Safe Abortion 4



She decides: Across Southern Africa, there is a groundswell of support for women to be able to make their own choices.
Photo: Colleen Lowe Morna

KEY POINTS

- The overturning of Roe v Wade by the US Supreme Court emboldens the international anti-abortion movements. Examples of this are emerging in Southern Africa, for example in Malawi.
- On the other hand, in an important new development, the World Health Organisation (WHO), African Union (AU) Special Rapporteur on the Rights of Women, and the International Federation of Gynaecology and Obstetrics (FIGO) are calling for the *complete decriminalisation of abortion*. This debate is yet to take off in Southern Africa.
- There has been no change in any legislation related to abortion in any SADC country over the past year. However, advocacy and activism on safe abortion are gaining momentum notably in Madagascar, Lesotho and Namibia. SAfAIDS, which leads the Alliance SRHR cluster, is working closely with the SADC Parliamentary Forum engaging parliamentarians on the urgent need for the removal of policy restrictions on access to safe abortion. The engagements with parliamentarins have documented SADC parliamentarians' recommendations on a possible model law. The *My Choice, Our Choice* campaign has identified prominent champions for safe abortion around the region, some profiled in this chapter.
- A ruling by the Constitutional Court in South Africa has helped to safeguard the progressive provisions in the one out of two SADC countries (the other is Mozambique) that allows a woman to choose to have an abortion in the first trimester.
- There is little hard data on how COVID restrictions affected access to contraceptives or abortions, though a few studies reflect disruptions.
- Activists have been slow to cotton onto the growing global discussion on medication abortion that provides safe, self-managed alternatives for women in restrictive environments.
- Post abortion care continues to consume a high percentage of health budgets and to make little sense of the rigid anti-abortion stances, given the age-old wisdom that prevention is better (and cheaper) than cure.

Introduction

Between 4.7% and 13.2% of maternal deaths worldwide are a result of unsafe abortions. The United Nations Fund for Population (UNFPA) calls the 45% of all abortions that are unsafe a "public health emergency". According to the World Health Organisation (WHO), almost 75% of abortions in Latin America and Africa are unsafe. Nearly 50% of abortions in Africa are least safe or dangerous (the highest proportion that is least safe of any of the regions in the world).[1]

The Programme of Action of the International Conference on Population and Development (ICPD) adopted in 1994 recognised that human rights and dignity, including rights to universal access to Sexual and Reproductive Health information and services are a fundamental condition for sustainable development.

Sustainable Development Goal (SDG) Goal 3 (ensure healthy lives and promote well-being for all at all ages) aims in 3.1 to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. SDG Goal 5 (achieve gender equality and empower all women and girls) aims in 5.6 to: "ensure universal access to sexual and reproductive health and reproductive rights."

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (commonly known as the Maputo Protocol), adopted by African Union in 2003, was the first human rights treaty to explicitly recognise abortion as a human right, under some circumstances. The SADC Gender Protocol boldly aims to eliminate maternal mortality. Yet governments are slow to translate these commitments into action.

Globally, the overturn by the US Supreme court of Roe v Wade, which guaranteed the right to abortion in the United States, is a major reversal.

The ripple effects of Roe v Wade in the United States

The US Supreme court decision to overturn Roe v Wade on 24 June 2022 sent shock waves around the globe. That the self-proclaimed global custodian of human rights would so easily trample on the rights of those who can become pregnant seems incomprehensible. Many have expressed dismay and solidarity with women in the United States and many others expressed delight and hope that they also can bring similar changes in their countries.

Dr Alvaro Bermejo, Director of the International Planned Parenthood Federation warned, "The fallout from this calculated decision will also reverberate worldwide, emboldening other anti-abortion, anti-woman and anti-gender movements and impacting other reproductive freedoms. The justices who put their personal beliefs ahead of American will, precedent and law will soon have blood on their hands, and we are devastated for the millions of people who will suffer from this cruel judgment".[2]

> The fallout from the overturn of Roe v Wade will reverberate worldwide

[1] WHO, 2022. Abortion Fact Sheet. https://www.who.int/news-room/fact-sheets/detail/abortion accessed 15 August, 2022.
[2] IPPF Africa Region, 25 June, 2022. U.S Supreme court overturns Roe v. Wade in biggest blow to women's health and rights in recent history. https://africa.ippf.org/media-center/us-supreme-court-overturns-roe-v-wade-biggest-blow-womens-health-and-rights-recent accessed 30 June, 2022.

Dr Veena JS, an Indian activist who is known for her social media presence on reproductive health issues, says the Roe v Wade ruling will have a cascading effect around the world. "America is generally a model for the world and I fear, at some point, India could take a cue from them and bring in similar legislation. And we will be forced to raise children we don't want. Research has shown that post-partum psychosis and depression increases in women who are forced against their will to give birth. The quality of life of these 'unwanted' children will also be poor."[3]

In SADC, unwanted pregnancy can often be the result of sexual violence. In South Africa alone, 11,000 women reported that they had been raped between January and March 2022,[4] while New Zimbabwe reports that an average of 21 women report that they have been raped in Zimbabwe daily[5]. As rape is almost always under-reported, the true picture is much worse. With such alarming rates of violence against women, moving backward on abortion is absurd.

Laws that outlaw abortion do not stop the demand for, or access to, abortions. They do make safe abortion unavailable, forcing women to resort to illegal and less safe forms of abortion. Globally, in the year under review, the World Health Organisation (WHO) released a new, updated and consolidated Abortion Care Guidelines in 2022[6]. The WHO 2022 Guidelines note that abortion is a "safe and non-complex health-care intervention that can be effectively managed using medication or a surgical procedure in a variety of settings".[7] The guidelines further state that all who need abortion care should receive quality of care that is effective, efficient, accessible, acceptable/patient centred, equitable and safe. The WHO classifies abortions as safe, unsafe and dangerous. The least safe, or dangerous, abortions often result in serious illness, infertility and sometimes even death.

UNFPA calls the 45% of all abortions that are unsafe a "public health emergency". Unsafe abortion results in expensive hospitalisation of about seven million women a year in developing countries and resulted in an estimated 193,000 maternal deaths between 2003 and 2009[8]. The rate of deaths is between 30 deaths per 100 000 unsafe abortions in developed countries to 220 per 100 000 unsafe abortions in developing countries.[9]

Laws do not stop abortions. They make safe abortion unavailable

[3] Pandey, G. June 25, 2022. 'America is a model for the world' https://www.bbc.com/news/world-us-canada-61788929 accessed June 27, 2022.
[4] Charles, M. June 4, 2022. Brutal start to the year for SA with nearly 11 000 rape cases in just the first 3 months. https://www.news24.com/news24/southafrica/news/rape-in-sa-a-brutal-start-to-the-year-for-women-and-children-20220604 accessed 21 July, 2022.
[5] Chibamu, A. July 13, 2022. Parliament told 21 women raped everyday; MP calls for castration of rapists. https://www.newzimbabwe.com/parliament-told-21-women-raped-everyday-member-calls-for-castration-of-rapists/ accessed 21 July, 2022
[6] World Health Organization. 2022. Abortion care guideline. Geneva, World Health Organization. https://apps.who.int/iris/handle/10665/349316. License: CC BY-NC-SA 3.0 IGO accessed 21 June, 2022
[7] WHO, 2022: https://srhr.org/abortioncare/
[8] UNFPA, 2022. Op Cit.
[9] WHO, 2022. Abortion Fact Sheet. https://www.who.int/news-room/fact-sheets/detail/abortion accessed 15 August, 2022.

Table 4.1: Key facts on abortion in Southern Africa

Country	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Laws	Penal Code 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
Abortion on request	Yes	Not specified	No	No	No	No	No	Not specified	No	Yes	No	Not specified	Yes	Not specified	Not specified	No
Unmet Need for Modern method of Contraception																
% of unmarried sexually active women 15 - 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
Unintended Pregnancy and Abortion rates																
Unintended pregnancy rate per 1000 women 15 -49	120	97	95	117	111	99	95	115		88	104		81	105	123	74
Abortion rates per 1000 women 15 - 49	33	31	31	33	29	23	60	31		40	29		30	38	35	18
% of unintended pregnancies which end in abortion	28	32	32	28	27	24	63	27		47	28		37	36	28	25
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

Sources: 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. Bearak JM, Popinchalk A, Beavin C, et al. Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019. BMJ Global Health 2022;7:e007151. doi:10.1136/bmjgh-2021-007151. https://gh.bmj.com/content/7/3/e007151 accessed 20 June, 2022

Table 4.1 shows that no country has made progress in expanding access to legal and safe abortion or post abortion care, despite courageous efforts in a few countries. Reasons for failing to translate SRHR commitments into accessible services include:

- Insufficient political will and leadership, especially around upholding the rights of girls and women.
- Strong opposition which is often well resourced by international anti-abortion groups.
- Weak health systems made even weaker by the COVID pandemic.

As there are no new DHS surveys in any SADC country since 2018 (the most recent DHS survey was in Zambia in 2018), there is no new comparative data on access to contraception.

