

*SOUTHERN AFRICA GENDER 2026*

# BAROMETER

Voice



+



Choice



Safe  
Abortion

# Acknowledgements

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## Alliance partners

### Angola

Plataform da Mulheres Acção

### Botswana

Botswana Network on Ethics, Law and HIV/AIDS

### DRC

Union Congolaise des Femmes des Medias

### Eswatini

Eswatini Young Women's Alliance

### Lesotho

She-Hive Association

### Madagascar

Fédération Pour la Promotion Féminine et Enfantine

### Malawi

Malawi Human Rights Resources Centre

### Mauritius

Media Watch Organisation

### Mozambique

Forum Mulher

### Namibia

Namibia Non-Governmental Organisation Forum

### Seychelles

GEM Plus

### South Africa

South African Women in Dialogue

### Tanzania

Tanzania Gender Network Programme

### Zambia

Women and Law in Southern Africa – Zambia

### Zimbabwe

Women's Coalition of Zimbabwe



# Safe Abortion

# 5



Showing support for the right to choose.

Photo: Colleen Lowe Morna

## Key points

- Progress in making safe abortion more easily available is painfully slow across the region even as it is acknowledged that unsafe abortions contribute significantly to high maternal mortality ratios (MMRs).
- The African Union (AU) Special Rapporteur on the Rights of Women repeated the call for complete decriminalisation on International Safe Abortion Day, 28 September 2025.
- The 2026 Barometer uses scores from the Southern Africa Safe Abortion Assessment completed by national members of the Safe Abortion Alliance of Southern Africa (SAASA) to rank countries' progress on the provision of safe abortion. The overall score for the region is 34%, with only three countries scoring over 50%. This indicates how difficult it is for women to access safe abortion in the region.
- Without commitment to overhaul legislation that is based on antiquated colonial era laws, activists engage in protracted legal battles to achieve slow change. Several strategic litigation cases in different countries, have had mixed outcomes. Two which were successful are:
  - In a landmark victory, the Malawi High Court ruled in October 2025 that a girl who had become pregnant because of sexual violence has the right, under section 19 of the Gender Equality Act to a safe abortion, without any obstacles.
  - The High Court in Zambia overturned a seven-year jail term meted out to a woman who procured an illegal abortion in January 2026.
- There is increasing momentum in the region around medication or self-managed abortion which puts power in the hands of women. Stock-outs of Misoprostol and Mifepristone are a barrier to availability of medication abortion.
- Zambia, DRC and South Africa are reviewing their abortion care guidelines to align to the most up to date World Health Organisation (WHO) guidelines. This includes guidelines for medical abortion which may be self-managed and roles in abortion care for a range of health care practitioners including nurses, midwives and pharmacists.
- Excellent standards and guidelines need to be disseminated to health care providers, with comprehensive training.

# Introduction



Photo: Trevor Davies

Unplanned and unintended pregnancies as well as pregnancies that are a danger to the physical or mental health or life of the mother or of the unborn child are not a new phenomenon. Termination of unintended pregnancies is not new either. Indigenous knowledge systems in many cultures include various potions that are intended to terminate pregnancies. There is evidence that abortions were performed in precolonial times<sup>1</sup>, without sanction for either the pregnant person who procured the abortion or for the person who provided the potion.

Criminalisation of abortion is a colonial construct, with legislation derived from antiquated legislation of the colonial masters (the French Napoleonic criminal code of 1810 in Franco-phone countries, the Portuguese Penal Code of 1886 in Lusophone countries and the British

Offences Against the Person Act or OAPA of 1861 in Anglophone countries). Imported Victorian mores, amplified by well-funded, Western anti-abortion organisations, continue to define abortion as anti-Christian even as countries accede to more modern views of dignity, equality and the rights of women to bodily autonomy, enshrined for instance, in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, commonly referred to as the Maputo Protocol.

Most member states of SADC have legislation that at least meets the requirements of the Maputo Protocol to allow abortion in the case of pregnancy resulting from 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. However, the legislation often requires cumbersome administrative procedures which makes it impossible to access legal, safe abortion within the tight time limits allowed. Further, health and judicial officials are often poorly acquainted with the provisions for legal abortion or are not supportive of providing abortions which are allowed in the law. There has been some progress in raising awareness of the circumstances in which safe abortion is allowed and must be provided as well as in developing guidelines for these.

## Legislation does not reduce the number of abortions

There is evidence that legislation does not reduce the number of abortions which occur. When a person becomes pregnant when they had not intended to be, or when they are not ready to have a child and care for one, they often choose to terminate the pregnancy. If access to safe

<sup>1</sup> Chingore-Munazvo, N. & S. Boshia, "Towards a constitutionally compliant Termination of Pregnancy Act in Zimbabwe: Upholding a rights-based approach to abortion." In Ngwenya et al eds. 2025. Abortion law reform in Africa: A reproductive health and rights perspective. Pretoria, Pretoria University Law Press, pg 113 - 4.

abortion is criminalised, they will find a way to terminate the pregnancy. Those with economic means access safe abortions, while those without, who are often younger and more rural, risk their lives to terminate an unintended and unwanted pregnancy using a variety of physical objects and potions. Unsafe abortions continue to contribute to high maternal mortality ratios in SADC.

Medication abortion (also referred to as medical abortion) is a non-surgical abortion, using two

medications - misoprostol alone or a combination of misoprostol and mifepristone. As this becomes more available, the risks of a clandestine abortion are declining. The WHO guidelines are that medication abortions can be safely supported by health workers such as nurses, community health workers and pharmacists, who are not doctors, up to 12 weeks gestation. Medication abortion is safe if good quality drugs are used, at the correct dosage and timing and the person procuring the abortion has access to prompt medical attention in case of any complications.

## The Southern Africa Safe Abortion Assessment

The 2026 chapter has scored all 16 SADC states against seven scales in the Southern Africa Abortion Assessment for the first time.

The **methodology** for this assessment is comparative expert-based indicator scoring which provides an independent civil society-led assessment for every country. Women's rights advocates or human rights lawyers served as specialised evaluators, one expert from each of the 16 countries. They scored their respective national governments to generate a comparative analysis of abortion policy and practice across the region. Evaluators were qualified as "domain experts" if they were one of the following:

- Affiliated with an NGO that is focused on gender equality or SRHR, with a focus on National members of the SAASA (Safe Abortion Alliance of Southern Africa).
- A legal practitioner with expertise in women's law or SRHR.

### *Themes and the 0-4 Scoring Framework*

The evaluation matrix comprises a composite indicator across seven themes - Compliance with Maputo Protocol; Strategic litigation; Parliamentary debate; National Association of Gynaecologists / Obstetricians support; Provider awareness / support; Public discourse score; and Abortion or post abortion care guidelines.

Each indicator was scored using a standardised 0-to-4 Likert-type scale, defined as follows:

- 0 Total Restriction / Non-Compliance.
- 1 Basic Framework / Weak Implementation.
- 2 Moderate Compliance.
- 3 High Compliance / Minor Gaps.
- 4 Full Realisation / Best Practice.

### *Data collection and analysis*

The breakdown of these questions is provided at relevant points in the chapter. To mitigate the subjective bias inherent in expert scoring and ensure cross-country consistency, evaluators provided qualitative justifications, legal citations, or empirical data to defend assigned scores. The quantitative 0-4 scores were normalised to a 100-point scale. This generates a civil society abortion assessment index, facilitates direct cross-country comparisons, identifies regional trends, and highlights specific policy sectors requiring urgent attention.



Safe Abortion Alliance of Southern Africa (SAASA) members prepare presentations for Barometer launch. Photo: Colleen Lowe Morna

