2019-2030:** Rates of un-planned pregnancies and unsafe abortion are reduced.

[27] Burtscher, D et al. 2020 "Better dead than being mocked": an anthropological study on perceptions and attitudes towards unwanted pregnancy and abortion in the Democratic Republic of Congo. Sexual and Reproductive Health Matters, 28:1, DOI: 10.1080/26410397.2020.1852644
[28] 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 - https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf, accessed 27 May, 2020
[29] Nairobi Statement on ICPD25: Accelerating the Promise https://www.nairobisummiticpd.org/content/icpd25-commitments, accessed 27 May, 2020
[30] 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.

Ironically the continent with the first human rights instrument to recognise abortion under certain conditions as a woman's human right to be claimed without restriction or fear of being prosecuted is still also a region of extremely restrictive legislation and practice on abortion.

The Protocol to The African Charter on Human and People's Rights on the Rights of Women in Africa (commonly referred to as the Maputo Protocol) aims "to ensure that the rights of women are promoted, realised and protected in order to enable them to enjoy fully all their human rights." The Assembly of the African Union adopted the Maputo Protocol at its meeting in Maputo, Mozambique, on July 11, 2003. Twenty member states had signed the protocol by the end of 2003. It entered into force in November, 2005 after 15 nations had ratified it (including five nations in SADC.)

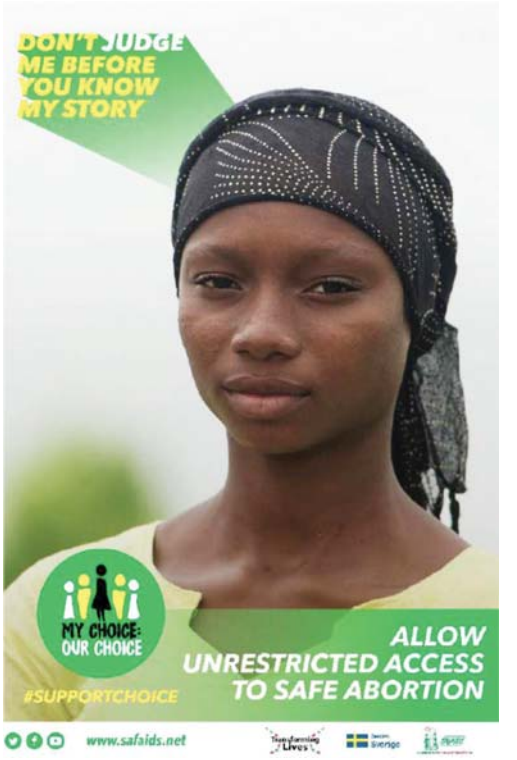



Table 4.6 Ratification of the Maputo Protocol by SADC Member States

| COUNTRY | DATE OF SIGNATURE | DATE OF RATIFICATION | DATE DEPOSITED |
|---|---|---|---|
| Comoros | 26/02/2004 | 18/03/2004 | 16/04/2004 |
| Namibia | 09/12/2003 | 11/08/2004 | 26/08/2004 |
| Lesotho | 27/02/2004 | 26/10/2004 | 05/11/2004 |
| South Africa | 16/03/2004 | 17/12/2004 | 14/01/2005 |
| Malawi | | 20/05/2005 | 29/06/2005 |
| Mozambique | 15/12/2003 | 09/12/2005 | 30/12/2005 |
| Seychelles | 24/01/2006 | 09/03/2006 | 25/04/2006 |
| Zambia | 03/08/2005 | 02/05/2006 | 07/06/2006 |
| Tanzania | 05/11/2003 | 03/03/2007 | 07/05/2007 |
| Angola | 22/01/2007 | 30/08/2007 | 09/11/2007 |
| Zimbabwe | 18/11/2003 | 15/04/2008 | 05/09/2008 |
| DRC | 05/12/2003 | 09/06/2008 | 09/02/2009 |
| Eswatini | 07/12/2004 | 05/10/2012 | 06/11/2012 |
| Mauritius | 29/01/2005 | 16/06/2017 | 23/06/2017 |
| Madagascar | 28/02/2004 | | |
| Botswana | | | |

*Source: Adapted from African Union. List of Countries which have Signed, Ratified/Acceded to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.*[31]

Table 4.6 shows that all member states of SADC have ratified the Maputo Protocol except Botswana and Madagascar.

[31] African Union. List of Countries which have Signed, Ratified/Acceded to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLE%27S%20RIGHTS%20ON%20THE%20RIGHTS%20OF%20WOMEN%20IN%20AFRICA.pdf, accessed 14 June, 2021

Table 4.7: Legal provisions regarding abortion in SADC[32]

| Country | Law | Conditions under which an abortion may be granted | Gestational limits | Consent | Provided by | Penalties for an illegal abortion |
|---|---|---|---|---|---|---|
| **ABORTION AVAILABLE ON DEMAND** | | | | | | |
| **South Africa** | Choice of Termination of pregnancy Act (92/1996) amended in 2008[33] | N/A<br>Available on demand | Within the first trimester | Right to terminate without consent of other parties apart from medical practitioners | | None |
| **Mozambique** | Amended Penal Code | N/A | 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[34] | A certified practitioner must perform termination at designated facilities[35] | None |
| **ABORTION AVAILABLE IN FOUR CIRCUMSTANCES** | | | | | | |
| **Zambia** | Termination of Pregnancy Act, 13 October 1972, amended in 2005 and Penal Code | If the pregnancy will cause death to the mother, mental or physical damage to the woman, or if the child is at risk of mental and physical deformities | | Once three medical practitioners have agreed | | Seven years for person who administers; seven years for woman who administers own abortion |
| **Botswana** | Penal Code (Amendment) Act, 1991 - Section 160 | In cases of rape or incest, if the mother's life is at risk, or the pregnancy may cause mental harm; if the unborn child will suffer or later develop physical or mental abnormality; in cases of defilement | Termination must be performed before 16 weeks[36] | Consent of parent or next of kin for minors; two doctors | Licensed facility | Three years for procurement; seven years for aiding |
| **ABORTION AVAILABLE IN THREE CIRCUMSTANCES** | | | | | | |
| **Angola** | Penal Code 2017[37] | 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 |

| Country | Law | Conditions under which an abortion may be granted | Gestational limits | Consent | Provided by | Penalties for an illegal abortion |
|---|---|---|---|---|---|---|
| **Comoros** | Comoros-Penal-Code-1995 | In the case of rape or incest; for a very serious medical reason, if a mother's mental state is at risk, or the child's life is at risk | Not specified | Two doctors | One doctor | Penalties for the woman and provider |
| **DRC** | Penal Code 2004, superseded by Maputo Protocol, 2018 | 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 | | 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[39] | In cases of incest, or rape, but not marital rape, 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 |
| **Lesotho** | The Penal Code (2012)[39] | In cases of incest or rape; to save the woman's life, to prevent the birth of a child who will be seriously physically or mentally handicapped | | By a registered medical profes-sional, with the written opinion of another regis-tered medical professional | | A fine of M5000-M10 000 or imprisonment of up to three years |
| **Mauritius** | Penal Code 1983; Criminal Code Amendment Act 2012[40] | To save the life of the woman; or prevent permanent physical damage; If the foetus may suffer severe mal-formation or abnormalities; if the 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 | 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;[41] If the woman is deemed to be an idiot or imbecile as per the Immorality Act 1957, which criminalises sex with her ; 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 preg-nancy is a risk | Licensed facility | A fine not exceeding N$5000 or imprisonment not exceeding five years, or both |