Table 4.1 includes estimates of unintended pregnancy rates, abortion rates and the proportion of unintended pregnancies that end in abortion for most countries in SADC. Researchers from Guttmacher and the UNDP/UNFPA/ UNICEF/ WHO/ World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Department of Sexual and Reproductive Health and Research, based in the WHO, developed a model to estimate unintended pregnancy and abortion rates.

The complex model uses information on contraceptive needs and use, contraceptive method mix, birth rates, the proportions of births from unintended pregnancies and abortion incidence data to estimate the rates of unintended pregnancy and abortion. The researchers were able to produce estimated rates in five-year bands for 150 countries and territories. WHO published the model online to make it available for scrutiny and questioning. National focal points had the opportunity to review the data for their countries through a WHO country consultation process, which does not mean that countries have endorsed the estimates. The data, published in the BMJ Global Health[10], includes estimates for the period 2015 to 2019. Some important points to note from this data are:

- The estimated rates of unintended pregnancy per 1000 women aged 15 - 49 range from a low of 74 in Zimbabwe (which has had a community based family planning programme for a long time) to a high of 123 in Zambia.
- The estimated abortion rates per 1000 women aged 15 - 49 range from a low of 18 in Zimbabwe to a high of 60 in Madagascar, which has the most stringent law against abortion in SADC.
- The proportion of unintended pregnancies that end in abortion range from 24% in Lesotho to 63% in Madagascar.

Unintended pregnancy: The root cause of abortion



A call to end unintended pregnancies at the launch of the 2021 Barometer in Eswatini. Photo: Gender Links

UNFPA's 2022 report on the State of the World's Population is titled: *Seeing the Unseen: The Case for Action in the Neglected Crisis of Unintended Pregnancy*. Despite commitments of the ICPD, the SDGs and impressive gains in developing new methods of contraception, close to 50% of all pregnancies in the world are unintended. Dr Natalie Kanem, UNFPA Executive Director, claims "Every human being has the right to bodily autonomy, and perhaps nothing is more fundamental to the exercise of that right than the ability to choose whether, when and with whom to become pregnant."[11]

[10] Bearak JM, Popinchalk A, Beavin C, et al. Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019. BMJ Global Health 2022;7:e007151. doi:10.1136/ bmjgh-2021-007151 https://gh.bmj.com/content/7/3/e007151 accessed June 20, 2022.
[11] UNFPA, 2022. State of World Population 2022. Seeing the Unseen: The Case for Action in the Neglected Crisis of Unintended Pregnancy. New York, UNFPA.

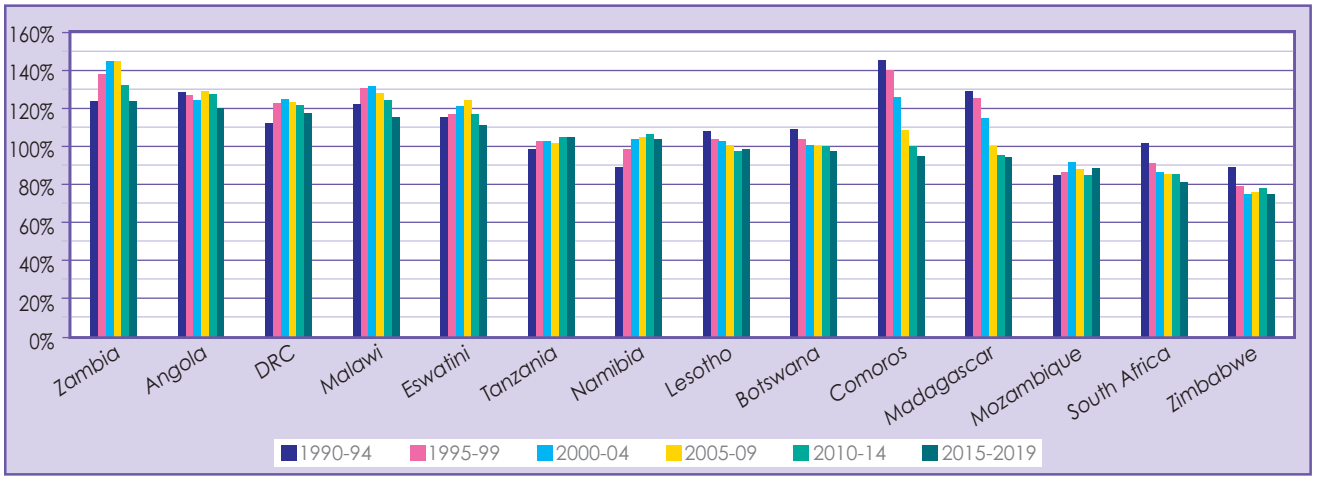
Every human being has the right to bodily autonomy

UNFPA defines unintended pregnancy as "A pregnancy that occurs to a woman who was not planning to have any (more) children, or that was mistimed, in that it occurred earlier than desired. This definition is applied independent of the outcome of the pregnancy (whether abortion, miscarriage or unplanned birth)." The UNFPA defines unwanted pregnancy as "1. A pregnancy that a woman does not want to have. 2 (academic) When measured in surveys, a pregnancy that occurred when a woman did not want to have any children at all, or any more children. The academic definition does not recognise that a woman might decide she wants the pregnancy after it occurs, even if she was not planning to have any (more) children." An unintended pregnancy may be wanted or unwanted.

Table 4.2: Unintended Pregnancy per 1000 women aged 15-49 in SADC[12]

Country	1990-94	1995-99	2000-04	2005-09	2010-14	2015-19
Zambia	123	123	145	145	132	123
Angola	128	128	125	129	127	120
DRC	113	113	127	124	121	117
Malawi	124	124	132	127	124	115
Eswatini	115	115	121	124	117	111
Tanzania	97	97	103	102	105	105
Namibia	89	89	104	105	107	104
Lesotho	108	108	103	101	98	99
Botswana	109	109	101	100	100	97
Comoros	145	145	125	109	100	95
Madagascar	129	129	115	100	96	95
Mozambique	84	84	92	87	84	88
South Africa	102	102	86	85	85	81
Zimbabwe	89	89	74	76	78	74

Figure 4.1: Unintended Pregnancy per 1000 women aged 15-49 in SADC



[12] Source: Gender Links compiled from Country sheets data in https://www.guttmacher.org/geography

Table 4.2 and Figure 4.1 shows the estimated annual rates of unintended pregnancy, in five-year bands, for SADC member states, as determined from the Guttmacher / WHO model. The table and its graphical representation show rates of unintended pregnancy in SADC range from 74 in Zimbabwe to 123 in Zambia. In Africa, the range is 49 in Niger to 145 in Uganda. Globally the range is 11 in Montenegro to 145 in Uganda.

The data reflects differences between the member states of SADC. Comoros and Madagascar show a dramatic reduction, South Africa and Zimbabwe fairly steady reduction and Lesotho and Botswana, steady but smaller reduction. Namibia has witnessed a steady increase. These variations in SADC differ from other regions that reflect a consistent decline between 1990 and 2019.

In Europe and North America, the rates of unintended pregnancy declined by 50%; in Southern and Central Asia and Latin America by 28%. Overall in Sub Saharan Africa the rate of unintended pregnancy declined by only 12%[13].

Women in all age groups experience unintended pregnancy, though there is often an assumption that adolescents are more likely to have unintended pregnancies. The costs of unintended pregnancy are however, higher for adolescents than older women.[14]

The UNFPA report ascribes the continued high rates of unintended pregnancy to women's lack of agency to make and act on informed decisions regarding their own child bearing. A number of factors contribute to improved agency, including:

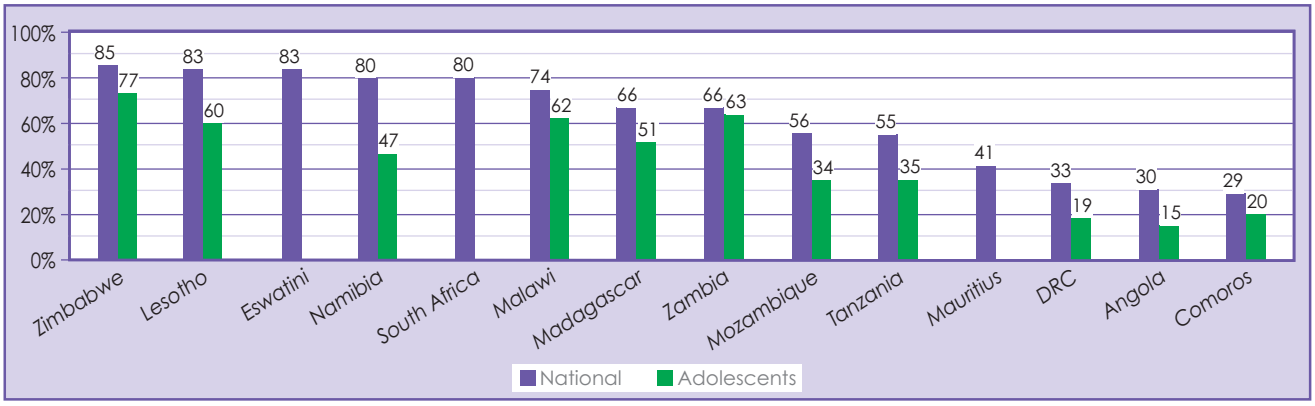
- Education of both women and men (in Sub Saharan Africa women with primary and secondary education were found to be 26 and 29% less likely to have an unintended pregnancy than those without any education).
- More equitable gender attitudes and gender equality.
- Higher income and access to services.
- Ability of couples to articulate and negotiate fertility preferences (in general men in Sub Saharan Africa want to have more children than women).