Table 5.1: Key data on abortion in Southern Africa

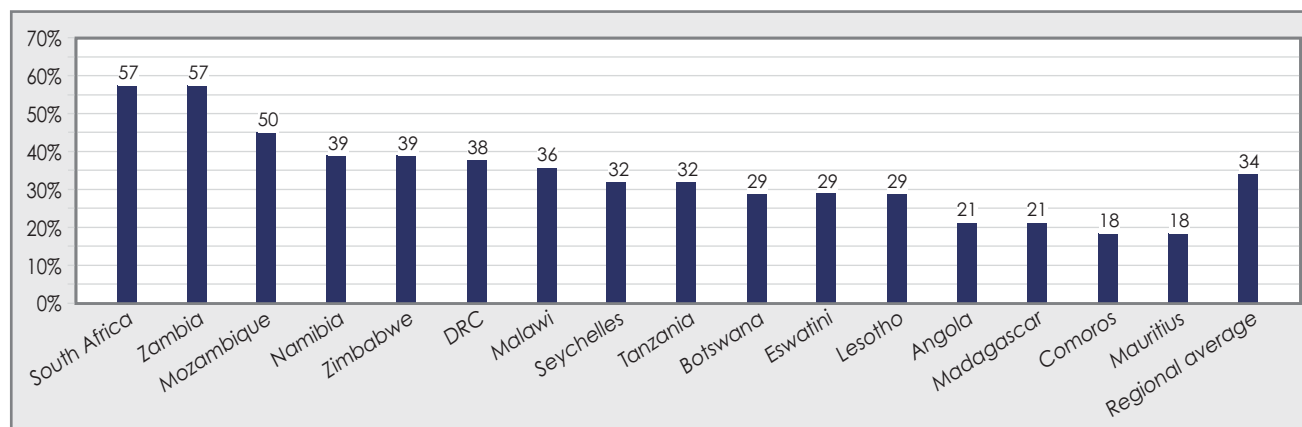
| Country                                                                                                                     | Angola          | Botswana                  | Comoros                                 | DRC                           | Eswatini                           | Lesotho         | Madagascar                                               | Malawi          | Mauritius              | Mozambique      | Namibia                             | Seychelles                                         | South Africa                                                     | Tanzania        | Zambia                                                | Zimbabwe                                                   |
|-----------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------|-----------------------------------------|-------------------------------|------------------------------------|-----------------|----------------------------------------------------------|-----------------|------------------------|-----------------|-------------------------------------|----------------------------------------------------|------------------------------------------------------------------|-----------------|-------------------------------------------------------|------------------------------------------------------------|
| Laws*                                                                                                                       | Penal Code 2017 | Penal Code Amendment 1991 | Penal Code 1981, Public health act 1995 | Maputo Protocol gazetted 2018 | Constitution 2005, Health Act 2023 | Penal Code 2010 | Penal Code 1998, Criminal Procedure Law, Health act 2011 | Penal Code 1930 | Criminal Code Act 2012 | Penal Code 2019 | Abortion and Sterilisation act 1975 | Termination of Pregnancy Act 1994, Penal code 1955 | Choice of Termination of pregnancy Act (92/1996) amended in 2008 | Penal Code 1945 | Termination of Pregnancy Act 2005 and Penal Code 2014 | Termination of Pregnancy act, 1977, Criminal law act, 2006 |
| <b>Southern Africa Safe Abortion Assessment</b>                                                                             |                 |                           |                                         |                               |                                    |                 |                                                          |                 |                        |                 |                                     |                                                    |                                                                  |                 |                                                       |                                                            |
| Overall score**                                                                                                             | 21              | 29                        | 18                                      | 38                            | 29                                 | 29              | 21                                                       | 36              | 18                     | 50              | 39                                  | 32                                                 | 57                                                               | 32              | 57                                                    | 39                                                         |
| Compliance with Maputo Protocol score**                                                                                     | 25              | 50                        | 25                                      | 50                            | 50                                 | 50              | 0                                                        | 25              | 50                     | 75              | 50                                  | 100                                                | 75                                                               | 25              | 75                                                    | 25                                                         |
| Strategic litigation score**                                                                                                | 0               | 0                         | 0                                       | 0                             | 0                                  | 50              | 0                                                        | 75              | 0                      | 0               | 50                                  | 0                                                  | 0                                                                | 25              | 75                                                    | 50                                                         |
| Parliamentary debate score**                                                                                                | 25              | 0                         | 0                                       | 0                             | 75                                 | 0               | 75                                                       | 25              | 0                      | 100             | 50                                  | 0                                                  | 25                                                               | 25              | 0                                                     | 25                                                         |
| National Association of Gynaecologists/Obstetricians support score**                                                        | 25              | 25                        | 25                                      | 75                            | 25                                 | 25              | 0                                                        | 50              | 25                     | 75              | 0                                   | 50                                                 | 75                                                               | 25              | 75                                                    | 25                                                         |
| Provider awareness / support score**                                                                                        | 25              | 50                        | 75                                      | 38                            | 0                                  | 50              | 0                                                        | 25              | 25                     | 25              | 50                                  | 75                                                 | 75                                                               | 25              | 50                                                    | 50                                                         |
| Public discourse score**                                                                                                    | 25              | 50                        | 0                                       | 25                            | 25                                 | 25              | 75                                                       | 25              | 0                      | 0               | 25                                  | 0                                                  | 75                                                               | 25              | 25                                                    | 50                                                         |
| Abortion or post abortion care guidelines score**                                                                           | 25              | 25                        | 0                                       | 75                            | 25                                 | 0               | 0                                                        | 25              | 25                     | 75              | 50                                  | 0                                                  | 75                                                               | 75              | 100                                                   | 50                                                         |
| <b>Maternal Health Indicators</b>                                                                                           |                 |                           |                                         |                               |                                    |                 |                                                          |                 |                        |                 |                                     |                                                    |                                                                  |                 |                                                       |                                                            |
| % of women 15 - 49 with unmet need for contraception***                                                                     | 37              | no data                   | 32                                      | 31                            | 20                                 | 23              | 13                                                       | 13              | 13                     | 27              | 15                                  |                                                    | 19                                                               | 21              | 16.5                                                  | 7                                                          |
| Maternal mortality ratio (MMR) 2025***                                                                                      | 170             | 177                       | 186                                     | 746                           | 452                                | 530             | 445                                                      | 224             | 47                     | 233             | 139                                 |                                                    | 89                                                               | 104             | 187                                                   | 212                                                        |
| Obstetric admissions due to treatment of abortion***                                                                        | 5.4             | 8.2                       | 2.7                                     | no data                       | 5.7                                | 61.1            | 3                                                        | 3.6             | 6.4                    | 15.2            | 0.2                                 | 77.1                                               | no data                                                          | 2.1             | 14.1                                                  | no data                                                    |
| <b>Key</b> <span>Very good</span> <span>Medium</span> <span>Low</span> <span>Very low</span> <span>Insufficient data</span> |                 |                           |                                         |                               |                                    |                 |                                                          |                 |                        |                 |                                     |                                                    |                                                                  |                 |                                                       |                                                            |

Sources: \*WHO, Global Abortion Policies Database: <https://abortion-policies.srhr.org/>, accessed 15 April 2020; \*\*Gender Links and Safe Abortion Alliance of Southern Africa (SAASA), 2026. Southern Africa Safe Abortion Assessment; \*\*\*SADC SRHR Scorecard, 2025, <https://www.2gether4srhr.org/data> accessed 13 May 2026

Maternal mortality ratios (MMR) in SADC are unacceptably high

Table 5.1 presents some key data on the need for and availability of safe abortion in SADC. This includes all the scores for the seven scales of the Southern Africa Abortion assessment which are discussed at relevant points throughout the chapter.

Figure 5.1: Southern Africa safe abortion assessment overall score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

Figure 5.1 shows that the overall score, or average score for the seven themes, for all countries is 34%. - ranging from 18% in Comoros and Mauritius to 57% in South Africa and Zambia. Mozambique, South Africa and Zambia are the only countries which scored above 50%. This reflects the challenges of securing a safe abortion, without stigma and discrimination, across the region.

Maternal health indicators come from the SADC SRHR (sexual and reproductive health and rights) scorecard. This indicates that there is still high unmet need for contraception (ranging from 7% of women of reproductive age in Zimbabwe to over 30% in Angola, Comoros and DRC). Providing contraception reduces the risk of unintended pregnancy which also reduces the demand for abortion. Though the data is not disaggregated, unmet need for contraception is generally higher in poorer, younger and more rural women.

The data also show that only Mauritius has achieved the SDG target of maternal mortality ratio (MMR) which is lower than 70 deaths per 100 000 live births. South Africa is the only other country with an MMR which is below 100. The ratios range to as high as 746 in the DRC. Though data on unsafe abortions is sparse it is widely accepted that unsafe abortion contributes to increased MMR. This is an avoidable tragedy as

the World Health Organisation (WHO) states categorically that "Abortion is safe when carried out using a method recommended by WHO, appropriate to the pregnancy duration and by someone with the necessary skills".<sup>2</sup>

Unsafe abortions are performed by persons lacking the necessary information or skills or in an environment that does not meet minimal medical standards, or both. The persons, skills and medical standards considered safe are different for medical and surgical abortion and by pregnancy duration. What is considered 'safe' or unsafe needs to be interpreted in line with the most current WHO technical and policy guidance.

States should reduce the rates of unintended pregnancies, and thus the demand for safe abortion, through making effective contraception accessible and available. They should also enhance protection from sexual violence. The United Nations Human Rights Council adopted Resolution A/HRC/60/L.20/Rev.1 on Preventable Maternal Mortality and Morbidity and Human Rights by consensus in October 2025.<sup>3</sup> The resolution notes that maternal deaths can be prevented, they are not inevitable, and this is an SDG target. It urges states to eliminate legal, structural, and social barriers that deny women and girls access to life-saving sexual and

<sup>2</sup> WHO (2026). Abortion. Available at [https://www.who.int/health-topics/abortion#tab=tab\\_1](https://www.who.int/health-topics/abortion#tab=tab_1) accessed on 15 May, 2026.

<sup>3</sup> UN General Assembly, (2025). Human Rights Council 60th Session. Resolution A /HRC/60/L.20/Rev.1. 3 October. Available at [https://docs.un.org/en/a/hrc/60/l.20/rev.1?utm\\_](https://docs.un.org/en/a/hrc/60/l.20/rev.1?utm_) accessed 10 May, 2026

reproductive health services by repealing discriminatory laws, combating gender stereotypes, and ensuring access to comprehensive sexuality education.

Table 5.1 shows that **11 of 16 countries in SADC use the Penal Code, or criminal law, to regulate access to abortion.** In seven of these the Penal Code is the only legislation governing access to abortion.

## Normative frameworks



**Maputo Protocol 14.1:** State 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 fetus.

**SADC SRHR Strategy 2018-2030:** Rates of unplanned pregnancies and unsafe abortion are reduced. An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6). Barriers - including policy, cultural, social and economic - that serve as an impediment to the realisation of SRHR in the region removed (SDGs 5.1 and 5c).

**SADC Protocol on Gender and Development: Article 26:** State Parties shall, in line with the SADC Protocol on Health and other regional and international commitments by Member States on issues relating to health, adopt and implement legislative frameworks, policies, programmes and services, to enhance gender sensitive, appropriate and affordable, quality health care, in particular, to: (a) eliminate maternal mortality.

**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.<sup>4</sup>

**Nairobi Statement on ICPD25: Accelerating the Promise<sup>5</sup>**

2. Zero unmet needs for family planning information and services, and universal availability of quality, accessible, affordable, and safe modern contraceptives.