| Country | Law | Conditions under which an abortion may be granted | Gestational limits | Consent | Provided by | Penalties for an illegal abortion |
|---|---|---|---|---|---|---|
| **ABORTION AVAILABLE IN ONLY TWO CIRCUMSTANCES, EXCLUDING SEXUAL ASSAULT** | | | | | | |
| **Seychelles** | Termination of Pregnancy Act, 2012<br>Penal Code | If the woman's life is deemed to be in danger 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[42] | | 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[43] | If a woman is at risk of death, or the preg-nancy 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 Constitution | Only if the life of the woman is in danger[44] Or in cases of unlawful intercourse with mentally retarded female | | One doctor | | Life imprisonment |
| **ONLY ONE GROUND FOR TERMINATION** | | | | | | |
| **Malawi** | Penal Code | Only to save a woman's life | | | | 14 years for having an abortion; 3 years for supplying instruments to conduct an abortion |
| **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 |

[32] 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.
[33] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[34] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[35] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
[36] 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
[37] http://srhr.org/abortion-policies/documents/countries/01-Angola-Penal-Code-2014.pdf
[38] http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html
[39] https://lesotholii.org/ls/legislation/num-act/6
[40] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[41] https://laws.parliament.na/cms_documents/abortion-and-sterilization-c5c7b99b28.pdf
[42] https://srhr.org/abortion-policies/documents/countries/01-Seychelles-Termination-of-Pregnancy-Act-2012.pdf
[43] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
[44] http://srhr.org/abortion-policies/country/swaziland/

Table 4.7 shows that almost all member states in SADC still have very restricted abortion legislation, which is quite anachronistic in the twenty first century. South Africa has the most modern Choice of Termination of Pregnancy Act (1996) allowing for safe abortion on demand within the first trimester. Mozambique has modernised its Penal Code.

Table 4.8: Grounds for obtaining an abortion in SADC countries

| Country | Stand alone law/Penal Code | 1. Risk to life | 2. Rape or sexual abuse | 3. Serious foetal anomaly | 4. Risk to physical and sometimes mental health | 5. Social and economic reasons | 6. On request |
|---|---|---|---|---|---|---|---|
| South Africa | SAL | 1 | 1 | 1 | 1 | 1 | 1 |
| Mozambique | PC | 1 | 1 | 1 | 1 | 1 | 1 |
| Zambia | SAL | 1 | 1 | 1 | 1 | | |
| Namibia | SAL | 1 | 1 | 1 | 1 | | |
| Botswana | PC | 1 | 1 | 1 | 1 | | |
| Angola | PC | 1 | 1 | 1 | 1 | | |
| Comoros | PC | 1 | 1 | 1 | 1 | | |
| DRC | PC | 1 | 1 | 1 | | | |
| Zimbabwe | SAL | 1 | 1 | 1 | | | |
| Lesotho | PC | 1 | 1 | 1 | | | |
| Mauritius | PC | 1 | (statutory rape) | 1 | | | |
| Seychelles | SAL | 1 | | 1 | | | |
| Tanzania | PC | 1 | | 1 | | | |
| Eswatini | Const | 1 | | | 1 | | |
| Malawi | PC | 1 | | | | | |
| Madagascar | SAL | 1 | | | | | |
| Total | | 16 | 10 | 13 | 8 | 2 | 2 |

*Source: Gender Links 2021. SAL= Stand Alone; PC= Penal Codes; Const= Constitution.*

Table 4.8 is an analytical summary of the information in the previous table. The first column concerns the legislation that governs abortion in SADC countries. Six SADC countries have stand alone abortion laws (South Africa, Zambia, Namibia, Zimbabwe, Seychelles and Madagascar). In one case the (Eswatini) the Constitution spells out how abortion is to be handled. In nine countries (Botswana, Angola, Comoros, DRC, Lesotho, Mauritius, Tanzania and Malawi) abortion is covered under Penal Codes (a code of laws concerning crimes and offenses and their punishment[45]) many inherited from colonisers who have since radically adapted their own codes, granting women greater freedom and enabling progression in education and their careers.[46]

Former colonies, many of which achieved independence following bitter armed struggles for self-determination (for example Namibia) have clung to legislation that amounts to structural violence perpetrated in highly patriarchal systems against women, denying them self-determination. This violence targets the weakest women - young, poor and rural - as those who can afford to procure abortion, at home or abroad.

The table lists the six main grounds for allowing abortion ranging from the mot exceptional to the least restrictive grounds.

[45] Meriam Webster Dictionary
[46] Rodgers, Y. et al. (2021) 'The macroeconomics of abortion: A scoping review and analysis of the costs and outcomes', PLoS ONE, 16, p. e0250692. doi: 10.1371/journal.pone.0250692

Figure 4.1: Legal grounds for permitting an abortion




The analysis shows that *all* SADC countries allow abortion on some grounds, in other words, no SADC country outlaws abortion completely. All SADC countries allow abortion if it is a risk to the woman's life. This is consistent with global trends. By the end of the twentieth century, abortion was legally permitted to save the life of the woman in 98% of the world's countries.[47]

However, only two countries, South Africa and Mozambique permit abortion on demand. Five SADC countries, (Namibia, Botswana, Angola, Comoros and Zambia) permit abortion on four out of the six grounds. Four SADC countries (DRC, Zimbabwe, Lesotho and Mauritius) allow abortion in three out of the six grounds. Three SADC countries (Seychelles, Tanzania and Eswatini) permit abortion on two grounds. It is significant that in these countries *abortion is not permitted in the case of rape*. Abortion laws are most restrictive in Madagascar and Malawi where the only ground for abortion is *risk to life*. It is significant that no SADC country (except for South Africa and Mozambique that allow abortion on demand) allows for abortion for social and economic reasons; a highly significant factor in a region with high levels of poverty. Examples from around the SADC region show how advocacy on safe abortion is gradually gaining momentum. The analysis also suggests the need for a more clear and concerted regional strategy.

**Mozambique** has set a good precedent for the region[48] (reported in previous Barometers) by reforming its penal code holistically and addressing several key issues from a more progressive perspective. These include safe abortion, sexual diversity, sexual assault, human trafficking and domestic violence. Abortion had previously been legal only in the case of a threat to a woman's life or health. Women can now terminate pregnancies during the first 12 weeks, extended to 16 weeks in the case of rape. The code stipulates that abortions must be carried out in approved health centres by qualified practitioners and is available as a free service.

Women over the age of 16 provide consent for themselves. Below the age of 16 consent must be provided by a parent, or other trusted adult over the age of 21 (age of majority in Mozambique) to have an abortion. There is a 48 hour waiting period before the woman receives an abortion.

## Good laws are only meaningful if implemented

The liberalisation of abortion in the 2015 Penal Code is the culmination of over 30 years of activism by medical professionals and SRHR activists. The main challenge now is the implementation of these new laws.