Factors, which reduce agency, include:

- Inconsistent and incorrect use of contraceptives.
- Failure of contraceptive method.
- Sexual violence.

SADC has high rates of unintended pregnancy: 74 - 123 per 1000 women aged 15 - 49

Figure 4.2: Demand for family planning met by modern methods, 2021



Source: Gender Links compiled from Maternal and Newborn Health Coverage Database.[15]

[13] UNFPA, 2022. Op Cit.
[14] UNFPA, 2022. Op Cit.
[15] https://data.unicef.org/topic/maternal-health/antenatal-care/ accessed 19 July, 2022

Figure 4.2 illustrates that the rate of provision of modern contraception varies in SADC from a low rate of 30% of all women's demand for contraception met in Angola to a high of 85% in Zimbabwe. Botswana and Seychelles did not share data. There is considerable variation within countries in the rate of access for adolescents and access for all women, with the largest discrepancies being in Angola and Namibia where coverage for all women and that for adolescents is 30% to 15% in Angola and 80% to 47% in Namibia.

The model developed by Guttmacher[16] and WHO estimated the following annual rates of abortion (in five year bands from 1990 to 2019) for SADC member states:

Table 4.3: Estimated annual abortion rates per 1000 women aged 15 - 49 in SADC

Country	1990-94	1995-99	2000-04	2005-09	2010-14	2015-19
Madagascar	60	66	63	56	59	60
Mozambique	27	33	35	34	38	40
Tanzania	27	34	33	32	36	38
Zambia	24	33	34	33	35	35
Angola	27	30	31	32	34	33
DRC	26	30	32	31	33	33
Botswana	22	27	28	27	30	31
Comoros	28	34	31	28	30	31
Malawi	19	25	25	24	29	31
South Africa	21	25	26	26	29	30
Eswatini	19	25	28	28	30	29
Namibia	16	23	27	26	29	29
Lesotho	18	23	24	22	23	23
Zimbabwe	14	17	17	17	19	18

Source: Gender Links compiled from Country sheets data.[17]

Figure 4.3: Estimated annual abortion rates: Trends from 1990-95 to 2015-19

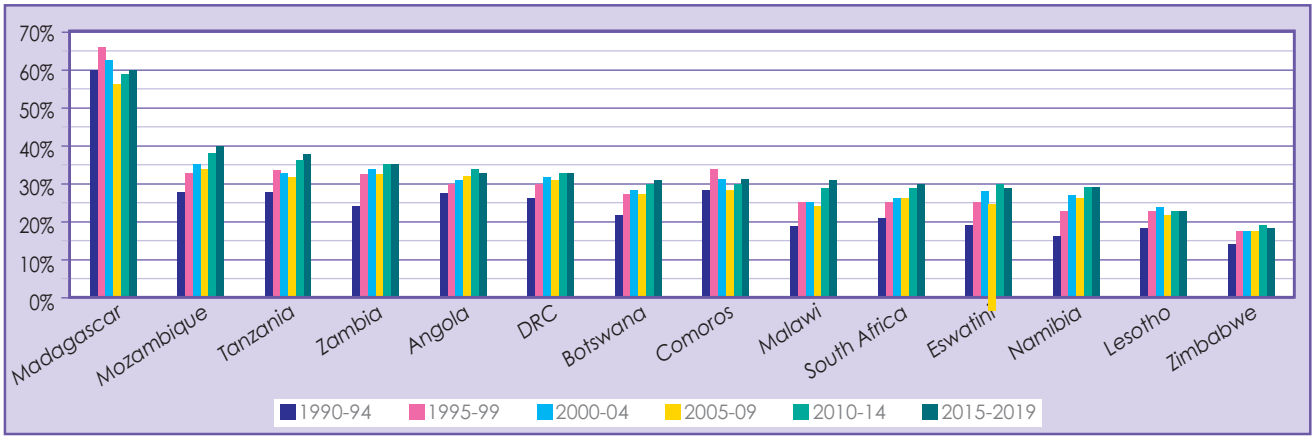
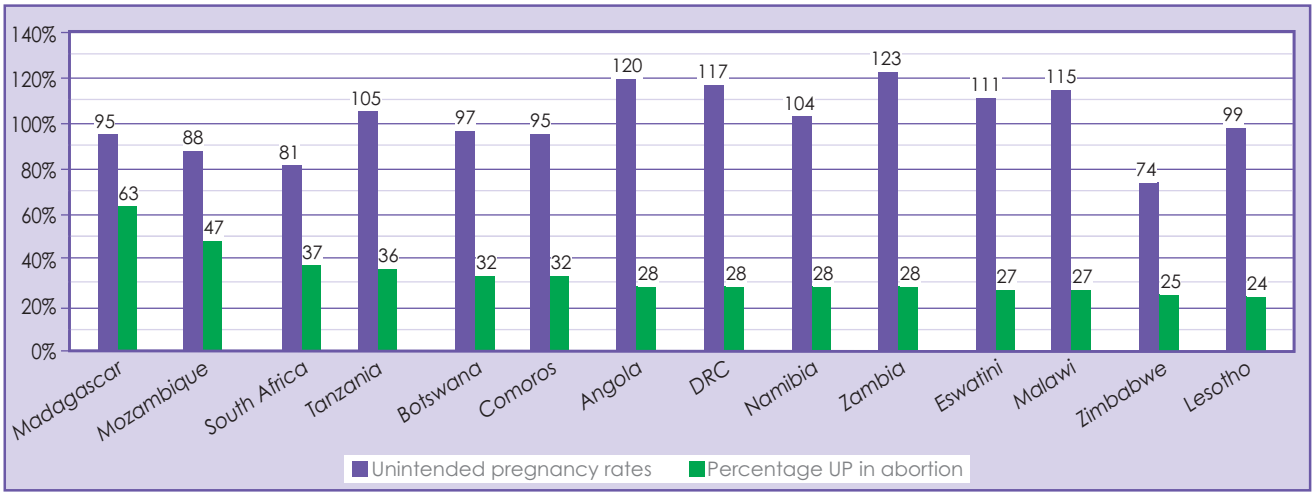


Table 4.3 and Figure 4.3 show that Madagascar, with the most stringent law against abortion, has the highest annual rate of abortion at 60 per 1000 women aged 15 - 49. The rates in other member states range from 40 per 1000 women in Mozambique to 18 per 1000 women aged 15 - 49 in Zimbabwe.

[16] Bearak et al, 2022, Op Cit.
[17] https://www.guttmacher.org/geography

All countries, except Madagascar (that has remained quite constant) reflect steady increases in the rates of abortion between 1990 - 1995 and 2015 - 2019. The highest rates of increase have been in Malawi (19 to 31 per 1000 women aged 15 - 49) and Namibia (16 to 29 per 1000 women aged 15 - 49). The population average abortion rate in Africa is 34; compared to Central and Southern Asia (46); Europe and North America (17); Latin America and the Caribbean (32); Asia (43), and Oceania 21. Guttmacher also estimated the proportion of unintended pregnancies that ended in abortion:

Figure 4.4: Proportion of Unintended Pregnancies (UP) that end in abortion



Source: Gender Links from data in the Supplementary material, Bearak J et al.[18]

Figure 4.4 shows that the proportion of unintended pregnancies that end in abortion is highest in Madagascar (63%) and lowest in Lesotho (24%). These are lower proportions than the global average. However, lower proportions of a high rate of unintended pregnancy is still a high overall abortion rate.

The impact of COVID-19

The restrictions imposed to curtail the spread of COVID-19 resulted in supply chain challenges in the production and distribution of contraceptives; disruption of contraceptive service delivery from health centres and increased gender based violence. Many people in Sub Saharan Africa moved deeper into poverty, owing to reduced employment opportunities. There is little hard data on how COVID restrictions affected access to SRH services in general and contraceptives or abortions in particular, though a few studies reflect disruptions.

A study conducted in Malawi, Burkina Faso, Ethiopia, Kenya, and Uganda found that restrictions and lockdowns in response to COVID-19 resulted in reduced access to SRH services[19], including contraceptives, antenatal care, Post-Abortion Care (PAC), HIV prevention and care as well as disruptions to other sectors, such as transport, health, trade, and security.

Some health facilities closed or converted to COVID-19 isolation and treatment centres during the pandemic. Clients reported that the longer distances, combined with a fear of contracting the virus, elevated costs of healthcare. Negative attitudes of some providers impeded access to SRH services. Many stopped visiting health facilities, delayed or postponed care seeking, or utilised non-facility-based care. Some treated themselves with over-the-counter medications, while others sought alternative care sources (traditional healers and birth attendants).