3. Zero preventable 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.<sup>6</sup>

<sup>4</sup> 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](https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf), accessed 27 May 2020

<sup>5</sup> <https://www.nairobisummiticpd.org/content/icpd25-commitments>, accessed 27 May 2020

<sup>6</sup> 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](https://www.nairobisummiticpd.org/sites/default/files/Nairobi%20Summit%20Report%20on%20ICPD25_0.pdf), accessed 31 May 2020

## Addis Ababa Declaration on Population and Development after 2014 (AADPD)

37. Eliminate preventable maternal mortality and neonatal mortality through ensuring that births are attended by skilled health personnel, and that there is universal access to prenatal and postnatal care and family planning, emergency obstetric and neonatal care, and management of pregnancy-related complications and preventable complications arising from unsafe abortion in order to protect the health and safeguard the lives of women, adolescent girls and neonates;

38. Expand access for all women and adolescent girls to timely, humane and compassionate treatment of unsafe abortion complications and, in accordance with national laws and policies, provide access to safe abortion services.<sup>7</sup>

The African Union (AU) adopted the Maputo Protocol, the first legal treaty in the world to recognise abortion as women's human right, to fulfil its commitment to promote gender equality and to eliminate all forms of discrimination against all girls and women. The AU further adopted General Comment Number 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol<sup>8</sup> in 2014 to provide guidance on domestication and implementation of Article 14. The General Comment urges governments to adopt neutral policies to reduce cases of unsafe abortion, and to develop and implement national action plans to mitigate the prevalence of unintended pregnancies and unsafe abortions.

Women's rights to sexual and reproductive health, which are rights to exercise control over one's fertility, to decide one's maternity, the number of children and the spacing of births, and to choose a contraception method, are inextricably linked, interdependent and indivisible. The right to dignity enshrines the freedom to make personal decisions without interference from the State or non-State actors. The woman's right to make personal decisions allows her to interrogate beliefs, traditions, values and cultural or religious practices, and to choose to ignore any or all of them.

Other issues raised by general comment 2 are:

- Article 15.1.b) of the International Covenant on Economic, Social and Cultural Rights

(ICESCR) states that every individual must benefit from scientific progress and its applications. Women who are denied the means to interrupt an unwanted pregnancy safely, using effective modern services, such as medication abortion, are denied the right to benefit from this progress.

- Article 4 of the Protocol prohibits cruel, inhuman, and degrading treatment. Forcing a woman to keep a pregnancy resulting from sexual assault, rape and incest constitutes additional trauma which affects her physical and mental health.
- State Parties must ensure that law practitioners, judges and magistrates and judicial police officers are trained on respecting the rights of women, so that women are not arrested, charged and prosecuted when they seek safe abortion services or post-abortion care.
- State parties should avoid unnecessary or irrelevant restrictions on the service providers authorised to practice safe abortion and the requirements of multiple signatures or approval by committees. In many African countries, there are not enough trained physicians available. Mid-level providers such as midwives and other health workers should be trained to provide safe abortion care. The training of health workers should include non-discrimination, confidentiality, respect for the autonomy and free and informed consent of women and girls.

<sup>7</sup> African Union (2013) Addis Ababa Declaration on Population & Development after 2014. Available at [https://au.int/sites/default/files/newsevents/workingdocuments/43264-wd-AADeclarationPopulationAndDev\\_E.pdf](https://au.int/sites/default/files/newsevents/workingdocuments/43264-wd-AADeclarationPopulationAndDev_E.pdf) accessed 11 August, 2026..

<sup>8</sup> African Commission on Human and Peoples' Rights (2014) "General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights", 28 November. Available at <https://achpr.au.int/index.php/en/node/854> accessed 5 May, 2026.

Table 5.2: Legal provisions regarding abortion in SADC<sup>9</sup> and alignment with the Maputo Protocol

| Country                                                                               | Law                                                                            | Conditions under which an abortion may be granted |    |    |    |    |    |     |     |    |   | Gestational limits                                                                                                             |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------|----|----|----|----|----|-----|-----|----|---|--------------------------------------------------------------------------------------------------------------------------------|
|                                                                                       |                                                                                | ES                                                | FI | In | WD | Ra | WH | Wmh | Wph | WL | O |                                                                                                                                |
| Available on demand - Provisions are more than required by the Maputo Protocol        |                                                                                |                                                   |    |    |    |    |    |     |     |    |   |                                                                                                                                |
| South Africa                                                                          | Choice of Termination of pregnancy Act (92/1996) amended in 2008 <sup>10</sup> | Available on demand.                              |    |    |    |    |    |     |     |    |   | On demand to 13 weeks; under specific conditions, 13 to 20 weeks if her or fetus' life in danger or fetal anomalies, 20 weeks. |
| Mozambique                                                                            | Amended Penal Code 2019                                                        | Available on demand.                              |    |    |    |    |    |     |     |    |   | On demand to 12 weeks; in the case of incest, 16 weeks; in the case of fetal anomalies, 24 weeks.                              |
| Available on socio-economic grounds - more than required by the Maputo Protocol       |                                                                                |                                                   |    |    |    |    |    |     |     |    |   |                                                                                                                                |
| Seychelles                                                                            | Termination of Pregnancy Act, 2012<br>Penal Code                               | X                                                 | X  | X  | X  | X  |    | X   | X   | X  |   |                                                                                                                                |
| Zambia                                                                                | Termination of Pregnancy Act, 1972, amended in 2005 and Penal Code 2014        | X                                                 | X  |    |    |    | X  |     |     |    |   | Not specified.                                                                                                                 |
| Abortion available in specific circumstances - in compliance with the Maputo Protocol |                                                                                |                                                   |    |    |    |    |    |     |     |    |   |                                                                                                                                |
| Angola                                                                                | Penal Code 2020                                                                |                                                   | X  |    |    |    |    | X   | X   | X  | X | 16 weeks to preserve health, fetal impairment no limit.                                                                        |
| Botswana                                                                              | Penal Code (Amendment) Act, 1991 - Section 160                                 |                                                   | X  | X  |    | X  |    | X   | X   | X  | X | Termination must be performed before 16 weeks. <sup>12</sup>                                                                   |
| DRC                                                                                   | Act of Access to Maputo Protocol, 2018                                         |                                                   |    | X  |    | X  |    | X   | X   | X  | X | Up to 14 weeks.                                                                                                                |
| Eswatini                                                                              | The Constitution, 2005                                                         |                                                   | X  | X  |    | X  |    | X   | X   | X  | X | Up to 14 weeks.                                                                                                                |
| Lesotho                                                                               | The Penal Code 2012 <sup>14</sup>                                              |                                                   | X  | X  |    | X  | X  |     |     |    |   | Up to 14 weeks.                                                                                                                |
| Mauritius                                                                             | Penal Code 1983; Criminal Code Amendment Act 2012 <sup>15</sup>                |                                                   | X  |    |    | X  |    | X   | X   | X  | X | If a pregnancy is within 14 weeks and the girl is younger than 16.                                                             |
| Namibia                                                                               | Abortion and Sterilisation Act 2 of 1975                                       |                                                   | X  | X  |    | X  |    | X   | X   | X  |   |                                                                                                                                |
| Partial compliance with the Maputo Protocol                                           |                                                                                |                                                   |    |    |    |    |    |     |     |    |   |                                                                                                                                |
| Comoros                                                                               | Comoros-Penal-Code-The Health Act 1995                                         | Very serious medical reasons.                     |    |    |    |    |    |     |     |    |   | Not specified.                                                                                                                 |
| Malawi                                                                                | Penal Code 1930                                                                | Only to save a woman's life.                      |    |    |    |    |    |     |     |    |   |                                                                                                                                |
| Tanzania                                                                              | Penal Code 1981 <sup>16</sup>                                                  | Only to save a woman's life.                      |    |    |    |    |    |     |     |    |   |                                                                                                                                |
| Zimbabwe                                                                              | Termination of Pregnancy Act 1977 <sup>17</sup>                                |                                                   | X  | X  |    | X  |    |     | X   | X  | X |                                                                                                                                |
| Not compliant with Maputo Protocol                                                    |                                                                                |                                                   |    |    |    |    |    |     |     |    |   |                                                                                                                                |
| Madagascar                                                                            | Penal code, 1981, Reproductive Health and Family Planning Law 2017             | Abortion is prohibited.                           |    |    |    |    |    |     |     |    |   |                                                                                                                                |

<sup>9</sup> 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. Further refined with input from Centre for Reproductive Rights, The World's Abortion Laws. <https://reproductiverights.org/maps/worlds-abortion-laws/> accessed 29 August 2024, and Centre for Reproductive Rights, Maputo Protocol at 20. <https://reproductiverights.org/maputo-protocol-at-20/#:~:text=Twenty%20years%20ago%2C%20the%20African,rape%20and%20incest%3B%20when%20the> accessed 29 August 2024. Also <https://www.afro.who.int/publications/who-african-regions-countries-abortion-health-profiles> accessed 30 August, 2024

<sup>10</sup> [https://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169\\_1.pdf](https://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf)

<sup>11</sup> <https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique>

<sup>12</sup> <https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique>

<sup>13</sup> <http://www.gov.bw/en/Citizens/Sub-Audiences/Women/Unsafe-Abortions>, <https://www.hsph.harvard.edu/population/abortion/BOTSWANA.abo.htm>

<sup>14</sup> [http://www.wipo.int/wipolex/en/text.jsp?file\\_id=238601](http://www.wipo.int/wipolex/en/text.jsp?file_id=238601)