The Associação Moçambicana de Obstetras e Ginecologistas (AMOG) has been working with

[47] United Nations Population Division. Abortion policies: A global review. 2002 http://www.un.org/en/development/desa/population/publications/abortion/abortion-policies-2002.shtml major dimensions of abortion policies.
[48] Gender Links: Mozambique Penal Code Reform Case Study for the Equality & Justice Alliance (EJA) 2018

the government of Mozambique and several other partners, including the Ministry of Health, IPAS, DKT and Pathfinder International, to create materials to sensitise health workers about the change in the legislation around abortion and their responsibilities under the new legislation. The group is also raising awareness with women that such services are available.

Professor Fernanda Machungo, AMOG member said, *"the 10 years of work that resulted in the law on the decriminalization of abortion (… ) were the beginning of a new battle: to make the law known to all girls and women, particularly in rural areas; create conditions for them to have access to quality services for safe abortion and post-abortion services; train quality personnel to carry out these services."*[49]

AMOG strives towards a future where all women in Mozambique have access to Family Planning and Safe Abortion services, regardless of their socioeconomic status, race, religion, culture and marital status. AMOG works with civil society, community and religious leaders, women and youth, the providers of safe abortion services, key government partners (Ministries of Health; Education; Youth and Technology; Women, Gender, Children and Social Action; and Justice) as well as legislators.[50]



When **Angola** gained independence in 1975, they adopted the colonial penal code that had been in effect since 1886 in its entirety. The Penal Code was only reviewed in 2019, and finally enacted in February 2021. The Penal Code reform now allows same sex relations, but still does not include abortion on demand.[51] Rather, women can now access abortions when their life or mental health is in danger, when the child will suffer deficiencies after birth or in the event of rape. The Catholic Church has been instrumental in lobbying for the ban of abortion, while the president's daughter, business woman Isabel Dos Santos spoke out against the lack of abortion rights during the iconic march in 2017 which saw over 200 women take to the streets in protest against a total ban on abortion.



**DRC**: A study conducted in North and South Kivu in the Eastern DRC, where abortion is still highly stigmatised, found that discussions with communities could begin to address stigma which is associated with abortion being viewed as repudiation of traditional female roles of motherhood and procreation. Community attitudes on abortion were initially negative but most expressed understanding and empathy for women who opt for abortion after rape or sexual assault perpetrated by armed groups in the ongoing conflict; when a woman's husband was unsupportive, unfaithful, or abusive; when a couple could not afford to feed another child; if a woman had recently given birth or already had many children; an unmarried girl who would want to avoid the stigma of becoming an unwed mother, or who wanted to finish her education. Many community members agreed that abortion should be allowed to save a woman's life. Almost all members agreed that a woman who had made the personal decision to induce an abortion should receive post abortion care and be reintegrated into society. Many said they would support a woman to access post abortion care.[52]

In late 2020 Youth organisations, including the Youth Action Movement, Afia Mama, Habari RDC, and the African Youth and Adolescents Network (AfriYAN) led an online campaign to promote SRHR during the coronavirus pandemic and beyond. IPAS DRC was one of the "Abortion: Let's Talk About It!" campaign coordinators. "Young people are seeking reliable information about their sexual and reproductive health and need access to services during COVID-19," said Dr. Jean-Claude Mulunda, country representative of Ipas DRC. "There is an increase in the number of unwanted pregnancies, sexual violence and maternal deaths due to clandestine abortions,

[49] Figo.org. OBGYNs in Mozambique call to strengthen gender equality and access to safe abortion https://www.figo.org/news/obgyns-mozambique-call-strengthen-gender-equality-and-access-safe-abortion, accessed 22 June, 2021
[50] Ibid
[51] Agencia EFE. 2019. Angola decriminalizes same-sex relations, allows abortion in certain cases. https://www.efe.com/efe/english/life/angola-decriminalizes-same-sex-relations-allows-abortion-in-certain-cases/50000263-3877510, accessed 26 June 2021.
[52] https://theconversation.com/attitudes-towards-abortion-in-the-drc-suggest-there-are-ways-to-overcome-stigma-156392,, accessed June 14, 2021

while access to services is more difficult. Reproductive health services, including abortion, must be part of essential health care."




"Access to health care is a right and not a favour that we grant to young people," says Benjamin Sabue of the Youth Action Movement. "Young people in good health are the future of the country."[53]



In **Namibia**, debate on review of the Abortion and Sterilization Act 2 of 1975, which has been raging for several years, continues. The current act which was adopted from an apartheid era South African law (long since abandoned in South Africa) stipulates that abortion is allowed:

- In order to save the life or the mental or physical wellbeing of the woman.
- In the event the child will suffer physical or mental defects.
- In the event that the pregnancy is as a result of rape, incest or unlawful sexual relations whereby a woman has severe mental incapacity.

Further to this, two medical professionals need to advocate for the abortion, and in the case of rape or incest, a magistrate must approve[54]. South African adopted the Choice of Termination of Pregnancy Bill in 1996. The Namibian law on the other hand has not changed. In June 2020, Namibian feminist and psychologist Beauty Boois, started a pro-abortion petition. At the time of writing this had over 62,000 signatures. Zelda Van der Colff has started a counter an anti-abortion petition.

The Deputy Minister of Health and Social Services, Esther Muinjangue tabled a motion in parliament in June 2020 noting that whether abortion was legal or not, young women and girls were engaging in backyard abortions and that Parliament needed to debate the issue. She said, "Let us acknowledge the devastating effects of illegal backyard abortions on girls and women. Let us acknowledge that women cross the border into South Africa or elsewhere where abortion is legal."[55] In February, 2021, a spokesperson for the National Assembly confirmed that although the Deputy Minister still expected the matter to be debated, abortion had only been tabled for discussion, not debate, and that it had since lapsed.[56]



Esther Muinjangue, Deputy Minister of Health and Social Services.
Photo courtesy of New Era Live

[53] Source: IPAS https://www.ipas.org/news/social-media-campaign-in-drc-reaches-youth-with-abortion-information/, accessed on 18 June, 2021
[54] Legal Assistance Center. Abortion Current Law http://www.lac.org.na/index.php/projects/gender-research-advocacy-grap/abortion/#:~:text=Current%20law,her%20physical%20or%20mental%20health, accessed 22 June, 2021
[55] The Namibian. 2020. Parliament asked to consider abortion https://www.namibian.com.na/202039/archive-read/Parliament-asked-to-consider-abortion, accessed 16 July, 2021
[56] Windhoek Observer. 2021. Abortion debate huddles in Parliament https://www.observer24.com.na/abortion-debate-huddles-in-parliament/, accessed 16 July, 2021



**Zambia** is one of ten countries in Africa and Latin America that are being supported by FIGO (the International Federation of Gynecology and Obstetrics) which is a professional organisation that brings together obstetrical and gynaecological associations from all over the world to support women to achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives) in a programme to build the capacity of National Member Societies to lead advocacy on safe abortion in their countries. This programme has included engaging with traditional healers who are often the first point of call for women seeking abortion[57].



On 24 June 2021, the **Malawi** High Court reaffirmed the statutory protections for legal abortion under narrow circumstances[58]. The case concerned a 15 year old girl who experienced statutory rape and fell pregnant during the COVID-19 lockdown. In seeking a safe abortion, she claimed that this affected her physical and mental health[59].