[18] Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015-2019.
[19] African Population & Health Research Center, 2021. Impact of the COVID-19 Pandemic on Sexual and Reproductive Health Services in Burkina Faso, Ethiopia, Kenya, Malawi and Uganda. https://aphrc.org/wp-content/uploads/2022/05/APHRC-COVID-Report-Final-3.pdf accessed 15 July, 2022.

Health providers reported reduction in the availability of some SRH services due to supply shortages; an absence of trained personnel and the closure of health facilities. Some facilities implemented innovative strategies to ensure continuity of SRH services, including telemedicine, self-care approaches, changes in timing for services, and altering referral patterns for care services. Members of marginalised communities such as the LGBTQI communities experienced even more restrictions to access of services.



The human toll of illegal abortions during COVID-19

Twenty-nine year old Chikondi in peri-urban Lusaka, Zambia became pregnant during the COVID-19 lockdown. Chikondi already had two daughters that she was struggling to provide for, as the occasional agricultural work that had sustained them was scarce during COVID-19 lockdown. Her boyfriend was supportive but unable to provide financially for a child. COVID restrictions had made it difficult for her to get to the health centre, 70 kilometres away, for contraceptives. The mobile services that used to come to her village were suspended and her friends could not afford to go to Lusaka and bring contraceptives back for her.

Though abortions are legal in some circumstances in Zambia they are difficult to obtain. Chikondi resorted instead to a bitter mixture of herbs recommended by a friend who had used it. After several days of severe bleeding her boyfriend managed to get her to hospital, where doctors removed the foetus and cleaned the blood out of her uterus. She also had a blood transfusion.

Dr Mulindi Mwanahamuntu, head of clinical care at the Lusaka University Teaching Hospital's Obstetrics and Gynecology department, is quoted as saying emergency gynecological admissions spiked during the pandemic. More than half were linked to non-clinical abortions. "I am imagining how many women are out there that have failed to access post-abortion care, those that are silently dying," he said.

Source: Phiri, Prudence. February 27, 2022. "Bitter Brew: Pandemic Spurs Uptick in Abortions".[20]

Table 4.4: Deliveries and terminations of pregnancy in girls aged 10 - 19 years in the public sector, South Africa, 2017/18 - 2021/22

	2017-18	2018-19	2019-20	2020-21	2021*	Increase 2017-18 to 2021 %
Population 10 - 14 years, n	2 546 451	2 628 874	2 689 346	2 769 793	2 806 206	8.8
Population 15 - 19 years, n	2 304 256	2 373 843	2 316 027	2 371 690	2 439 133	2.9
Population 10 - 19 years, n	4 850 707	5 001 717	5 005 373	5 141 483	5 245 339	6
Deliveries 10 - 14 years, n	2 726	3 527	3 870	4 053	2 226	48.7
Deliveries 15 - 19 years, n	114 329	121 059	127 028	134 267	70 656	17.4
Deliveries 10 - 19 years, n	117 055	124 586	130 898	138 320	72 882	16.8
Terminations 10 - 19 years, n	12 896	14 441	16 301	13 972	7 211	8.3

*Data for 2021 is for 6 months 1 April 2021 to 30 September 2021.[21]
**all rates are per 1000 girls of the same age band.



South Africa: Abortion is legal in South Africa. Pregnancy in the 10 - 14 age group is, by definition, evidence of statutory rape. As reflected in Table 4.4 terminations of pregnancies in public facilities increased between 2017 and 2020 and then

[20] https://globalpressjournal.com/africa/zambia/bitter-brew-pandemic-spurs-unsafe-abortions/
[21] Ibid.

dropped quite dramatically between 2020 and 2022, even as pregnancies in both 10 - 14 year olds and 15 - 19 year olds increased. This suggests a curtailment in access to abortion services due to the COVID-19 restrictions[22]. An October 2021 article described the lengths that girls and women had to go to, queueing for more than 24 hours in the open in freezing weather to be one of the 21 that would be served on a Monday or Wednesday at an Mthatha clinic[23]. The humiliating and expensive experience for the women forced some who failed to access the service to illegal and unsafe providers. News stories provide details of some of the struggles that women had to endure during the COVID-19 lock downs.

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 disproportionate burden of care affecting women: (b) Ensure universal access to good-quality health care, including testing and treatment for HIV and AIDS, and sexual and reproductive health; (d) Reduce maternal mortality rates and prevent deaths of newborn babies and children under the age of five years.[24]

Nairobi Statement on ICPD25: Accelerating the Promise[25]
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.[26]

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 unplanned pregnancies and unsafe abortion are reduced.

Ironically the continent with the first human rights instrument to recognise abortion, under certain conditions, as women's human rights is still also a region of extremely restrictive legislation and practice on abortion.

[22] Barron P, Subedar H, Letsoko M, Makua M, Pillay Y. Teenage births and pregnancies in South Africa, 2017 - 2021 - a reflection of a troubled country: Analysis of public sector data. S Afr Med J 2022;112(4):252-258. https://doi.org/10.7196/SAMJ.2022.v112i4.16327
[23] Sizani M and Jubase H.-Pregnant women resort to sleeping rough outside abortion clinic. Daily Maverick 21 Oct 2021. https://www.msn.com/en-za/news/other/pregnant-women-resort-to-sleeping-rough-outside-abortion-clinic/ar-AAPMZP8?ocid=entnewsntp accessed 22 October, 2021.
[24] 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
[25] https://www.nairobisummiticpd.org/content/icpd25-commitments accessed 27 May, 2020.
[26] 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.


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RAPE
WOMEN IS
RAPE MUST
FALL
NASA
GIVE HOPE
INSPIRE LIFE

Table 4.5: Legal provisions regarding abortion in SADC[27]

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[28]	N/A Available on demand	Within the first trimester	Right to terminate without consent of other parties apart from medical practitioners		Yes, for the woman, provider, and person who helps a woman obtain abortion
Mozambique	Amended Penal Code	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[29]	A certified practitioner must perform termination at designated facilities[30]	Yes, for the woman, provider, and person who helps a woman obtain abortion
ABORTION AVAILABLE IN 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[31]	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[32]	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[33]	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)[34]	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[35]	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 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[37]		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[38]	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[39] 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

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

Table 4.5 shows that almost all member states in SADC still have very restricted abortion legislation. 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. There are six main grounds for allowing abortion that apply in most countries (see table below):

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

Legislation in SADC is often archaic, based on inherited colonial legislation not changed in decades, and which does not uphold commitments to women made in multiple forums. The table shows that only South Africa and Mozambique permit abortion on all six grounds. Zambia, Namibia, Botswana, Angola and Comoros permit abortion on four out of six grounds. DRC, Zimbabwe, Lesotho and Mauritius permit abortion on three out of six grounds. Seychelles, Tanzania and Eswatini permit abortion on two out of six grounds. Malawi and Madagascar permit abortion on just one ground - risk to life. Such restrictive legislation has been described as "compulsory childbearing"[40].

> Restrictive legislation is compulsory childbearing

[40] UNFPA, 2022. Op Cit

Southern Africa: Movement for safe abortion gains momentum[41]



The Southern Africa Gender Protocol Alliance marches for #VoiceandChoice. Photo: Colleen Lowe Morna

Members of the Southern African Gender Protocol Alliance commemorated International Safe Abortion Day on 28 September 2021 in a dialogue on the prevention of unsafe abortion in SADC. The dialogue provided an opportunity for sharing experiences from across the region, on challenges, strategies, advocacy and initiatives to end unsafe abortion.

The Alliance is a network of national women's rights networks in 15 SADC countries that campaigned for the SADC Protocol on Gender and Development in 2008, and now its implementation. Gender Links, a Southern African women's rights organisation based in Johannesburg coordinates the Alliance and the annual Barometer measuring progress on gender equality in the region.

Rather than decreasing, as is the case in many parts of the world, the abortion rate in Africa has increased since 1994 as described in the preceding paragraphs. Unsafe abortions affect mostly poorer, unmarried women and adolescents fuelling high maternal mortality rates in the region. The risk of dying from an unsafe abortion is much higher in Africa than in any other region. Africa accounts for 62% of the global deaths resulting from abortion.

Lintle Ramatla, of Bokamoso 974 FM in Lesotho highlighted the important role of the media: "Most media are not giving women the opportunity to talk about this issue". According to Pansi Katenga of Ipas, a non-governmental organisation that advocates for access to safe abortions and contraception, "when we start reflecting on why we should make unsafe abortion history, we start realising it is about someone's life."

Katenga shared the experience of Malawi where Ipas is working with government, parliamentarians, chiefs, religious leaders and the media to help them appreciate that "unsafe abortion is a crisis in Malawi and that something needs to be done… we need to start talking about experiences and why law reform is needed."

Highlighting the root causes of unsafe abortion such as unmet needs for contraception, sexual violence and teenage pregnancy is important.

[41] Gender Links News, 27 October 2021. Susan Tolmay, "Southern Africa: Women call for an end to unsafe abortion".