<sup>15</sup> <https://lesotho.ii.org/ls/legislation/num-act/6>

<sup>16</sup> <https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf>

<sup>17</sup> [https://www.globalfinancingfacility.org/sites/gff\\_new/files/Tanzania\\_One\\_Plan\\_II.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf)

<sup>17</sup> Termination of Pregnancy Act, <http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html>

| Consent                                                                                                | Provided by                                                      | Penalties for an illegal abortion                                                              |
|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 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.                    |
| Parental consent for minors; a health unit committee determines legal grounds. <sup>11</sup>           | A certified practitioner at designated facilities. <sup>12</sup> | Yes, for the woman, provider, and person who helps a woman obtain abortion.                    |
| If three medical practitioners agree in good faith, termination can be done at Victoria Hospital, Mahe |                                                                  | Imprisonment up to 14 years.                                                                   |
| Once three medical practitioners have agreed.                                                          |                                                                  | Seven years for person who administers; seven years for woman who administers own abortion.    |
| Parental consent for minors.                                                                           | Licensed facility and one doctor.                                | Four to ten years in prison.                                                                   |
| Consent of parent or next of kin for minors; two doctors.                                              | Licensed facility                                                | Three years for procurement; seven years for aiding.                                           |
| Parental consent for minors.                                                                           |                                                                  | Yes, for the woman, provider, and person who helps a woman obtain abortion.                    |
| Two doctors.                                                                                           |                                                                  | Life imprisonment.                                                                             |
| By a registered medical professional, with written opinion of another registered medical professional. |                                                                  | A fine of M5000 - M10 000 or imprisonment of up to three years.                                |
| Parental consent for minors.                                                                           |                                                                  | Imprisonment of up to ten years.                                                               |
| Two medical practitioners must approve that the pregnancy is a risk.                                   | Licensed facility.                                               | A fine not exceeding N\$5000 or imprisonment not exceeding five years, or both.                |
| Certified in writing by at least two doctors.                                                          | One doctor.                                                      | Imprisonment six months to two years & a fine of 15 000 to 100 000 francs.                     |
|                                                                                                        |                                                                  | 14 years for having an abortion; three years for supplying instruments to conduct an abortion. |
|                                                                                                        |                                                                  | Seven years for procurement; three years for suppliers.                                        |
| A magistrate must grant permission.                                                                    |                                                                  | Five years in prison and/or fine not exceeding \$5000.                                         |
|                                                                                                        |                                                                  | Not explicit, but death, forced labour or life are most severe punishments.                    |

| KEY | Acronym |                                                            | Acronym |                                       |
|-----|---------|------------------------------------------------------------|---------|---------------------------------------|
|     | ES      | For economic or social reasons                             | WH      | To preserve a woman's health          |
|     | FI      | In cases of fetal impairment                               | Wmh     | To preserve a woman's mental health   |
|     | In      | In cases of incest                                         | Wph     | To preserve a woman's physical health |
|     | WD      | In cases of intellectual/cognitive disability of the woman | WL      | To save a woman's life                |
|     | Ra      | In case of rape                                            | O       | Other                                 |

# Legislation governing abortion

Table 5.2 has information on the specific requirements in every country, regarding gestation periods, consent and who may provide the abortion. Many of these are so onerous that women and girls who should qualify for safe

abortion under the law are unable to access the service within the short timeframe that is allowed. These conditions are not aligned to General Comment 2.

Table 5.3: Adherence to the abortion provisions in the Maputo Protocol in SADC countries

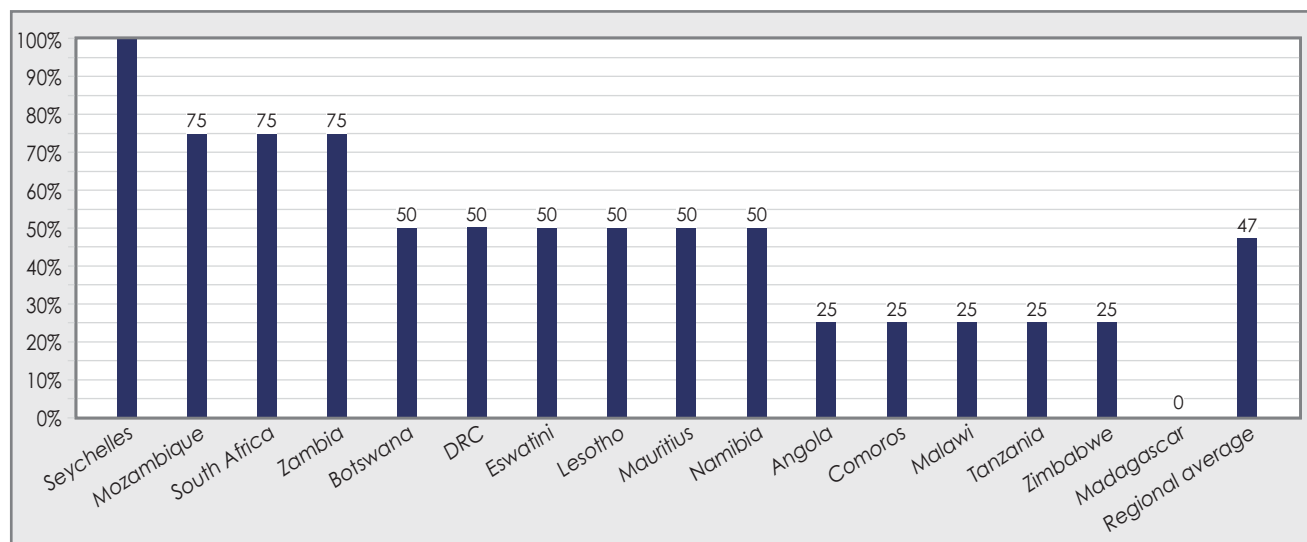
| Number of countries | Which countries                                                      | Abortion laws in relation to Maputo Protocol                                            |
|---------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| 4                   | South Africa, Mozambique, Seychelles and Zambia                      | Allow abortion under more circumstances than the Maputo Protocol;                       |
| 7                   | Angola, Botswana, the DRC, Eswatini, Lesotho, Mauritius and Namibia) | Compliant with the Maputo Protocol;                                                     |
| 4                   | Comoros, Malawi, Tanzania and Zimbabwe                               | Allows abortion under circumstances which are more restrictive than the Maputo Protocol |
| 1                   | Madagascar                                                           | Prohibits abortion under all circumstances.                                             |

Table 5.3 shows that four SADC countries exceed the provisions of the Maputo Protocol; seven are compliant; four are more restrictive and one country (Madagascar) does not allow abortion under any circumstances. The Compliance with the Maputo Protocol score in the Southern Africa abortion assessment is based on the following question and five possible answers. The response that is chosen determines the score which is achieved:

Does abortion legislation meet the conditions of the Maputo Protocol?

- (0) Abortion legislation does not meet the conditions of the Maputo Protocol.
- (25) Abortion legislation partially meets the conditions of the Maputo Protocol.
- (50) Abortion legislation meets the minimum conditions of the Maputo Protocol.
- (75) Abortion legislation exceeds the minimum conditions of the Maputo Protocol.
- (100) Abortion is available on request or through a highly accessible legal framework.

Figure 5.2 Compliance with Maputo Protocol score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

The results of the Southern Africa Safe Abortion Assessment closely mirror these legal realities (Figure 5.2). Seychelles scored 100 while South Africa, Mozambique and Zambia scored 75. These are the countries with legislation that provides for more than the Maputo protocol does. Although the legislation in Angola does

comply with the Maputo protocol, implementation of that legislation does not provide abortion services and thus it was ranked as 25 rather than 50. The lowest score on this scale is for Madagascar at zero, where abortion is completely outlawed. The regional average is 47.

## A movement for the total decriminalisation of abortion

When abortions are not legal, the rate of abortion does not decline. Rather, women resort to unsafe practices at great risk to their own health, future fertility and lives. There is a global movement urging states to decriminalise abortion which means removal of abortion from criminal law and regulation under health legislation as a medical procedure.

Professors Ngwena, Durojaye, Nabaneh and Murungi of the Centre for Human Rights at the University of Pretoria<sup>18</sup> note, "in light of women's rights to equality, which are constitutionally guaranteed, the onus is on the state to demonstrate that using highly intrusive and punitive criminal law is rational and proportionate to the state's legitimate goals. If the goal of criminalising abortion is to protect women from unsafe practices and/or to protect prenatal life, then current laws fail in both instances... criminalisation has served to harm rather than protect the lives and health of women. Equally, criminalisation has not protected pre-natal life."

There have been several calls for African states to decriminalise abortion altogether. On the International Safe Abortion Day, 28 September 2025, The Special Rapporteur on the Rights of Women in Africa and Vice-Chairperson of the African Commission on Human and People's Rights (ACHPR), Honourable Commissioner Janet Ramatoulie Sallah-Njie, called on African Union Member States<sup>19</sup> to:

- Take immediate steps to repeal laws that criminalise abortion, thereby ending the persecution and imprisonment of women, girls,

and healthcare providers for seeking or delivering essential medical care.

- Ratify, Domesticated, and Implement the Maputo Protocol.
- integrate comprehensive safe abortion and post-abortion care as core, accessible and affordable services within national health systems
- Dismantle stigma through education and information, so that women and girls can make informed decisions about their bodies and health.
- Protect healthcare professionals from intimidation, harassment or legal retaliation.



Honourable Commissioner Janet Ramatoulie Sallah-Njie. Photo: African Union

<sup>18</sup> Ngwena, C, Durojaye, E, Nabaneh, S. & Murungi, N. eds. (2025) Abortion law reform in Africa: A reproductive health and rights perspective. Pretoria, Pretoria University Law Press. p 4.