In the ruling, Justice Mzonde Mvula clarified that women and girls seeking abortion should demonstrate to the doctor how a pregnancy would undermine their health and life in general. While the Penal Code only allows for abortion when the life of the woman or girl is in danger because of the pregnancy, the court recognised in this ruling that preservation of life also entails safeguarding the mental and physical health of the woman or girl.

The ruling follows the withdrawal of an abortion bill from debate following opposition to the proposal to liberalise the country's law, which only allows abortions when the mother's life is at risk. The current 160-year-old law criminalizes abortion, with the only exception being if the mother's life is in danger. Offenders face up to 14 years in jail. The measure could have allowed abortions in cases of rape and incest. Mathews Ngwale is chairperson for the Parliamentary Committee on Health that was tasked with presenting the bill in parliament. A joint study by Malawi's College of Medicine and the U.S.-based Guttmacher Institute reveals more than 140,000 backstreet abortions take place illegally every year in Malawi and 12,000 deaths result.[60]




Reacting to the High Court ruling, Dr. Godfrey Kangaude, an attorney and reproductive health scholar, said: "This is a good development since current legal provisions on termination of pregnancy are couched in language that makes it difficult for health providers to implement. This ruling is a welcome step towards an authoritative interpretation of the abortion law and opens the door for women and girls to seek lawful access to safe abortion in Malawi." Dr. Kangaude expressed optimism that the Ministry of Health will take the initiative to advance necessary legal and policy reforms to address the inconsistencies between the current law and Malawi's obligations under national and international law on reproductive rights of women and girls."[61]

[57] Figo.org Advocating for Safe Abortion Project ; https://www.figo.org/advocating-safe-abortion-project; accessed 30 May, 2021, accessed 30 May, 2021
[58] Chitete, Suzgo, the Nation, 25 June 2021
[59] Ibid
[60] Masina, Ameck, Voice of America, June 19, 2021 01:42 PM
[61] Chitete, Suzgo, the Nation, 25 June 2021

# Media NGO campaigns for termination of pregnancy bill

Since Malawians voted in the disputed May 21, 2019 elections, the public sphere for policy debates has shrunk. Despite this, the Centre for Solutions Journalism (CSJ) declared the year 2020 'the year for the new abortion law'.

The proposed Termination of Pregnancy (T.O.P) bill, which was developed by the Law Commission in 2015 as one way of reducing maternal deaths, still needs to be tabled in parliament. The TOP allows for conditional relaxation of restrictions to cater for certain instances where termination of pregnancy should be permissible. Termination of a pregnancy may be performed by a certified health service provider where he /she is of the opinion in good faith that:

- The continued pregnancy will endanger the life of a pregnant woman;
- It is necessary to prevent injury to the physical or mental health of a pregnant woman;
- There is severe malformation of the foetus which will affect its visibility or compatibility with life; or
- The pregnancy is as a result of rape, incest or defilement. Provided the incident of rape, incest, defilement has been reported to police and that the pregnancy has not exceeded sixteen (16) weeks from the date of conception.

To advocate for the awareness of SRHR and the passing of the bill to law, CSJ is running a multimedia programme mobilizing support among faith-based groups, policy makers and members of the general public. CSJ is using various platforms to engage experts and members of the general public on issues of safe abortion. These include training, newspaper columns-opinion and analysis, Chichewa language radio programmes on local radio stations called Uchembere ndi Ufulu loosely translated as Motherhood and Rights. So far CSJ has conducted training for Members of Parliament, religious leaders, NGOs and youth groups to orient these stakeholders on the contents of the bill so that they fully understand it. The programmes also aim at neutralizing anti-choice activities.

Part of the campaign is documenting stories of survivors; they premiered a documentary on three national television channels: Times, ZBS and Mzati. Mdula Moyo wa Chinunu (Silent Killer on the Prowl) is based on true stories of women in Lilongwe and Blantyre districts in Malawi who died due to pregnancy related causes.

Experts provide evidence-based background and context for the TOP bill. For instance, Dr. Chisale Mhango, a gynecologist with the College of Medicine, has been running a column in the Daily Times on safe abortion and the proposed law. CSJ sponsors opinion and analytical articles in the daily newspapers as a way of challenging anti-choice sentiments among members of the public.

Some articles are published by pastors drawing lessons from scriptures. Pastor Esitedi Chikopa, for example, intimates in one of the entries that the death of two members in his congregation due to unsafe abortion sparked his interest in the debate on abortion. He says the condemnation of women who procure abortion distresses him while observing that: "As master condemners, we have no compassion for many women who induce abortion in Malawi annually. 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 (interpretation, especially of the Bible or literary texts)."

"Malawi's political turbulence since May 2019 elections and the nullification of the elections has created a hostile environment for the enactment of the bill as most MPs are afraid to discuss abortion issues to avoid losing their political support base. The COVID-19 pandemic has also limited awareness campaigns as social

distancing measures and restrictions prohibit mass gatherings", says Brian Ligomeka, Executive Director, CSJ.

However, positive impacts of the initiative by CSJ are now visible. An increased understanding of the bill and acceptance of its benefits are reflected in the signing of a communique to lawmakers by chiefs, religious and political leaders from across the country who urged law makers to pass the TOP Bill in parliament.

Many faith leaders have joined the movement to make the public and policy makers understand the importance of having such a law in place. One of the participants Rev. Cliff Nyekanyeka said: "People need to have their physical, psychological and emotional needs met. If one is sick the hospital is the best place to seek medical attention. In the same way if the people are facing spiritual problems, the best place to rush to is the church. This is why churches are building hospitals and clinics. … It is not our duty as churches to make laws for all citizens. We simply make rules and regulations for our members." Nyekanyeka feels the government must be allowed to make good laws on abortion so that those desperate for such services should not die.

*Source: GL Media, 2021. Malawi Media NGO defies political crisis to build momentum for Termination of Pregnancy Bill*[62]



In February, 2021 Nifin'Akanga (a women's advocacy group named after a plant that is used as an abortifacient in **Madagascar**) released a documentary on 15 women who accessed illegal and unsafe abortions. Mbolatiana Raveloarimisa, one of the founders of Nifin'Akanga, commented, "The word that always comes up in the women's stories .. is 'fear': fear of society, fear of dying, fear of the law, and fear of being frowned upon. Ultimately, it is this fear that is undermining people and causing collective hypocrisy to grow day by day. But this fear also opens the door to going underground. And to expose all the terrible practices that can kill women, practices that cost women's lives in some cases. So apart from those who provide clandestine abortion in a professional manner, there are plenty of others who butcher women, who are killing women and without qualms because they know the women are afraid, and they take advantage of that."