The 48 participants from across the SADC region who joined the debate on International Safe Abortion Day noted that abortions happen whether it is legal or not. It is a time-sensitive medical service that is a basic human right and should be provided without restriction to save the lives and livelihoods of women and girls.

Alliance members in 15 SADC countries are crafting national advocacy strategies on Adolescent Sexual and Reproductive Health and Rights (ASRHR) policy and teenage pregnancy, safe abortion and child marriage, targeting key policy makers and influencers, with a strong focus on youth involvement. Amplify Change, a global fund to promote SRHR, supports these campaigns.

SAfAIDS leads the SRHR cluster of the Alliance. SAfAIDS and the SADC Parliamentary Forum (SADC-PF) jointly hosted a hybrid side event on SRHR during the 51st Plenary Assembly of the SADC-PF in April 2022. The joint meetings built on the Regional Policy Advocacy Dialogue held with Parliamentarians on 1 April 2021 which resulted in key recommendations passed by Members of Parliament towards a Regional Roadmap on Ending Unsafe Abortion and Early and Unintended Pregnancy (EUP).

The side event during the Plenary Assembly was a first of its kind. It brought together representatives from 15 SADC countries representing SADC-PF Standing Committees on Gender Equality, Women Advancement and Youth Development (GEWAYD); Human and Social Development and Special Programmes (HSDSP), the Regional Women's Parliamentary Caucus and representatives of the SADC-PF Secretariat.

Forty-nine delegates participated in the regional event (38 MPs).

Members of Parliament (MPs) present acknowledged that unsafe abortion and related consequences continue to deter efforts to improve maternal and reproductive health for women and adolescent girls, and negatively affect their health and wellbeing. The MPs called for advocacy and capacity strengthening to support parliamentarians to take bold steps towards policy review to remove restrictions on access to safe abortion in the respective Member States. Recommendations and proposed action plans included:

- SADC-PF should consider a Model Law on Safe Abortion to guide Member States on reviewing current policies and laws in favour of removal of legal restrictions.
- The need for increased efforts to build, strengthen and sustain the capacity of MPs, and support them to be champion is safe abortion in their parliaments and constituencies.
- SADC-PF, SAfAIDS and other key stakeholders should strengthen support for MPs pushing for abortion laws and policies to be tabled in Madagascar, Malawi, Eswatini, Zimbabwe and Lesotho, to strategically push back on and counter opposition.
- The need for cross learning and experience sharing for SADC Parliamentarians with a view to adopting best practices in advocacy for ending unsafe abortions and early and unintended pregnancies.
- Ensuring Member States domesticated Article 14 of the Maputo Protocol, and increase investments to strengthen implementation of the SADC SRHR Strategy and Sustainable Development Goals.

The section that follows details measures taken at national level to advance access to safe abortion in Madagascar, Lesotho, Malawi and Eswatini. Despite the slow progress, collaboration between civil society, Members of Parliament (MPs) and the media is gradually bearing fruit in these particularly conservative SADC countries. Meanwhile, a Constitutional court test case in South Africa showed just how fragile liberal provisions are in the few countries where these exist.



Madagascar: Section 317 of the penal code prohibits termination of pregnancy for any reason. Any abortion can expose women to two years in prison. Madagascar inherited this provision from the Napoleonic Penal Code of 1817. Despite French law changing, the provision remains in place in Madagascar.

Marie Jeanne d'Arc Masy Goulamaly a member of Parliament in Madagascar and vice-president of the Gender Equality, Promotion of Women and Youth Development Committee of the Parliamentary Forum of the Community of Southern African States, tabled a proposed law PPL 004-2021/PL on Therapeutic Termination of Pregnancy (ITG) on 18 October 2021 in the National Assembly, for inclusion in the Parliamentary agenda.

The proposed bill allows for therapeutic abortion in cases where the pregnancy is a danger to the life of the mother, foetal impairment, where pregnancy is the result of rape or incest as well as for women who are mentally incapable of assuming the role of a parent. A similar bill tabled in 2017, as part of a bill on family planning, failed to gain traction. Despite civil society demonstrations, parliament has still not debated the bill.[42]

An estimated 75,000 abortions take place in Madagascar annually, many unsafe. Since 2017 various organisations have challenged the existing law and organised events to highlight the damaging impact that the law has on women's lives and health. Nifin'Akanga, a leading advocate for decriminalisation of therapeutic abortion in Madagascar, celebrated World Safe Abortion Day in 2021 by sharing the results of the largest national survey on abortion practices in Madagascar. The survey, conducted in late 2020, covered 4,478 people (3,568 women and 910 practitioners). Selected results included:

- Women of all ages have abortions. The age range was between 14 and 50.
- Women have abortions regardless of their level of education. Those with education up to secondary school represent 38.5% and university graduates were more than 42%.
- Women who have/have had a stable relationship represent more than 51% of those accessing abortions.
- Christians constituted just over 81% of respondents, even though Christians adopt the most virulent and closed discourse when it comes to the decriminalisation of abortion.
- Fifty two percent of abortions take place in inappropriate settings, such as women's homes or the homes of practitioners.
- People with no medical training perform 31% of abortions. Paramedics perform 29.5% doctors 22% and matrons 18% of abortions.
- Eighty eight percent of women in Madagascar do not use any contraceptive method.
- Reasons given for abortion were: 23,2% pregnancy too early; 20,1% unwanted pregnancy and 20,3% other (including medical or therapeutic, rape and incest)

The stories were, above all, of courage and demands for change in the law

Nifin'Akanga has also compiled a booklet with stories of 15 women who have undergone abortions and survived. The stories are of love, loss, abuse, incest, pain, but above all courage and demands for change in the law to respect the bodily autonomy of women. A few were able to access medication abortion but without expert advice on how to use it. Some needed post abortion hospitalisation and for some this ended in hysterectomy. Many knew of women who had died because of abortion but it did not deter them.

[42] Compiled from: Safe Abortion: Women's Right, "Madagascar - New Therapeutic abortion bill tabled in Parliament", News: Madagascar. https://www.safeabortionwomensright.org/news/madagascar-new-therapeutic-abortion-bill-tabled-in-parliament/ accessed 7 July, 2022. Amnesty International, "Report Madagascar", https://www.amnesty.org/en/location/africa/southern-africa/madagascar/report-madagascar/ accessed 9 July, 2022. Tétaud, Sarah, Afrique 4 June, 2022,"Madagascar: the law on therapeutic termination of pregnancy again excluded from the Assembly" https://www.rfi.fr/fr/afrique/20220604-madagascar-la-loi-sur-l-interruption-th%C3%A9rapeutique-de-grossesse-%C3%A0-nouveau-%C3%A9cart%C3%A9e-de-l-assembl%C3%A9e accessed 9 July, 2022. Ramavonirina, Patricia. LaVerite, 13 Mai, 2022, "Proposition de loi sur l'interruption médicale de grossesse - Manifestation de la société civile devant l'Assemblée nationale", https://laverite.mg/societe/item/16213-proposition-de-loi-sur-l-interruption-m%C3%A9dicale-de-grossesse-manifestation-de-la-soci%C3%A9t%C3%A9-civile-devant-l-assembl%C3%A9e-nationale.html accessed 9 July, 2022

[43] Safe Abortion: Women's Right, News, Madagascar https://www.safeabortionwomensright.org/news/madagascar-lets-continue-the-legacy-of-mireille-rabenoro-28-september-2021/



His Eminence Great Mfuti of Zambia, Sheikh Assadullah Mwale and Her Royal Highness Princess Mihanta Ramanantsoa of Madagascar during the SAfAIDS Regional Religious and Traditional Leaders Sectoral Policy Advocacy Dialogue on Preventing Unsafe Abortion. Photo: SAfAIDS, My Choice Our Choice

The SAfAIDS champion, Her Royal Highness Princess Mihanta Ramanantsoa, a traditional leader has been supporting Marie Jeanne d'Arc Masy Goulamaly, the parliamentarian who tabled the Therapeutic Abortion Bill in parliament. The Bill will enable Malagasy women and adolescent girls to legally access safe abortion in selected circumstances. She is arguing that unsafe abortions have a negative impact on lives and wellbeing of women and girls. They are collaborating with Nifin'Akanga.



In 2010, **Lesotho** promulgated the Penal Code 2010, which legalised abortion in the case of rape; where the life of the mother is in danger; or where the fetus is extremely deformed. This resulted in uproar and anger in some quarters. In 2018, the parliament social cluster committee, civil society organisations, non-governmental organisations and individuals began the arduous campaign for legalisation of abortion in Lesotho.

Despite evidence that illegal and unsafe abortions are taking a heavy toll on the health and wellbeing of girls and women, there is stiff resistance to relaxing the legislation that governs the provision of this service, particularly from traditional communities and fundamentalist Christians. The parliament social cluster has mounted countrywide consultations on the need for Lesotho to act on legal and safe abortion for all who need the service.

In light of the backlash experienced in 2010, many parliamentarians fear that their constituents may turn against them. The hope is for a policy or law on safe abortion even though it is not clear when parliament or responsible ministries intend to develop legislation on safe abortion. Activists hope that a bottom-up approach will have more chances of being accepted.