<sup>19</sup> African Commission on Human and People's Rights (2025) "Statement by the African Commission on Human and Peoples' Rights on the Occasion of International Safe Abortion Day", 28 September. Available at <https://achpr.au.int/en/news/press-releases/2025-09-28/statement-african-commission-human-and-peoples-rights-occasion> accessed 15 October, 2025.

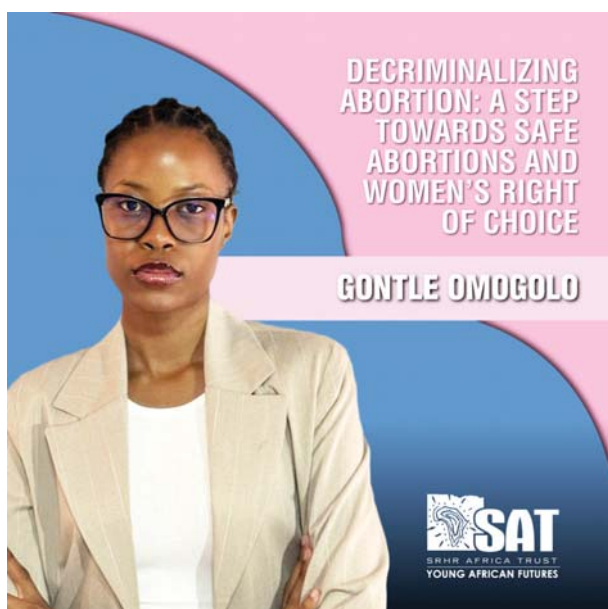
# Criminalisation has served to harm rather than protect the lives and health of women

Affected women are speaking out and calling their governments to change as illustrated by the cases of Botswana and Namibia. The legislation in both countries meets but does not exceed the grounds in the Maputo Protocol.



In a blog featuring voices of young people in **Botswana**, Gontle Omogolo<sup>20</sup>, says "It's simple really, despite what the

lawmakers tell you about not allowing abortions, the fact of the matter is that only safe and legal abortions are not allowed. Abortions are still carried out, just backstreet and unsafe. Young people especially are the victims of backstreet abortions through hangers, pills and chemicals. This is a direct result of banning access to health care, abortion should not have to be a crime. It is a right, a choice and women should not have to go through something as traumatic as rape in order to be allowed to exercise that right...



Gontle Omogolo.

Photo: SAT

The law of Botswana allows abortion under limited conditions: if the pregnancy is a result of rape or incest, or if continuing it would seriously harm the woman's physical health. All these instances have a common recurring theme of extreme trauma. Why is it that a woman is only given her right of choice under circumstances that are deemed untoward by the society? It's like saying we will allow it but only if you suffer enough to earn it. But rights are not earned, they just are. Why is this right of choice conditional? That is because it is an illusion of choice, not real choice. What we are offered is not freedom over our bodies - it's fear, bureaucracy and deafening silence. Who else do you know whose body is policed the way women's bodies are? What further makes it an illusion is that despite this limited access, in practice it is almost impossible to access...

## ... we will allow it, but only if you suffer enough to earn it

The world is progressing at a fast rate whether we like it or not and it is high time Botswana followed suit. No more having to cross the border to procure an abortion. No more breadcrumbs. The truth is a right that cannot be accessed is not a right at all. It's a performance. A way for power to look progressive without ever letting go of its grip on women's bodies and an injustice to anyone is an injustice to everyone. We will not be truly liberated until we are all free."

**Namibia's** Abortion and Sterilisation Act of 1975 is a relic of its apartheid past not repealed in the 2018 mass repeal of 144 discriminatory, pre-independence acts, ordinances, and proclamations dating from 1915 to 1992<sup>21</sup>. The Act restricts abortion access to narrow grounds of danger to the woman's life, physical or mental health; serious risk of the child being born with severe physical or mental defects or the pregnancy is a result of rape or incest. Bureaucratic barriers, stigma, facility shortages



<sup>20</sup> Omogolo, G. (2025) "Decriminalizing abortion: A step towards safe abortions and women's right of choice", SRHR Africa Trust Young African Futures. Available at <https://www.srhrafricatrust.org/decriminalizing-abortion-a-step-towards-safe-abortions-and-womens-right-of-choice/> accessed 10 August, 2026.

<sup>21</sup> The Namibian (2018). "144 apartheid laws to be repealed", The Namibian 3 December. Available at [namibian.com.na/144-apartheid-laws-to-be-repealed/](http://namibian.com.na/144-apartheid-laws-to-be-repealed/) accessed 12 September, 2026

and provider refusal make abortion under these grounds virtually inaccessible. This has fuelled widespread unsafe abortions, contributing an estimated 12-16% of maternal deaths and

thousands of complications every year. Poor, rural and marginalised women-including LGBTQIA+ groups carry the heaviest burden.

### **Namibia: 60 000 call for abortion law reform**

Voices for Choices and Rights Community (VCRC) Health and Research Institute launched in 2020, following a national petition of over 60,000 signatures demanding legal reform and safer reproductive health services. VCRC has built a nationwide network of 500 community mobilisers who facilitated dialogues across six of Namibia's 14 regions, centring lived experience for reproductive justice.

"People are dying because they have to go to dark corners. Whether it is legal or not, people are doing it," noted Hage G. Geingob, former President of Namibia.

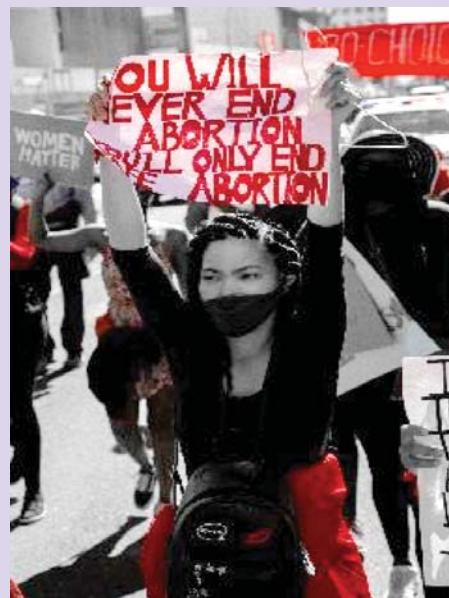
A powerful combination of research, mobilisation and digital storytelling is beginning to change the narrative. VCRC produced four major research papers-covering legal analysis, medical impacts of unsafe abortion, socio-cultural barriers and an economic review. VCRC presented these papers which have been referenced by lawmakers and the Ministry of Health and Social Services to Parliament's Standing Committee. VCRC's digital studio produced 13 multimedia pieces amplifying LGBTQIA+ voices and promoting inclusive SRHR narratives. Public awareness grew through the Annual Feminist Festival, which hosts more than 300 participants each year.

Working collaboratively with the Ministry of Health and Social Services (MOHSS), VCRC contributed to a draft reform paper in 2025. Although the draft has not yet progressed to Parliament, it marks the first formal movement toward legal change in decades. Faced with legislative delays, VCRC will lead a constitutional challenge in 2026, arguing that the 1975 law violates constitutional rights to dignity, life, equality, health and privacy. This litigation represents a pivotal next step in securing safe, legal abortion access for all. "We want a new bill that not only prioritises abortions but also provides access to comprehensive sexual health education," said VCRC Director Ndiilokelwa Nthengwe.

As a result of the campaign, grassroots networks are stronger, public awareness has expanded, and SRHR narratives now include previously excluded, marginalised groups. Communities are better informed, stigma is reduced, and policymakers now engage with evidence rather than silence. The movement has shifted Namibia from stagnation to serious, rights-based consideration of abortion law reform.

Sustaining this change requires continued community mobilisation, dissemination of research findings, expansion of grassroots networks and ongoing collaboration with frontline partners. Digital storytelling and public events will maintain visibility, while litigation and policy advocacy will push for structural reform. The model is rooted in resilience, inclusion and evidence-and is poised to shape long-term reproductive justice in Namibia<sup>22</sup>.

Source: Ndiilokelwa Nthengwe, (2026). *Stories of Change Namibia*. 16 February.



Pro-abortion march, Namibia. Photo: Ndiilokelwa Nthengwe

<sup>22</sup> <https://www.genderlinks.org.za/change/stories-of-change/namibia-from-60-000-signatures-to-draft-abortion-law-reform>

Despite the kinds of calls, there is entrenched resistance to change in most Southern African countries, fuelled by deeply seated patriarchal gender norms, presented as “culture” and “religion”, which deny women bodily autonomy. The resistance leads to many slow, prolonged and expensive battles to make small changes to existing legislation. Some of these are discussed in the chapter. The fierce resistance to change is evidenced for instance in Madagascar:

During the 59th session of the UN Human Rights Council, **Madagascar** declined to implement 28 of 237 recommendations made during its Universal Periodic Review (UPR),<sup>23</sup> including the decriminalisation of therapeutic abortion, which risks the woman's health or life or foetal abnormality. The Minister of Justice and Keeper of the Seals, Benjamin Rakotomandimby explained that attempts to change the law on abortion in Madagascar had been rejected on the grounds that abortion was “ incompatible with Malagasy culture and values”. Christian leaders in Madagascar are also opposed to changes to the law.<sup>23</sup>