"During our field surveys, we noticed that whatever the reasons; whatever the constraints; if a woman decides to have an abortion, there is nothing that is capable of dissuading her. When a woman is pregnant and decides to have an abortion in Madagascar, nowadays, in 30 minutes, she can find a solution, but obviously this solution may not be the right one. There is always someone who knows someone who has had an abortion before," explains Dr Fanzy Mefire, head of research in Nifin'Akanga. [63]

> If a woman decides to have an abortion…. Nothing will dissuade her

[62] Gender Links. Malawi: Media NGO defies political crisis to build momentum for termination of pregnancy bill - https://genderlinks.sharepoint.com/:w:/r/programmes/alliance/_layouts/15/Doc.aspx?sourcedoc=%7BC937DF39-5A6A-4B32-BD6F-5396F27B4AF9%7D&file=Malawi_Media%20NGO%20builds%20momentum%20for%20termination%20of%20pregnancy%20bill%5B1%5D.docx&action=default&mobileredirect=true

[63] International Campaign for Women's Right to Safe Abortion. 2021. Madagascar - Women testify on the risks they experienced with clandestine abortion https://www.safeabortionwomensright.org/news/madagascar-women-testify-on-the-risks-they-experienced-with-clandestine-abortion/, accessed 30 May, 2021

# *My Choice, Our Choice (MCOC) SADC campaign*




Regional Coalition of Champions and Allies on Ending Unsafe Abortion. Photo: SAfAIDS

SAfAIDS, the Alliance SRHR cluster lead, launched the "My Choice, Our Choice" Campaign on ending unsafe abortion among adolescent girls and young women (AGYW) in the SADC region in 2020. The Campaign is premised on mobilising policy makers to review policies and remove restrictions, to close gaps in unmet need for contraceptives, to improve access to safe and legal abortion services; and to create an enabling environment for bodily autonomy of AGYW.

The campaign has been rolled-out at regional and national level concurrently with a series of regional and national Sectoral Policy Dialogues which has created an advocacy movement and impetus in the region to address policy barriers to provision of and access to Safe Abortion by Adolescent Girls and Young Women in SADC. The campaign has utilised virtual and online platforms including twitter, facebook and instagram and key campaign messages are digitally disseminated through animations, flash messages, Spotlight issues and video clips.

To strengthen synergies between the "My Choice, Our Choice" Campaign at regional and national levels, and create a collaborative and cross-learning mechanism which sustains and amplifies momentum on safe abortion policy advocacy, SAfAIDS established a Regional Coalition of Champions and Allies. The Coalition comprises Champions (primary targets of the My Choices, Our Choice Campaign), who are policy-makers, such as Members of Parliament and Sectoral leadership such as senior officials from Ministries of Health, Gender and Education; and Allies (secondary targets) representatives of Adolescent Girls and Young Women and Men and Boys bodies. Strategic partners include MenEngage, AfriYAN-ESA, SheDecides, the SADC Gender Protocol Alliance, FEMNET, Right Here Right Now, Sonke Gender Justice and Women's Action Group and media practitioners; representing the 16 SADC Member States.

The campaign is hinged on policy advocacy efforts to catalyse, stimulate or seed change in the SRH policy environment. This includes direct lobbying through one-on-one and roundtable meetings with senior SADC Secretariat, SADC-PF and Government Ministry officials, and broad Influencing through regional and national sectoral meetings and dialogues.

Campaign champions have been raising awareness on the prevailing status and extent of unsafe abortion and associated barriers in their respective countries and in the region.

- King Ntinu, President- Union of African Traditional Authorities, and King of the Kingdom of Kongo in **DRC** has been sensitising other traditional leaders on their role to address unsafe abortions in their chiefdoms and he

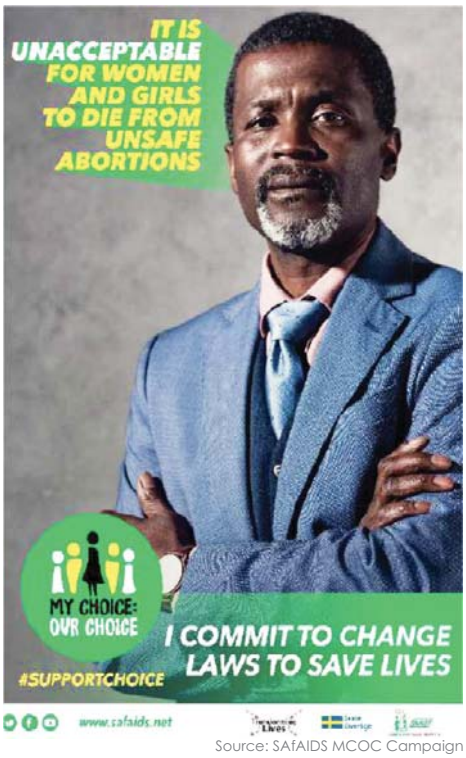
has actively been raising awareness of other traditional leaders on key policy gaps for provision of unrestricted safe abortion in the country.

- In **Lesotho** the campaign champion Fako Moshoeshoe, chairperson of the Lesotho SADC PF Parliament Cluster Committee, held joint radio/TV programmes on safe abortion. The Lesotho parliament tabled a motion to legalise abortion in November, 2020.
- In **Zimbabwe**, the Parliamentary Portfolio Committee on Health led by Dr Ruth Labode, a member of the SAfAIDS Regional Coalition of Allies and Champion, spearheaded week-long public hearings on age of consent as barrier to accessing sexual and reproductive healthcare services, including contraception, by young persons.
- In **Zambia** the campaign champion Dr. Christopher Karira argued against withdrawing Comprehensive Sexual Education (CSE) in Zambian schools, suggesting that CSE is a tool that can also help in reducing maternal deaths caused by unsafe abortion. The Motion to withdraw the CSE curriculum has since been withdrawn.
- In **Malawi** Chief Mabulabo has endorsed the urgent need to address unsafe abortions.

The Campaign has to date reached about 1,600,000 individuals in the SADC region including political, religious, traditional, health and justice leaders; media, adolescent girls, young women and boys and men. About 50,000 individuals have been reached through social media.

The 'My Choice, Our Choice' regional campaign has sparked regional discussion and dialogues on unsafe abortion among key stakeholders including the media and policy makers. It has contributed to enhanced capacity and understanding of policy makers on the impact of unsafe abortion at regional level.

Through the campaign, a regional advocacy movement and multi-point pressure has been created. There has been a positive transformation in the beliefs, opinions and attitudes of policy- and decision-makers' and leadership on abortion resulting in growing advocacy and resounding voice for change of policy environment for ending unsafe abortions amongst adolescent and young women.



Source: SAfAIDS MCOC Campaign

The Campaign has resulted in consensus amongst the policy makers and leaders to address policy barriers to provision and access of safe abortion services by Adolescent Girls and Young Women as part of the 2030 Agenda and SADC SRHR Strategy (2019-2030), through a harmonised regional approach.

Ultimately the campaign will result in SADC Member states developing a regional roadmap to support and guide the review of termination of pregnancy laws and policies for removal of restrictions for accessing safe abortion services by Adolescent Girls and Young Women and in turn mortality due to unsafe abortion will be reduced in the SADC region. SAfAIDS and the Southern African Gender Protocol Alliance plan to convene a group of technical experts to debate how to build on the momentum created thus far to come up with the best legal strategy for making safe abortion accessible to all SADC citizens.