However, with many of the hospitals and clinics run by churches, activists face several challenges.

Parliamentarians in Lesotho agreed with SAfAIDS that they need to take the discussion on safe abortion to different regions of the country. Evidence suggests that doctors are offering unsafe abortions in Lesotho under the counter. Those with means to cross into South Africa where they can access safe and legal abortion. COVID-19 lockdowns hampered this access.

Parliamentarians arranged to visit three regions of the country where they spoke with traditional leaders to assess sentiments to changing the law and expanding the circumstances under which a woman can access a safe abortion. This led to a recommendation for an inter-ministerial task force to look at the options for liberalising the law and expanding the circumstances under which women can access legal abortion.

One of the SAfAIDS champions in Lesotho, MP Ts'epang Mosena, argues that Lesotho has committed to many regional, continental and international protocols that bind it to improving the lives and wellbeing of women. She says Lesotho can only honour these commitments by expanding the circumstances under which safe abortions can be accessed.



Lesotho: Taking the campaign to the airwaves



Lintle Ramatla is a radio presenter on Bokamoso FM who champions safe abortion in Lesotho by involving and engaging with radio listeners and social media followers. Herself a teenage mother, Ramantla works closely with SAfAIDS, IPAS and Gender Links on safe and legal abortion. On her radio programme, women and girls share their lived realities. They speculate on how legalising abortion could change their lives.

The radio programme aims to curb the stigma associated with abortion and to assist with trauma counselling for women and girls who have undergone abortion are charged and imprisoned or must pay a fine. Failure to pay a fine results in imprisonment and a criminal record that affect employability.

Feedback from the programme suggests that even older people want abortion to be legal in Lesotho. One of the reasons that listeners give for legalising abortion is that it has social and economic implications for young girls. For instance, some church schools do not allow pregnant girls to remain in school. In some cases, they do not allow teenage mothers to attend their schools. This denial of access to education for teenage mothers has negative economic and social impacts for the mothers and their children.

Listenership to the programme on safe abortion has increased. Listeners give positive feedback regarding the need for legalisation of abortion in Lesotho. More people are advocating for legalising abortion on social media. Activists plan to use the responses to advocate with government to develop and implement a policy on safe abortion in Lesotho.

Political parties throughout the world will need to emancipate women by allowing them access to abortion when needed. As such, the next campaigns on safe abortion are targeting the leaders and women's leagues of political parties that are in parliament and make laws. Political parties should include issues of safe abortion in their manifestos.



Lintle Ramatla receiving an award from the Former Deputy Minister Marefuoe Muso during the 2020 SADC Protocol@Work Summit. Photo: Ntolo Lekau

Though COVID-19 restrictions and low levels of funding have limited campaigning on safe abortion, the campaign will be re-energised to close follow up on the Parliamentary motion on safe abortion.

Source: Gender Links News Service, July, 2022. Safe Abortion in Lesotho.



In October 2021, the Parliament of **Namibia** opened public hearings on a petition brought to parliament in 2020 to liberalise the law governing abortion and sterilisation. Namibia inherited its restrictive 'Abortion and Sterilisation Act No2 of 1975' from the apartheid administration. South Africa legalised abortion in 1996, through the Choice in Termination of Pregnancy Act. Namibia is clinging to the old Act.

There has been significant press coverage of the hearings with one opinion piece decrying the hypocrisy of lawmakers who have already made their anti-abortion sentiments public collecting allowances to traverse the country and listen to those in authority who will validate these positions. The article claims that "the same people fail to take action against those who abuse and rape young girls and women or to alleviate the emotional trauma and suffering of vulnerable women and young girls." Further, the writer says that those who support campaigns against comprehensive sexuality education in schools also support punishing young girls who resort to illegal and unsafe abortions but there is no support for vulnerable girls who are forced into pregnancy. "Those lawmakers know that the people who most need safe abortions will struggle to make their voices heard in a society that has no tolerance for women (even the oldest ones) to express their sexuality matters openly and freely," the article concludes.[44]

Senior sociology lecturer at the University of Namibia Lucy Edwards said, "it's a woman's right to choose whether she wants to terminate a pregnancy or not. Traditional leaders, who are mostly men, do not support abortion because they will never have to face this decision. It undermines a woman's right to choose, and the right to her bodily autonomy. I don't know why we are always peddling tradition when it comes to upholding women's rights... A lot of traditional views are deeply entrenched in patriarchy and the desire to control women's bodies."[45] The Voices for Choices and Rights Coalition (VCRC) is a nationwide movement of voices in Namibia, advocating for the choices reflective of bodily autonomy and freedom from the structural violence of restrictive abortion laws.





Malawi: There has been little progress in parliament with regard to the proposed Termination of Pregnancy Bill tabled in 2021 and then tactically withdrawn. An example of the ultra-conservative resistance to the bill in Malawi is the following extract of an article released by an American Catholic organisation:

"Fr. Z. got to work right away rallying pro-lifers in parliament and the Malawian people. With support from our donors, he built strong opposition to the bill through Radio and TV programs. This strategy still works, but it's getting more and more difficult.

Pro-abortion groups paid some networks not to run any pro-life material. On others they bought up the airtime, driving prices out of our budget range. Thanks be to God, the Catholic networks in Malawi did not accept any of their blood money. And they have a long reach. The pro-life message made a serious impact through these channels.

After Fr. Z. started talking about the bill, Malawians shouted for parliament to drop it. Lawmakers listened, and the abortion bill died before reaching the discussion stage. Thanks to all our donors for making this victory possible!

[44] Women's Law Centre. 18 October, 2021. Press Release. WLC supports liberalisation of abortion laws in Namibia - Women's Legal Centre (wlce.co.za) accessed 20 June, 2022.
Nthengwe, Ndilewa, 23 April, 2022. Abortion on Demand in Namibia. https://www.namibian.com.na/6219872/archive-read/Abortion-on-Demand-in-Namibia accessed 12 July, 2022
[45] Namibia. Traditional Leaders Oppose Abortion Law Reform. 24 January, 2022. https://allafrica.com/stories/202201240530.html accessed 12 July, 2022.

The Plan to Keep Pre-born Malawians Safe Long-term

The impact through the Catholic stations did the trick this time, but the pro-aborts aren't giving up. They'll be back next year with another scheme. With your pro-active support now, we can be ready for them…

But to stay ahead of the pro-aborts we need to step up our efforts. And you can help. Our donors made it possible to stop abortion from spreading in Malawi this year. And with your support, pre-born Malawians will be safe for years to come."

Source: Human Life International, October 19, 2021. Malawi's Secret Abortion Bill Exposed.[46]

SAfAIDS and the Coalition for the Prevention of Unsafe Abortion (COPUA) have been supporting the Chair of the Portfolio Committee on Health, Dr Matthews Ngwale, to lobby more parliamentarians, as many are new since the last elections. The strategy is to engage with parliament as an institution to build the capacity of all parliamentarians. Parliamentarians are conducting safe abortion dialogues at constituency level to mobilise support as Malawi is extremely conservative. One of the SAfAIDS champions, Senior Chief Inkosi Jere Mabulabo is a Traditional leader who is speaking on the need to expand circumstances in which safe abortion is allowed, and prevent the needless loss of lives of women and adolescent girls.



One of the SAfAIDS **Eswatini** SRHR champions, MP MacFord Sibandze, steered the debate on inclusion of access to safe abortion in the Public Health Bill. Although he faced much backlash for his stance, including personal attacks, he remained resolute in his advocacy, calling on other Parliamentarians to address policy restrictions to safeguard the health and wellbeing of women and adolescent girls in Eswatini. Following a presentation to parliament by opponents of abortion in the Public Health Bill, a group of CSOs, led by SAfAIDS and including Gender Links, held a dialogue with the Portfolio Committee on Health to advocate for inclusion of Safe Abortion in the Public Health Bill.



In **South Africa**, in the case, "CCT 120/21 Voice of the Unborn Baby NPC and Another v Minister of Home Affairs"[47], representatives of two anti-abortion groups and the Catholic Church sought to give the parents of an unborn child or foetus the right (though not obligation) to bury the remains. Although the law is silent on this issue, the regulations for birth and death registration consider a miscarriage to be of a foetus before 26 weeks and a stillbirth after 26 weeks. The procedure for a miscarriage is incineration of the remains in the hospital while remains of a stillbirth can be buried. The Women's Legal Centre argued that allowing burial of foetal remains could be a barrier to access of abortion services.[48]

The case originally brought to court in June 2018, went before the Constitutional Court in November 2021 with judgement in June 2022. The Constitutional Court rejected the application, accepting that the right to foetal burial might impact on the health care sector in South Africa. As things stand, access to abortion services is impacted by:

- Stigma and discrimination when seeking the service at health facilities;
- Lack of open and accessible information about where to access abortion services in South Africa;
- Poor supplies of reproductive health commodities and regular stock-outs of contraception and medical abortion drugs; and
- Limited numbers of trained and willing health personnel to provide the service and limited numbers of facilities designated to offer the service.