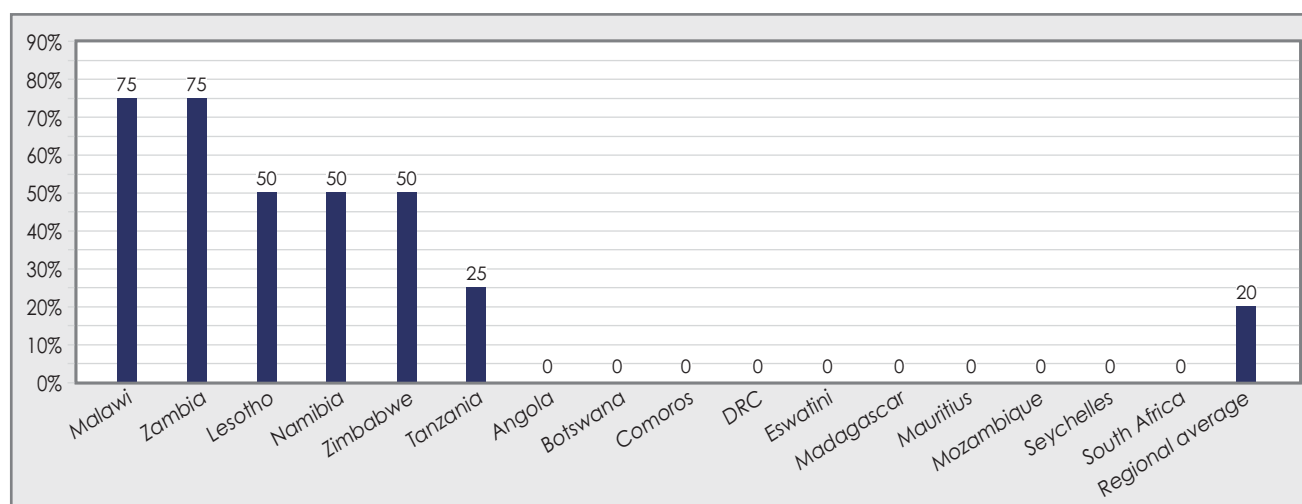
## Strategic litigation for improved access to safe abortion

There is ongoing advocacy for improved access to safe abortion, including through strategic litigation. The following question and five possible responses determined the strategic litigation score of the Southern Africa Safe Abortion Assessment. The response selected determines the score that is achieved:

Has there been any strategic litigation relating to access to safe abortion during the last eighteen months?

- (0) No.
- (25) Yes, but the litigation was unsuccessful or dismissed.
- (50) Yes, and the litigation is ongoing.
- (75) Yes, and the litigation was successful.
- (100) Yes, and the litigation resulted in significant legal, policy or access improvements.

Figure 5.3: Strategic litigation score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

<sup>23</sup> The UPS is conducted for every UN member state once in four and a half years to assess the fulfilment of the human rights commitments and obligations is conducted by peer member states.

<sup>24</sup> Radriamanga, T (2025) "Interruption thérapeutique de grossesse - Madagascar campe sur sa position restrictive", 3 July, L'express. Available at <https://www.lexpress.mg/2025/07/interruption-therapeutique-de-grossesse.html> accessed 14 May, 2026.

Figure 5.3 shows an average score of 20% for all SADC countries, showing the difficulty of relying on strategic litigation. Malawi and Zambia scored 75% as High Courts in both countries ruled in favour of cases. Tanzania scored 25% as the litigation was not successful and all other countries were zero, indicating that there has not been any strategic litigation in these

countries. Zimbabwe, Lesotho and Namibia scored 50%, indicating that litigation is on-going.

The case in **Malawi** involved a 14-year-old referred to only as AC who was initially denied a safe abortion and sued the initial provider and other responsible authorities.



### Malawi: Landmark ruling on abortion breaks new ground

In Malawi, a landmark ruling relying on the Gender Equality Act (GEA) has given a fresh impetus to the work of the Coalition for the Prevention of Unsafe Abortion (COPUA).

The case involves a 14-year-old, who had become pregnant because of sexual violence, sued the clinician who denied her an abortion, the Ministry of Health, Blantyre District Council and Malawi Human Rights Commission. The Nyale Institute, a member of COPUA, supported her in the case. Abortion in Malawi is governed by the Penal code and only allowed to preserve a woman's life.

But in October 2025 the High Court of Malawi ruled that denying a minor a safe abortion violated her rights to adequate sexual and reproductive health as provided in section 19 of the GEA.

Section 19 of the GEA provides rights to sexual and reproductive health (SRH) including family planning, protection from sexually transmitted infections, to choose the number of children and when to bear those children, to control fertility and to choose whether to have a child. Section 20 specifies that health officers have a duty to respect the SRH rights of every person without discrimination and to respect the dignity and integrity of every person accessing SRH services.

The judgement stated in part:

"A girl victim of a sexual offence who is pregnant as a result of such an offence definitely has a right to seek an abortion automatically upon indications that she had become pregnant as a result of a sexual offence being perpetrated on her. Further,... such a girl cannot be said to have exercised her right in section 19 of the Gender Equality Act to choose to have a child by falling pregnant following perpetration of a sexual offence on her. It follows that such a girl will inevitably suffer mental health ruin as a result of keeping this unwanted pregnancy to term. It is harsh and inhumane to insist that such a girl keep the pregnancy in such circumstances. It is therefore only logical and in accord with her sexual and reproductive health rights that such a girl be allowed, without let or hindrance, to demand if she so wishes upon exercise of her free will, access to abortion services so that her life be preserved from ruin by either mental or physical challenges associated with such an unwanted pregnancy."

The judgement further called for review of the Post Abortion Care guidelines to include explicit provisions ensuring that survivors of sexual and gender-based violence can access lawful terminations. It also mandated training for health professionals on the reviewed guidelines to remove uncertainty about who should be allowed to seek safe termination of pregnancy.



Emma Kaliya, Co Chairperson of the SADC Gender Protocol Alliance at the SAF-CNGO meeting in Durban, 2026.  
Photo: Colleen Lowe Morna

Women's rights activists have applauded the ruling, which clarifies that safe abortion for victims of sexual abuse who become pregnant is reproductive health care that they are entitled to. However, religious leaders and others, oppose what they perceive to be any relaxation of Malawi's abortion laws.

"This judgment is a vindication for all of us who have been lobbying for proper services for those who go through defilement and rape," said Emma Kaliya, chairperson of COPUA and the chairperson of the SADC Gender Protocol Alliance. "Most anti-abortion advocates practice double standards. These things are happening in their backyards - even their relatives have procured abortions. But, in public, they pretend otherwise."<sup>25</sup>

Source: Gender Links derived from M Machacha and T. Leatswe<sup>26</sup> and IPAS News<sup>27</sup>



The case in **Zambia** involved an older woman who already had two children and could not afford contraception. She fell pregnant, was abandoned by her partner and

could not afford the safe service from the health facility. She procured an illicit abortion, was arrested and tried for this<sup>28</sup>.



### Zambia: Women convicted for abortion set free

In Zambia, thanks to the intervention of Women in Law Southern Africa (WLSA) a woman convicted for abortion has been set free.

The legal framework for SRHR in Zambia is anchored in:

- i) Constitution of Zambia Amendment Act No.2 of 2016
- ii) Gender Equity and Equality Act No.22 of 2015 (GEEA)
- iii) Termination of Pregnancy Act Cap 304
- iv) Penal Code (Amendment) Act No.15 of 2005

GEEA defines sexual reproductive rights and includes the right to make free and responsible reproductive choices, receive sexual information based on scientific inquiry and receive sexual and reproductive health care in accordance with the Constitution and other laws. GEEA is an opportunity to advocate for promotion of sexual and reproductive health rights (SRHR); and review of the law to respond to the changing needs of society.



Sharon Williams.

Photo: WLSA Zambia

The Termination of Pregnancy Act permits abortion where there is a risk to the life of the woman, to the unborn infant as well as where there is a threat to the mental health of the woman or the welfare of other children she may have and on socio-economic grounds. Abortion can be accessed in Zambia up to 12 weeks' gestation.

The Penal Code provides that a pregnant woman who tries to end her own pregnancy by using poison, force, or any other method, or allows someone else to do so, commits a felony. Following a conviction for terminating a pregnancy, the courts sentenced Violet Zulu to seven years in prison

<sup>25</sup> Musvanhiri, P. (2025). Malawi permits safe abortion for survivors of sexual assault, DW, 6 November. Available at <https://www.dw.com/en/malawi-permits-safe-abortion-for-survivors-of-sexual-assault/a-74576001> accessed 9 May, 2026.

<sup>26</sup> Machacha, M. and Leatswe, T. (2025) The crisis of unsafe abortion in Malawi: When human rights are denied, women and girls die, NationOnline, November 25. Available at <https://nation.com/the-crisis-of-unsafe-abortion-in-malawi-when-human-rights-are-denied-women-and-girls-die/> accessed 9 May, 2026.

<sup>27</sup> IPAS News, (2025). Historic win as Malawi High Court approves abortion access for survivors of sexual violence. IPAS. Available at <https://www.ipas.org/news/malawi-high-court-approves-abortion-access-survivors-sexual-violence/> accessed 9 May, 2026.

<sup>28</sup> Center for Reproductive Rights (2025) "Justice denied: How poverty led a Zambian mother to jail for procuring an abortion", 11 December, Center for Reproductive Rights Available at: <https://reproductiverights.org/news/justice-denied-poverty-zambian-mother-jail-abortion/> accessed 9 May, 2026.

in January 2024. WLSA Zambia, with support from the Centre for Reproductive Rights (CRR), filed an appeal before the High Court in October 2025, citing shortcomings in procedure and a defective plea of guilty.

The High Court accepted that prolonged detention, lack of legal representation, and her vulnerable physical and emotional state had a negative impact on Zulu's understanding of the plea. The court reversed the conviction and set Zulu at liberty in January 2026.