*Source: Chrispin Chomba, Head of Country Programmes, Strategic Evidence and Country Business, SAfAIDS*

# Decriminalisation or legalisation?

From an impassionate health and rights perspective, a woman's right to bodily determination is violated when she is denied health care which empowers her to exercise that right and which still too often leads to death and disability. Thus,

> Abortion legislation is structural violence against women

Professor Joanna Erdman has argued that laws to govern abortion, which is a medical procedure, amount to structural discrimination.[64]

Dr Lucía Berro Pizzarossa, argues that even certain models of abortion law which are seen as liberal, fail to comply with human rights. She argues that there should be no criminal or specific law on abortion. She asks:
*Are we expending too much emotional energy on continuous, and seemingly never ending, battles to make minor changes to the "conditions under which abortion can be allowed" and losing sight of the war for women to have self-determination of their reproductive selves? Would it not be preferable to rather campaign for decriminalisation of abortion and removal of abortion from penal or other codes?*[65].

## Legalise or decriminalise: What's in a word?
By Marge Berer[66]

For many years, the abortion rights movement internationally has called for "safe, legal abortion." More recently, calls for the "decriminalisation of abortion" have also emerged. Do these mean the same thing? In simplistic terms, they might be differentiated like this: legalising abortion means keeping abortion in the law in some form by identifying the grounds on which it is allowed, while decriminalising abortion means removing criminal sanctions against abortion altogether.

Canada stands out as the only country to date that, through a Supreme Court decision in 1988, effectively decriminalised abortion altogether. No other country, no matter how liberal its law reform, has been willing to take abortion completely out of the law that delimits it. It is impossible not to think that no law is the best law when it comes to abortion, which brings us back to Canada, where abortion has not been restricted since 1988 and is available on request with no stipulations as to who must provide it or where. Although abortion is not easily accessible in remote areas, and Canada was exceedingly slow to approve mifepristone, opposition to abortion has never developed a foothold. The benefits for women of having no law are crystal clear.

Some abortion rights supporters seem to have an underlying fear that without leaving something in the criminal law, "bad things" may start to happen. Canada proves this is not the case. Granted, not everywhere is Canada. But there are general criminal laws that allow the punishment of wrongdoing-such as forcing a woman to have an abortion against her will, giving her medical abortion pills without her knowledge, or causing injury or death through a dangerous procedure. These are laws against grievous bodily harm, assault, or manslaughter,

[64] Stevens, Marion. 2020. Do we need the law to provide for a regular clinical medical procedure such as abortion? https://www.spotlightnsp.co.za/2020/08/12/do-we-need-the-law-to-provide-for-a-regular-clinical-medical-procedure-such-as-abortion/, accessed June 16, 2021
[65] Ibid
[66] Excerpts from Berer M. (2017). Abortion Law and Policy Around the World: In Search of Decriminalization. Health and human rights, 19(1), 13-27. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5473035/, accessed 5 August, 2021

which can be applied without the need for a criminal statute on abortion.

Those unable to contemplate no law at all must confront the fact that each legal ground for abortion may be interpreted liberally or narrowly, and thereby implemented differently in different settings, or may not be implemented at all. The challenge is to define which abortions should remain criminal and what the punishment should be. Even if only some grounds would be considered acceptable, the question of who decides and on what basis remains when reforming existing law.

Restrictive abortion laws are being broken on a daily basis by millions of women and numerous abortion providers. Even in countries where the law is less restrictive, research shows that the letter of the law is being stretched in all sorts of ways to accommodate women's needs. Yet opposition and a stubborn unwillingness to act continue to hamper efforts to meet women's need for abortion without restrictions

It should be clear that the plethora of convoluted laws and restrictions on abortion do not make any legal or public health sense. What makes abortion safe is simple and irrefutable-when it is available on the woman's request and universally affordable and accessible. From this perspective, few existing laws are fit for purpose but merely repeat every possible permutation of the self-same restrictions.

Treating abortion as essential health care is a major step forward, and where the national setting insists on some sort of law, advocates could draft the simplest, most supportive law possible, placing first-trimester abortion care at the primary and community level, ensuring second-trimester services, involving mid-level providers, increasing women's awareness of services and the law, aiming for universal access, integrating WHO-approved methods, and addressing social attitudes to reduce opposition.

If it were up to me, all criminal sanctions against abortion would be revoked, making abortion available at the request of the only person who counts-the one who is pregnant. And as with all pregnancy care, abortion would be free at the point of care and universally accessible from very early on in pregnancy.

Canada has proved that no criminal law is feasible and acceptable. Sweden has proved that abortions after 18 weeks can effectively disappear with very good services, and WHO has shown that first-trimester abortions can be provided safely and effectively at the primary and community level by trained mid-level providers and provision of medical abortion pills by trained pharmacy workers. Finally, web- and phone-based telemedicine services are showing that clinic-based services are not required to provide medical abortion pills safely and effectively.

## Medication Abortion




In many Latin American countries, abortion laws have remained highly restrictive despite SRHR campaigns. As a result, women have been using misoprostol to self-induce abortion. The medication is widely available for gastric ulcers. After women n in Brazil started using it, the practise spread to many other countries and regions. Countries such as Brazil and Egypt have tried to restrict use of the medication to little avail.

Since women in Latin America began to use misoprostol for abortion in the 1980s its use has expanded around the world. WHO recommends the combination of: mifepristone, which is more expensive, and used only to terminate a pregnancy, as it interferes with hormonal processes with misoprostol, which causes the cervix to dilate

and the uterus to contract, is cheaper, used for other reasons, such as to treat ulcers, and thus more readily available.

Medication abortion, even with Misoprostol alone, is much safer than even the previously used (and no longer recommended) invasive surgical technique of D&C (dilation and curettage).

In 2018 the WHO began to promote the concept of Self Care as a means to expand access to health care, while acknowledging that the world is faced with a critical shortage of health care providers. WHO describes self- care as "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a healthcare provider. The scope of self-care as described in this definition includes health promotion; disease prevention and control; self-medication; providing care to dependent persons; seeking hospital/specialist/primary care if necessary; and rehabilitation, including palliative care".

One of the recommendations of the WHO Consolidated Guideline for Health: Sexual and Reproductive Health is REC 17: Managing the mifepristone and misoprostol medication without direct supervision of a health-care provider is recommended in specific circumstances. We recommend this option in circumstances where women have a source of accurate information and access to a health-care provider should they need or want it at any stage of the process.[67]

Despite the fact that self-care and telemedicine have become more important in COVID-19 lock down conditions, many laws require the involvement of medical practitioners in abortions, or that abortions be administered from a health care facility. As such, self-managed medication abortions are often illegal even where abortions are otherwise legal. However, self-managed medication abortions address many of the reasons that women turn to the informal sector for abortion where abortion is legal that include fear of mistreatment by staff, long waiting lists, high costs, inability to fulfil regulations, privacy concerns, and lack of awareness about the legality of abortion or where to procure a safe and legal abortion. Further, where abortion is legal under certain conditions, the process of proving such conditions is often so long drawn out as to deny the abortion within the accepted time frame.

## Access to medication abortion reduces morbidity and mortality

Expanded access to medication abortion is playing a crucial role in providing access to safe, effective, and acceptable abortion care in many regions of the world, contributing significantly to the sharp decline in abortion related morbidity and mortality. There is need in SADC for expanding access to accurate information, support and access to misoprostol.