[46] https://www.hli.org/2021/10/malawis-secret-abortion-bill-exposed/ accessed 20 July, 2022.
[47] https://www.safeabortionwomensright.org/news/south-africa-voice-of-the-unborn-baby-constitutional-court-hearing-on-fetal-burial-after-miscarriage/ accessed 30 June, 2022.
[48] https://www.youtube.com/watch?v=qiqjYAzBmng accessed 30 June, 2022. WLC, June 2022. Press Statement on Safeguarding access to safe and legal abortions - Constitutional Court Judgment handed down in the matter of Voice of the Unborn Baby NPC and another v Minister of Home Affairs and another. https://wlce.co.za/safeguarding-access-to-safe-and-legal-abortions-voice-of-unborn-baby/?fbclid=IwAR2wEU93JF7sMOy7gbyHYbuBBh_Yc-PapmrGAdwx9opD7h24_Dvml_FzuV0 accessed 20 June, 2022.

A movement for the total decriminalisation of abortion

Decriminalisation means removing abortion from all penal / criminal laws

Local efforts continue to advocate for liberalisation of abortion laws with more grounds for safe abortions. Globally there is now a growing movement towards complete decriminalisation of abortion founded in notions of gender equality and human dignity, challenging legal restrictions to women's bodily autonomy. Legal campaigns for the decriminalisation of abortion embrace criminal, health, constitutional, and international law.[49]

Only a very few countries, such as China (1979), Canada (1988), Northern Ireland (2019), New Zealand (2020), and Australia (2021), have removed abortion from their penal laws completely. In a bold statement on this matter by a UN body, the first recommendation in the WHO 2022 Abortion Care Guidelines is "the full decriminalisation of abortion."[50] The guidelines say that decriminalisation:

- Means removing abortion from all penal/ criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.
- Would ensure that a woman who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care.
- Does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute serious assaults as these would be non-consensual interventions.[51]

The guidelines further recommend against laws and other regulations that restrict abortion by grounds and that abortion should be available on the request of the woman, girl or other pregnant person. The final recommendation on legislation is that abortion should not be restricted based on gestational age limits.

FIGO (the International Federation of Gynaecology and Obstetrics) describes decriminalisation as "the removal of specific criminal sanctions against abortion from the law so that no one is punished for providing safe abortion or for having an abortion. In practice, decriminalisation means that the police and the legal system are not involved in the investigation or prosecution of safe abortions. Instead, abortion care is treated like any other essential health issue in medicine, for which the standard of care is based on best practice guidelines, training and delivery, with regulation by health authorities."[52]

FIGO's statement in Feb 2022 called for "the total decriminalisation of safe abortion, and for the promotion of universal access to abortion, post-abortion care and evidence-based, non-biased abortion-related information, free of force, coercion, violence and discrimination. Abortion should be removed from criminal law and regulated by laws consistent with every other medical procedure, and with the wellbeing of women and girls placed at the centre of their care."

[49] Malagodi M, Gender Equality and the Complete Decriminalisation of Abortion , Int'l J. Const. L. Blog, Nov. 10, 2021, at:http://www.iconnectblog.com/2021/11/gender-equality-and-the-complete-decriminalisation-of-abortion/ accessed June 30, 2022.
[50] WHO, 2022. Op Cit.
[51] Ibid
[52] International Federation of Gynecology and Obstetrics. 2022. FIGO Calls for the Total Decriminalisation of Safe Abortion . Available from: www.figo.org/resources/fig52statements/figo calls total-decriminalisation safe abortion

On the Global Day of Action for Access to Safe and Legal Abortion, 28 September 2021, the AU Special Rapporteur on the Rights of Women, Honourable Commissioner Maria Teresa Manuela, reminded "African States of their obligations under the Maputo Protocol." She said these included their obligations to put in place appropriate measures to realise women's access to reproductive health care services. The Special Rapporteur further *called on States to decriminalise abortion*[53] and empower women and girls to make their own choices about their reproductive health."[54]

AU Special Rapporteur on the Rights of Women calls on States to decriminalise abortion

Medication Abortion

Since women began using Misoprostol for abortions, its use has expanded around the world. The WHO recommends a combination of Mifepristone and Misoprostol for medication abortion. Medication abortion is easier, less invasive and has similar results to other forms of safe abortion, particularly when used before nine weeks gestation. Misoprostol is generally cheaper and more readily available as it is used for other conditions as well. Misoprostol alone seems to have similar efficacy to the combination of the two drugs.

The move to self-management of abortion care accelerated rapidly to counter the compromises in abortion care during the COVID lockdowns. Global Doctors for Choice categorise SMMA (Self-Managed Medication abortion) as:

- Abortions using mifepristone and/or misoprostol, self-sourced and ingested without reliable support.
- Abortions obtained outside the formal health-care system using social networks, at pharmacies, or online, where some non-health system support is provided such as an accompaniment service or a safe abortion hotline.
- A "harm reduction" approach in legally restricted settings, where physicians date pregnancy, provide information about medications, warning signs of complications and post-abortion care, but medication is self-sourced. This approach was pioneered in Uruguay, when abortion was severely restricted.
- Abortions in a restricted context, with drugs prescribed by a clinician via telemedicine outside the formal healthcare system, with no in-person clinical encounters. An example is Women on Web, through which women obtain abortion medications online with support from a physician. Medications are sent via mail with support from a 24 hour telephone hotline with trained non-medical staff. Clients are advised to visit emergency services for symptoms of serious complications.
- Abortions with drugs prescribed within the formal healthcare system by a clinician via telemedicine, with medication taken at home.
- Abortions using drugs prescribed within the formal healthcare system, by a clinician in person, where at least one medication is taken at home. This includes outpatient medical abortion, where screening and mifepristone administration is in clinic, misoprostol is at home and post-abortion evaluation is in-clinic.[55]

Several studies have assessed the efficacy of self-managed abortion care (often with some

[53] Emphasis Gender Links.
[54] African Commission on Human and Peoples' Rights, 28 September, 2021. "Statement of the Special Rapporteur on the Rights of Women on the Occasion of the Global Day of Action for Access to Safe and Legal Abortion", 28th September 2021 https://www.achpr.org/pressrelease/detail?id=602 accessed 6 July, 2022.
[55] Global Doctors for Choice. 2021. Integrating Self-Managed Medication Abortion with Medical Care: A Briefing Paper. https://globaldoctorsforchoice.org/wp-content/uploads/SMMA-BP-7-6-21.pdf accessed July 10, 2022.

advice or accompaniment)[56]. Generally, women have found the process effective, with abortion outcomes achieved. A study to examine the availability of Misoprostol and Mifepristone in 44 countries around the world[57], including 17 in Sub Saharan Africa (of which DRC, Mozambique, South Africa, Tanzania, Zambia are in SADC) found that these were quite readily available in all countries, but with wide variation in pricing. Misoprostol is much cheaper than Mifepristone, which is relatively expensive and would be difficult for many poor women to access. In many cases, researchers could not verify the quality of the available medication.

WHO emphasises that all individuals engaging in self-management of medical abortion need accurate information, quality-assured medicines including for pain management, the support of trained health workers and access to a health-care facility and to referral services if they need or desire it.

A cursory google search of "abortion" and any one of the countries that neighbours South Africa produces details for abortion clinics in South Africa where abortion is legal. There is no data to confirm how many women from neighbouring countries seek abortion services from private providers in South Africa, some of whom advertise the availability of pills that can be delivered. There is also no information on the quality of information and instructions that are shared with women about use of the pills, or when to seek help. Those with economic means - who are often older and urban, have more options for quality abortion care.

Post Abortion Care

Even where abortions are not legal, most countries provide some access to post abortion care (PAC). This is often as a last resort, when less and least safe abortions have resulted in serious complications such as sepsis and excessive bleeding. A number of SADC countries have policies and guidelines on the provision of post abortion care (see Table 4.7).

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.

[56] See for instance: Moseson H, Jayaweera R, Egwuatu I, Grosso B, et al (2021) Effectiveness of self-managed medication abortion with accompaniment support in Argentina and Nigeria (SAFE): a prospective, observational cohort study and non-inferiority analysis with historical controls. Lancet Glob Health 2022; 10: e105-13 https://doi.org/10.1016/S2214-109X(21)00461-7 accessed 28 June, 2022.
Bercu C, Filippa S, Jayaweera R, Egwuatu I, et al. (2022) A qualitative exploration of how the COVID-19 pandemic shaped experiences of self-managed medication abortion with accompaniment group support in Argentina, Indonesia, Nigeria, and Venezuela, Sexual and Reproductive Health Matters, 30:1, 2079808, DOI: 10.1080/26410397.2022.2079808 accessed 28 June, 2022.

[57] Durocher J, Kilfedder C, Frye L J, Winikoff B & Srinivasan K (2021) A descriptive analysis of medical abortion commodity availability and pricing at retail outlets in 44 countries across four regions globally, Sexual and Reproductive Health Matters, 29:1, 196-213, DOI: 10.1080/26410397.2021.1982460 accessed 28 June, 2022.