The arrest and conviction of Violet Zulu highlights that access to a safe service that is legally available, is limited by lack of information and other barriers. Legal protections in relation to SRHR for women and girls in Zambia are needed to achieve national efforts to protect and advance access to justice

*Source: Sharon Williams, Director WLSA Zambia and Zambia representative to the SADC Gender Protocol Alliance, Co-lead of the Constitutional and Legal Cluster.*



In Tanzania, the High Court ruled against a petition brought by two girls and their mothers in September 2025. The girls had been impregnated by their biological fathers. The plaintiffs sought to have abortion in cases of sexual assault, rape, incest, defilement and where the continued pregnancy endangers the mental and physical health and social wellbeing of the women declared constitutional based on equality, dignity, non-discrimination,

privacy, the rights to life and protection of life. The Court determined that abortion was not explicitly a constitutional right and could not be deemed to be a right based on other rights. The court cited the American Dobbs decision in making the determination that abortion is not expressly declared a right in the constitution. The court concluded that the legislature needed to address issues of legislation.<sup>29</sup>

## Parliamentary debate to improve access to safe abortion

The Parliamentary debate score in the Southern Africa Safe Abortion assessment was derived from the question and possible answers below:

Has there been any discussion or debate on safe abortion in Parliament?

- (0) No discussion or debate.
- (25) Limited discussion or debate.
- (50) The issue has been formally tabled for debate.
- (75) Proposed legislation or policy reform relating to abortion has been tabled.
- (100) Legislation or policy reform has been adopted to improve access to safe abortion.

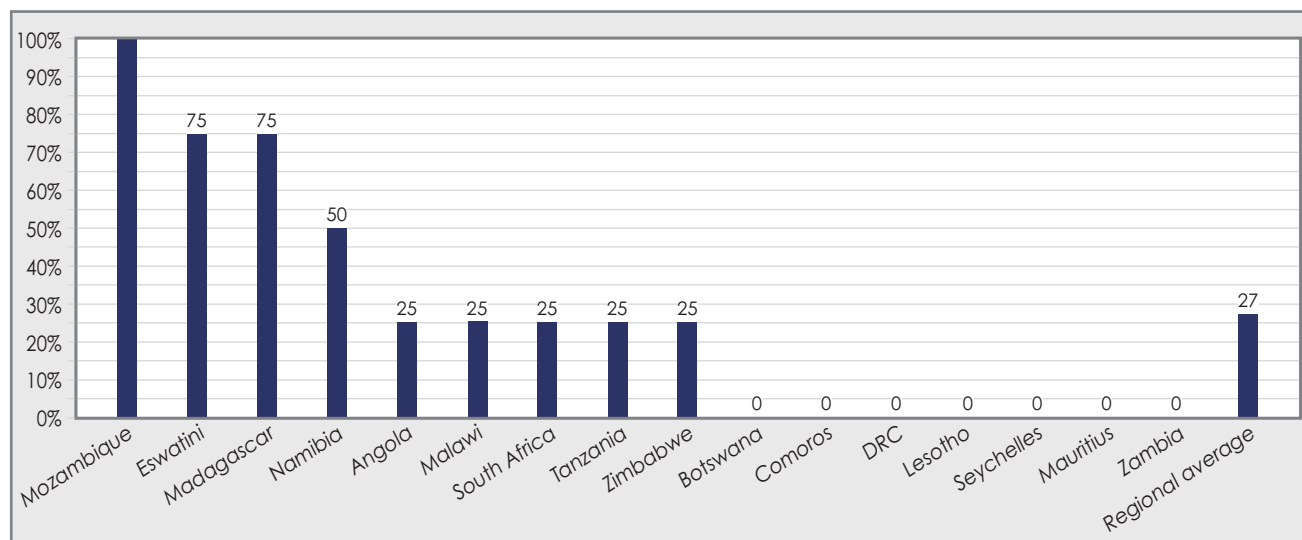


Abortion flyers in Duneen, Cape Town, South Africa.

Photo: Trevor Davies

<sup>29</sup> High Court, Dar es Salaam zone registry (2025) Mm and another vs Attorney General and another (Misc Civil Cause No. 31835 of 2024), 2 September. Available at <https://ianzlii.org/en/judgments/TZHC/TZHC-high-court-dar-es-salaam-zone-registry/2025/9/?page=2> accessed 24 August, 2026..

Figure 5.4: Parliamentary debate score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

As shown in Figure 5.4, the average score for SADC is only 27% which shows that there is very limited parliamentary debate in the region. The score ranged from 100% in Mozambique, to 75% in Madagascar and Eswatini, 50% in Namibia, 25% in five countries and zero in all others.

include sex with a minor under 18 and marital rape and (2) mental health be recognised as a ground for abortion. The constitutional court must confirm both cases before changes can be made to the law which is a lengthy process.



**Zimbabwe** is one of the countries where parliament has debated abortion, with several attempts to broaden the circumstances under which abortion is allowed between 2024 to 2026.

Writing about this issue in 2025, before the Constitutional Court ruling, Edinah Masiyiwa, then director of the Women's Action Group, commented:

In the case of WLSA Zimbabwe and Talent Forget, a young woman who fell pregnant at the age of 17 and was denied an abortion, the High Court declared in 2024 that Section 2(1) of the Termination of Pregnancy (ToP) Act is unconstitutional for failing to include sex with a minor under 18 and marital rape in the definition of "unlawful intercourse". The Constitutional court returned the case to the High Court in 2026, to be heard afresh as relevant government officials had not engaged with it.<sup>30</sup>

Strategic litigation cases brought to the High Court asked that (1) "unlawful intercourse" should



Edinah Masiyiwa.

Photo: LinkedIn profile page

<sup>30</sup> Taruvinga, M. (2026) "Constitutional court sends abortion law challenge back to the high court", New Zimbabwe, 14 August. Available at <https://www.newzimbabwe.com/constitutional-court-sends-abortion-law-challenge-back-to-high-court/> accessed 20 August, 2026.

"The Act allows termination in only three circumstances: if the pregnancy endangers the woman's life, if there is a serious risk the child would suffer permanent physical or mental defects, or if the pregnancy resulted from rape (excluding marital rape)... Zimbabwe has also put in place a post-abortion programme where women who had abortions, even unsafe abortions, can access care. This is not comprehensive enough. At the very least, it should also allow all adolescents to access abortion safely. ... Young women under 24 make up 25% of maternal deaths, with unsafe abortion being a huge part of this. ... Our message to politicians is that "Abortion is health care."<sup>31</sup>

In November 2025, the High Court ruled in an application by the Community Working Group on Health and Member of Parliament Nyasha Batisa that Section 4(a) and Section 2(1) of the ToP Act are invalid for omitting **mental health protections** and discriminating against mentally ill women. The judgement noted that failure to recognise mental health as a ground for abortion violates several constitutional rights, including the right to life (s 48), dignity (s 51), equality (s 56), and reproductive health (s 76)<sup>32</sup>. The ruling is suspended until it is confirmed by the Constitutional court.

Following intense lobbying by several women's rights and youth organisations, coordinated through a strong Safe Abortion Coalition, Zimbabwe's draft Medical Services Amendment Bill of 2025 included clause 11 which provided for:

- Expansion of the grounds for legal abortion where the pregnancy poses a risk to the woman's health, mental well-being, or socio-economic stability.

- Simplifying access to services: reducing bureaucratic hurdles and empowering medical practitioners and patients to make decisions, instead of requiring a magistrate's approval through a cumbersome judicial process.
- Inclusion of midwives: allowing trained midwives to provide abortion care, especially in rural areas, to address the shortage of medical practitioners.
- Recognition of women's autonomy: informed consent as the sole requirement for terminating a pregnancy, including pregnant minors.

These amendments align with Zimbabwe's Constitution of 2013 which provides for the right to make decisions concerning reproduction, the right to health and bodily autonomy, and with international commitments under the Maputo Protocol and Sustainable Development Goals (SDGs)<sup>33</sup>.

The bill passed through the National Assembly but clause 11 was removed when traditional leaders in the Senate objected to it<sup>34</sup>. Edwin Mushoriwa, a member of parliament, blamed misinformation for the very polarised public debate on clause 11. He explained that the clause was intended to clarify the situations in which termination of pregnancy is already allowed under the law and to make sure the statutes align with the Constitution, not to introduce abortion on demand<sup>35</sup>. It would have simplified the process for women who have been raped, for instance, to access abortion which the current law provides for. The **Medical Services Amendment Act, 2026** gazetted in July 2026 has no provisions on abortion.

<sup>31</sup> Masiyiwa, E. "Girls in Zimbabwe deserve access to safe abortion". Safe Abortion Action Fund, 21 March. Available at <https://saafund.org/girls-in-zimbabwe-deserve-access-to-safe-abortion/> accessed 15 May, 2026.

<sup>32</sup> Muzira, L. (2025). "High court rules parts of Zimbabwe's abortion law unconstitutional". Pindula News, 19 November. Available at <https://news.pindula.co.zw/2025/11/19/high-court-rules-parts-of-zimbabwes-abortion-law-unconstitutional/> accessed 9 May, 2026.

<sup>33</sup> Maponga, A and Chitiyo, D. "Zimbabwe is due to reform its abortion law." Safe Abortion Action Fund, 18 November. Available at <https://saafund.org/zimbabwe-is-due-to-reform-its-abortion-law/> accessed 15 August, 2026.

<sup>34</sup> Pindula News (2026) "Abortion clause deleted from Medical Services Amendment Bill". The Zimbabwean, 17 March. Available at <https://www.thezimbabwean.co/2026/03/abortion-clause-deleted-from-medical-services-amendment-bill/> accessed 10 July, 2026.