In Latin America it took many years for accurate information on the correct and safe use of Misoprostol to become widely and easily available. The MAMA network (Mobilising Activists around Medical Abortion) "understands that abortion pills create a universal opportunity for safe abortion regardless of how abortion is regulated by national laws. By providing women with accurate information about abortion with pills, activists challenge restrictive laws' legitimacy, contribute to dismantle abortion stigma and shame, foster women's empowerment and respect women's autonomy".[68]

[67] World Health Organization 2019. WHO Consolidated Guideline on Self Care interventions for Health: Sexual and Reproductive Health and Rights. Geneva. WHO. https://www.who.int/publications/i/item/WHO-RHR-19.14, accessed June 15, 2021
[68] Mama Network. https://mamanetwork.org/, accessed 18 June, 2021

MAMA network provides information materials for community distribution of protocols for medical abortion using Mifepristone and Misoprostol during the first 10 weeks of pregnancy which are readily available on their website. MAMA also offers helplines in local languages in several African countries, including DRC, Malawi, Tanzania and Zambia.

FIGO (the International Federation of Gynecology and Obstetrics) issued a statement on 18 March, 2021 endorsing the use of telemedicine for safe abortions which said in part, "FIGO considers reproductive autonomy, including access to safe abortion services, to be a basic and non-negotiable human right. Abortion is a time sensitive, essential medical service - one that should be provided in accordance with women and girls' preferences, and with safety, privacy and dignity at the forefront. FIGO demands that all governments remove the barriers that impede access to safe abortion services and ensure universal access to safe abortion for all girls and women - both during COVID-19 and afterwards. Telemedicine abortion programmes implemented during the pandemic have demonstrated that such services can provide efficacy, safety, efficiency and acceptability without an ultrasound scan." The statement quoted evidence from the UK and Australia to substantiate FIGO's claims that telemedicine has been proven to be safe and effective.[69]

Guttmacher compiled data from various surveys to estimate the source of support for abortion in eight Sub-Saharan countries including Malawi, Zimbabwe and Tanzania. Their estimations show that in 6 of these 8 countries the majority of abortions were supported by a non-clinician (being pharmacists, traditional providers and women themselves and Clinicians are nurses, midwives and doctors) the percentages attended by a non-clinician in the 3 countries are 74, 63 and 51 respectively.[70]



A qualitative study in **Zambia** interviewed pharmacy workers regarding how they made decisions regarding sale of Medication Abortion pills. The study found that many clients did not have prescriptions and the pharmacy workers became gate keepers of who could access medication abortion. They had to manage many risks which they did by, for instance, asking that the partner be involved in the decision, keeping in contact with the client while they were taking the pills to check on any complications and so on. The study found that pharmacies were playing an important, if sometimes conflicted role, in preventing unsafe abortions in an environment in which regulations are not clear and the overall system is failing women.[71]

## Post-abortion care

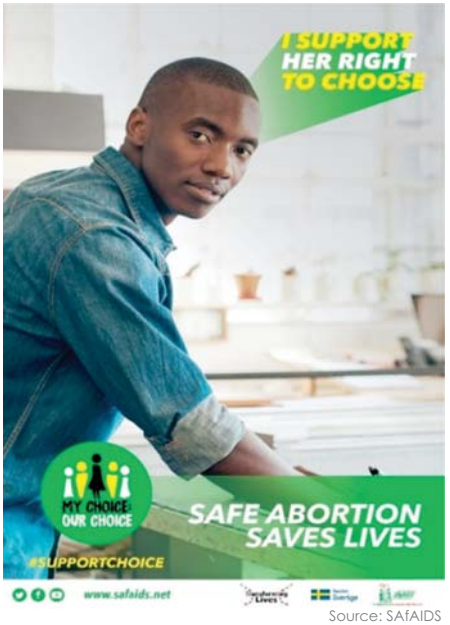
As abortion is still highly restricted and stigmatised, and access to contraception is inadequate, it is to be expected that clandestine and often unsafe abortions will continue. As such there is an ongoing need for post-abortion care. As shown in table 4.6 earlier, a number of member states have policies and guidelines on the provision of post abortion care.

[69] Figo. FIGO endorses the permanent adoption of telemedicine abortion services https://www.figo.org/FIGO-endorses-telemedicine-abortion-services, accessed 18 June, 2021
[70] Bankole, A. et al 2020. From Unsafe to Safe Abortion in Sub Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute https://www.guttmacher.org/sites/default/files/report_pdf/from-unsafe-to-safe-abortion-in-subsaharan-africa.pdf
[71] Footman, K. et al. (2021) 'Treading the Thin Line: Pharmacy Workers' Perspectives on Medication Abortion Provision in Lusaka, Zambia', Studies in Family Planning, p. sifp.12151. doi: 10.1111/sifp.12151.

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. |
| **Namibia** | The Namibia standard treatment guidelines (2011) |
| **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.*



Source: SAfAIDS

The high costs to nations and individuals of unsafe abortion have been documented in several studies. It is estimated that $228 million is spent in Sub-Saharan Africa every year on the provision of post abortion care. Most studies show that the financial costs to the health sector of post abortion care are at least double those of safe abortions, and these do not take into account the high emotional toll and ancillary financial costs to the women.

With adequate training of nurses and midwives, who are more accessible to women living in rural areas, can provide quality post abortion care. Limited available evidence suggests that there are high rates of unsafe abortion in adolescents and young women, who are less likely to seek post abortion care. There is need for active programmes to reach out to these young women with young friendly post abortion services. It is important to integrate counselling and contraceptive services into post abortion care, so that women leave the site of care with an effective means to prevent further unintended pregnancy.

A study which quantified the health burden experienced by women presenting with abortion-related complications in 11 sub-Saharan African countries (including DRC, Malawi and Mozambique) across 13 657 women and 210 health facilities found :[72]

[72] Qureshi, Z. et al. (2021) 'Understanding abortion-related complications in health facilities: results from WHO multicountry survey on abortion (MCS-A) across 11 sub-Saharan African countries', BMJ Global Health, 6(1), p. e003702. doi: 10.1136/bmjgh-2020-003702.

- 2.3% severe maternal outcomes and 7.0% potentially life-threatening complications, indicating that unsafe abortion is still a major public health challenge.
- 58% moderate and 32% mild complications which may be indicative of changes in abortion practices as a result of wider access to medication abortion.
- Severe abortion-related complications were associated with being single, having a prior pregnancy and late gestational age (≥13 weeks), which led to a twofold increase in odds among severe maternal outcomes. Severe abortion-related complications were also associated with expulsion of products of conception (POC) before arrival at the facility. It is suggested that this may be a result of inaccurate information regarding dosage, when to seek post abortion care, side effects and symptoms of possible complications. Women might also not be aware of the services available, may fear stigma and mistreatment and use methods which are unsafe.
- The findings highlight the need for more training and resources to provide the best post abortion care.
- Approximately half of the abortion-related complications were treated with both uterotonics and uterine evacuation. This may be a result of over medicalization as it is not consistent with recommendations.
- The management of abortion-related complications using MVA (manual vacuum aspiration), which is safe, low cost and recommended is increasing across countries in the study, but the use of D&C which is more invasive and not recommended persists.
- Oxytocin was used more frequently for uterotonics than misoprostol, which is recommended to manage abortion-related complications.
- 3091 of the women were recruited and participated in an exit interview. Half reported that they had experienced an induced abortion with 54,3% using misoprostol, 40,5% other medicines either orally or vaginally, 18,7% using dangerous methods such as herbs, antimalarial drugs, bleach, petrol and detergents and 14.3% reported using traditional abdominal massage. This supports other findings that medication abortion is becoming more common and may be resulting in lower levels of severe complications. 10% of the women accessed information from social media or the internet. Though this is a small percentage it suggests that telemedicine may be more widely used in the future.