Madagascar: Human resources norms and procedures for PAC include emergency care, counselling, and integrated services with direct links to the community. Public and private clinics, such as those operated by international organisations (e.g., Marie Stopes and Population Services International [PSI]) have PAC protocols and clinical guidelines for doctors and midwives. Government has not adopted these. Women face multiple barriers to accessing PAC services including: a restricted policy environment; limited access to poor quality health services with only 40% of the Malagasy population living within five kilometres of most health centres; lack of awareness of PAC services and stigma from the community and providers.[58]

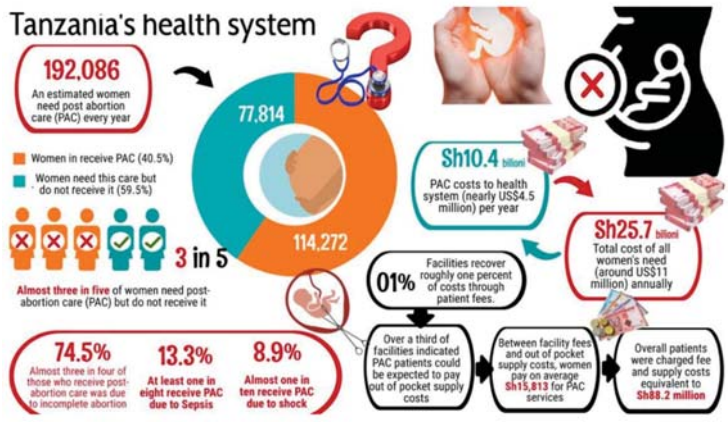
Malawi: Ipas is supporting the Ministry of Health in Malawi to provide capacity to health centres to provide PAC. Ipas is also raising awareness about the dangers of unsafe abortions and encouraging women to access PAC.[59] While PAC is available in most primary and secondary health facilities, the quality and quantity of equipment and service is often inadequate.

Zimbabwe: A qualitative study among young women who sell sex[60] found that 151 of the 198 young women, aged 16 - 24, had ever been pregnant and 44 of these had had an abortion. Of these 10 had experienced complications and 18 had had more than one abortion. Reasons that the young women gave for having an abortion included:

- Socio economic - not being able to care for a child.
- Not knowing the father of the baby.
- Still being in school.

Socio economic constraints drove women to less safe abortion methods. Many knew of safer services, including access to misoprostol, but chose old women who use a variety of traditional, mostly unsafe mechanisms. Few knew of formal PAC services or willingly accessed these for fear of the legal implications of reports that they had an abortion. They were aware of the need for "cleansing the uterus" and did this as best they could at home, with traditional remedies. An earlier study found that adolescents aged 15 - 19 comprise at least 12% of PAC patients in Zimbabwe.[61]

Tanzania: A study conducted by Guttmacher and Muhimbili University of Health and Allied Sciences (MUHAS) in Dar es Salaam, Tanzania[62], estimated the health system costs of offering PAC in Tanzania in 2018, at existing levels of care and when hypothetically expanded to meet all need. The study found that 77 814 women received PAC nationally at a cost of $4,5m. It is estimated that 192 086 women needed care and approximately 40% received it. Thus, the total cost could be over $11million. Public facilities bore the majority of PAC costs, and recovered about 1% of costs through charges to patients. The study concluded that government needs to do more to prevent unintended pregnancies.



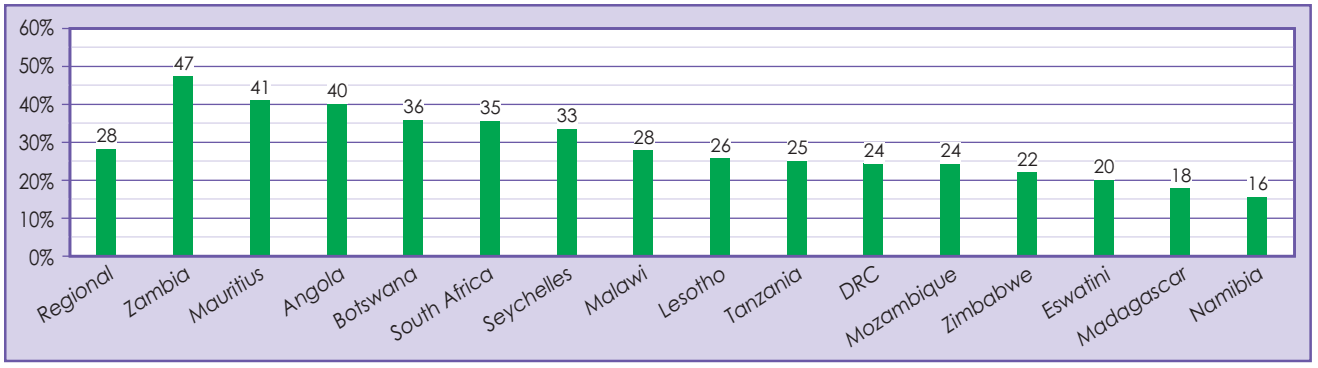
Source: Gregory, S. The costs of post-abortion care for Tanzania. The Citizen. November 1, 2021.[63]

[58] Engender Health, 2021. Madagascar PAC-FP Country Brief. https://www.engenderhealth.org/wp-content/uploads/2021/12/PAC-FP-Country-Brief_Madagascar.pdf accessed 28 June, 2022
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[60] Chareka S, Crankshaw TL, Zambezi P Economic and social dimensions influencing safety of induced abortions amongst young women who sell sex in Zimbabwe. Sexual and Reproductive Health Matters. Volume 29, 2021 -Issue 1. https://www.tandfonline.com/doi/full/10.1080/26410397.2021.1881209 accessed 17 July, 2022
[61] Madziyire MG, Polis CB, Riley T, et al. Severity and management of postabortion complications among women in Zimbabwe, 2016: a cross-sectional study. BMJ Open. 2018;8(2):e019658.
[62] Lince-Deroche, N et al. The Health System Costs of Post Abortion Care in Tanzania. BMC Health Services Research (2021) 21:720 https://doi.org/10.1186/s12913-021-06688-7 accessed July 7, 2022.
[63] https://www.thecitizen.co.tz/tanzania/magazines/health-/the-costs-of-post-abortion-care-for-tanzania-3604068

Changing attitudes

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

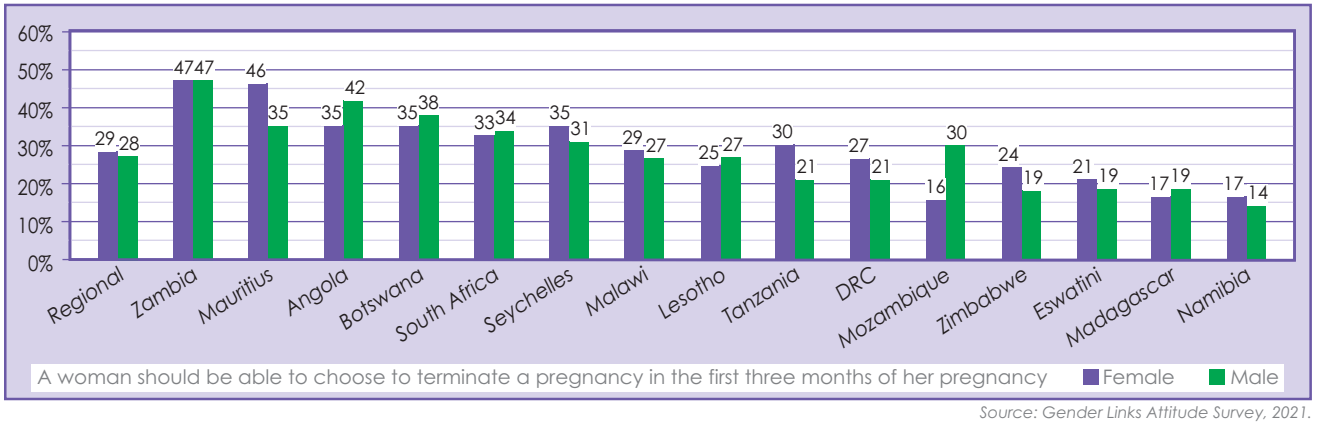
Figure 4.5: A woman should be able to choose to terminate a pregnancy, 2021



Source: Gender Links Attitudes survey, 2021.

Figure 4.5 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 4.6: Attitudes on abortion by sex



Source: Gender Links Attitude Survey, 2021.

Figure 4.6 shows the differences in attitudes between men and women in 2021 in relation to the question. The regional average is very similar between women and men with some differences between them in different countries.

Next steps

Key recommendations include:

- 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 available for both boys and girls - in and out of school.
- 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.
- Improved protection from sexual violence and work with communities to build safe communities that do not tolerate gender norms which perpetuate such violence
- 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.
- SADC Member states need to pay attention to medical experts in the WHO that are advocating for decriminalisation of abortion and critically consider why they believe it is necessary to keep such laws.
- 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.



Source: SAfAIDS, My Choice Our Choice

- 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 seek to expand access to medication abortion in as many different settings as possible. This is much safer and less invasive than traditional methods.

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