**Tanzania:** A study in Arusha found that only about 50% of women who procured abortions received any care in the formal health system, suggesting that methods of estimation of abortion rates that are based in hospital post abortion care may be substantially lower than the reality. Most women relied on traditional herbs for the abortion[73].

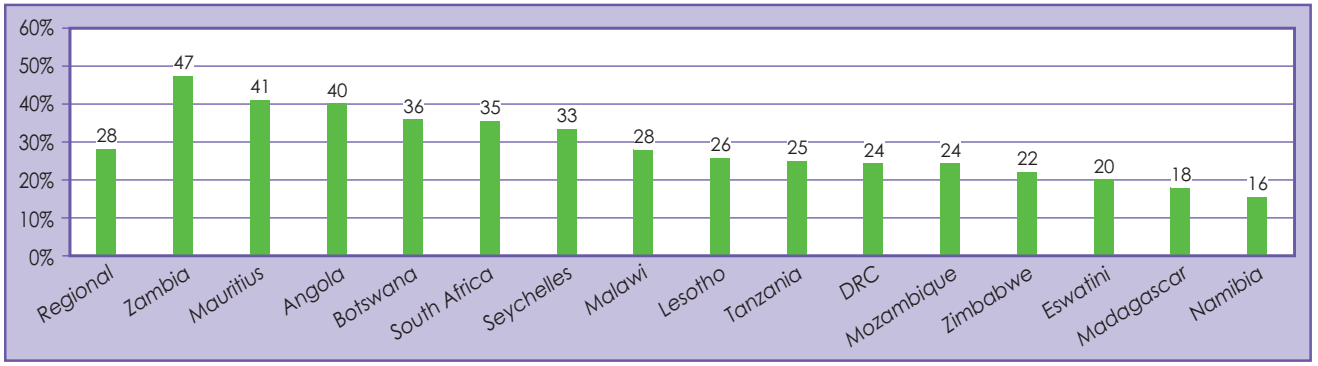
## Changing attitudes

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.

There is need to raise awareness about women's sexual and reproductive rights

[73] Estimating the lifetime incidence of induced abortion and understanding abortion practices in a Northeastern Tanzania community through a household survey - ScienceDirect (no date). Available at: https://www.sciencedirect.com/science/article/abs/pii/S0010782420303838?dgcid=raven_sd_via_email, accessed: 20 June 2021.

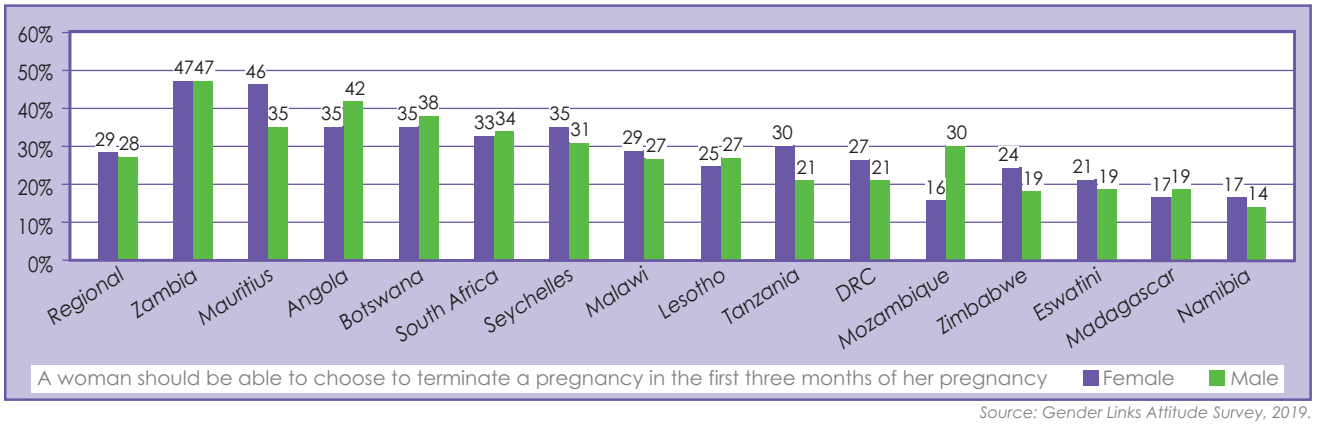
Figure 4.2: A woman should be able to choose to terminate a pregnancy, 2021




*Source: Gender Links Attitudes survey, 2021.*

Figure 4.2 shows that those who agree or strongly agree that a woman should be able to choose to terminate a pregnancy in the first three months across SADC is only 28% which is a slight shift from the last survey in 2019 of 26%. No country in the survey had 50% or more agreeing. This is a strong indication of the high levels of stigma that still exist in relation to abortion.

Figure 4.3: Attitudes on abortion by sex




*Source: Gender Links Attitude Survey, 2019.*

Figure 4.3 shows the differences in attitudes between men and women in 2021 in relation to the question. The regional average is very similar between women (29%) and men (28%). Across countries, women are generally more likely to agree with the statement than men, except in Angola, Botswana, Mozambique and Madagascar. Generally, the results show that concerted advocacy is required to change the attitudes of both women and men towards abortion in the region.

Concerted advocacy is required to change the attitudes of both women and men towards abortion in the region

# Next steps

For SADC to significantly reduce maternal mortality it is essential that all member states urgently address the issue of dangerous and unsafe abortion. This includes the factors that fuel rising unintended pregnancies, including violence against adolescents and women; access to SRHR information and contraception in a non-stigmatising environment. It also means addressing the very emotive issue of safe abortion in a calm and dispassionate way.

Key recommendations and next steps include:

- SAfAIDS/Alliance expert reference group meeting on the best legal strategies for making abortion safe - to decriminalise, legalise, or both.
- During the continuing COVID-19 pandemic, governments must define access to comprehensive SRH services as an essential service for all, irrespective of age, socio-economic status, or any other factor.
- There is an urgent need for open acknowledgement of the manner in which abortion legislation deprives women of self-determination of their own reproductive selves and debate on urgent reforms to either totally remove abortion from the statute books or relax all restrictions.



Pro-abortion march outside parliament in Namibia. Photo: Gender Links

- SADC governments must pay attention to 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 sexuality 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 and other marginalised women from accessing SRH services. There should be open dialogue between service providers and users of services.
- To save lives, all SADC member states should provide post-abortion care to all women with abortion complications and train staff in the safest and most up to date approaches as well as provide the necessary equipment and drugs.
- Activists and political leaders need to work together to share information about the conditions under which abortion can be accessed and ensure that both those that need abortions and those that provide abortions are aware of these circumstances.
- 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.
- Activists and governments should expand access to medication abortion which is much safer and less invasive than traditional methods.

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