<sup>35</sup> Muzira, L. (2026) "CCC MP blames misinformation for deletion of "Abortion clause" from Medical Services Amendment Bill", Pindula News, 16 March, Available at <https://news.pindula.co.zw/2026/03/16/abortion-clause-deleted-from-medical-services-amendment-bill/> accessed 9 May, 2026.

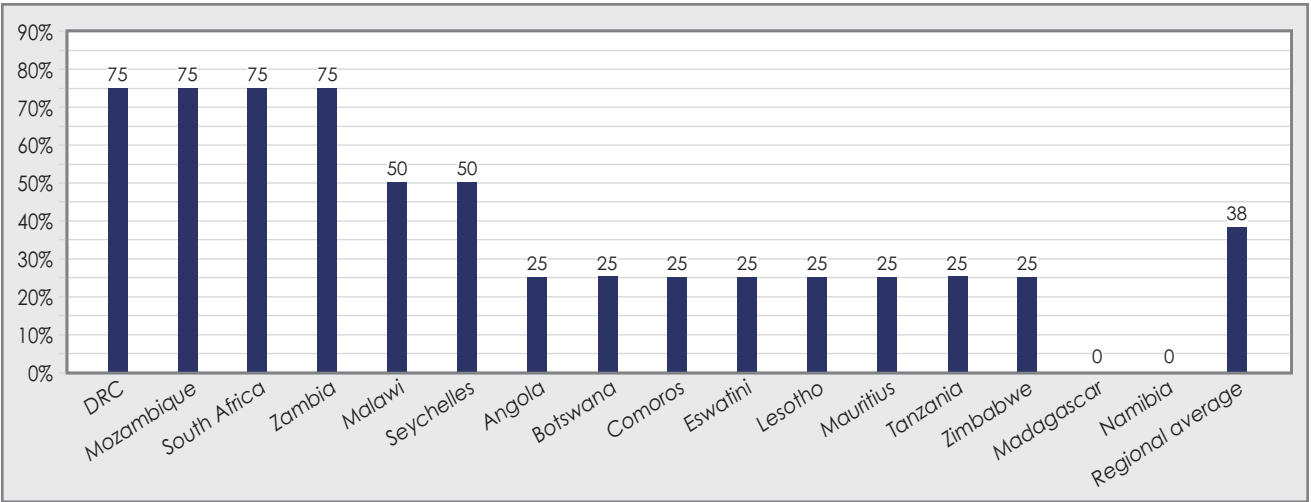
# Support from national associations of obstetricians and gynaecologists

National associations of obstetricians and gynaecologists across SADC support access to safer abortion to address the high rates of morbidity and mortality which result from unsafe abortions. This question and the five possible responses determine the National Association of Gynaecologists / Obstetricians support score in the Southern Africa abortion assessment:

Is the national association of obstetricians and gynaecologists supportive of the provision of safe abortion?

- (0) No, the association is not supportive.
- (25) The association is somewhat supportive but largely silent on the issue.
- (50) The association is publicly supportive of safe abortion services.
- (75) The association is supportive, vocal and actively engaged in initiatives promoting safe abortion.
- (100) The association is a recognised leader in promoting evidence-based safe abortion care and policy reform.

Figure 5.5: National Association of Gynaecologists / Obstetricians support score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

Figure 5.5 shows that Southern Africa scored 38% on average on support by National Associations of Gynaecologists / Obstetricians for safe abortion ranging from zero in Madagascar and Namibia to 75% in DRC, Mozambique, South Africa and Zambia where the national associations play critical roles in promoting safe abortion. The scores are 50% in Malawi and Seychelles where the associations are important allies in advocacy for a human rights-based approach to safe abortion. Some countries in SADC are so small that they do not have stand-

alone associations of obstetricians and gynaecologists.

Speaking at the second biennial congress of the **Botswana** Society of Obstetricians and Gynaecologists (BOSOG) in May 2025, the Acting Minister of Health, Mr Lawrence Ookeditse called for urgent action to improve access to safe abortion services as a means to protect girls and women, and especially those that cannot afford to go to South Africa for safe care.<sup>36</sup> This call sparked debate on social media.



<sup>36</sup> Thatayamodimo, L. (2025) "Ookeditse advocates for safe abortions", Daily News, 25 May. Available at <https://dailynews.gov.bw/news-detail/86590> accessed 12 April, 2026.

## Exercising agency to access safer options

Women and girls across SADC are exercising their agency to access safer options. Those who can afford it travel to South Africa or other countries where safe abortion is available. As medication abortion becomes more accessible, more are choosing this option rather than more intrusive or dangerous methods.

The "abortion pill," also known as medication abortion, is a safe and common medical way to end an early pregnancy using two different prescription medicines.

- **Mifepristone:** This is the first pill you take. It blocks progesterone, a natural hormone your body needs for a pregnancy to grow.
- **Misoprostol:** This is the second medicine. You take it 24 to 48 hours after the first pill. It causes your uterus to cramp and bleed so it can empty out the pregnancy tissue.

It is approved and most used during the first 10 to 11 weeks of pregnancy. The two-drug combination is 93% to 99% effective at ending the pregnancy without needing a surgical procedure. Both options are scientifically proven to be safe and effective. Misoprostol is a little less effective than the combination, but it is cheaper, and more pharmacies stock this medicine.



Launch of the Misocard.

Photo: Ronel Koekemoer

At the **Abortion and Reproductive Justice Conference 2026** in Nairobi, Women Help Women launched the Misocard. Based on the premise that abortion should be as easy to access, share, and hide as a greeting card or train ticket, the Misocard is a piece of paper infused with misoprostol. This invention (which is available in multiple flavours) allows abortion-seekers to manage their own abortion, despite the many restrictions placed on them by laws, attitudes, doctors, and borders.

Studies in **South Africa** have found that self-managed abortion through telemedicine is a safe, effective, and acceptable model of care<sup>37</sup>. **Abortion Support**<sup>38</sup> is a South African NGO that has information on where one can access an abortion. Abortion Support can also provide a prescription to a pharmacy close to the woman, within South Africa, for either:

- Misoprostol alone (which costs R300) and is about 90% effective; or
- A combination of Mifepristone and Misoprostol (cost between R950 - R1250) which is 95% effective. Mifepristone is not always in stock due to its cost, but pharmacies can order it and should be able to provide it within a few days.

A study in Maputo, **Mozambique**, found that a combi-pack four 200mg Misoprostol pills- with one 200mg Mifepristone pill was available in 125 out of 155 pharmacies, with and without a prescription. The price varied, tending to be higher in lower income neighbourhoods. Pharmacists provided limited information on how to administer the medication and potential side effects. The package insert provides only technical instructions in small print which is not easy for most clients to read or understand. The investigators recommend that efforts to improve counselling and provision of accurate information by Pharmacists would increase access to safe abortion.<sup>39</sup>

<sup>37</sup> Endler, M., et al (2022). A telemedicine model for abortion in South Africa: a randomised, controlled, non-inferiority trial. *Lancet* (London, England), 400(10353), 670-679. [https://doi.org/10.1016/S0140-6736\(22\)01474-X](https://doi.org/10.1016/S0140-6736(22)01474-X)

<sup>38</sup> Storey, S., Cleeve, A., & Endler, M. (2025). Implementing telemedicine for medical abortion within the public health system: a qualitative study on implementation bottlenecks and solutions in South Africa. *BMC public health*, 25(1), 3421. <https://doi.org/10.1186/s12889-025-24690-0>

<sup>39</sup> <https://abortionsupport.co.za/about-us/>  
Zachek C, et al. (2025) "Mapping access to medication abortion in Maputo, Mozambique", *Contraception*, 2025; 147. Available at <https://doi.org/10.1016/j.contraception.2025.110911>

## The MAMA (Mobilising Activists around Medical Abortion) Network

MAMA is a feminist network and movement of 67 grassroots member organisations in 21 countries (including DRC, Malawi, South Africa, Tanzania, and Zambia in SADC) that promotes self-managed abortion. MAMA trains activists, disseminates information, facilitates access to abortion pills and creates conditions for women and pregnant people to safely self-manage their abortions<sup>40</sup>. There are now MAMA affiliated hotlines in four SADC countries<sup>41</sup>:

### Tantine Marthe - DRC

The line is open 24 hours a day, 7 days a week, manned by counsellors.

**Numbers: (+243) 89 87 92 002, 99 66 55 418, (+243) 82 84 02 772**

Auntie Marthe is based in Uvira, South Kivu and covers all the 26 provinces of the DRC. Auntie Marthe provides accurate information on self-managed medical abortion, contraception, monthly cycle management and menstrual hygiene, and referrals for survivors of gender-based violence.



### Aunty Sissy - Malawi

is an Interactive Voice Response system, that provides information on contraception, unwanted pregnancy, abortion, and other sexual and reproductive health topics in Chichewa and English. Aunty Sissy Hotline gives information on Contraception, unwanted pregnancy and abortion, among other sexual and reproductive health topics.

Callers can leave a message or SMS and get a call back from a trained hotline counsellor if they have questions or want to speak with someone.

**Hotline numbers: +265 980 110 113 / +265 9801 10884**

### Aunty Tasha - Zambia

is an e-service platform in Zambia.

**Toll free line: 8880**

**Phone: 0955 325 325**

Email: [info@auntytasha.com](mailto:info@auntytasha.com)

Website: <https://auntytashazm.com/>

Facebook: <https://www.facebook.com/p/Aunty-Tasha-Helpline-100064179277063/>

Instagram:

<https://www.instagram.com/auntytashahelpline/>



### 577 Toll-Free Hotline - Zimbabwe

- a 24-hour confidential and youth-friendly helpline providing psychosocial support, counseling, guidance on Sexual and Reproductive Health (SRH), Gender-Based Violence (GBV), and referrals to essential services for adolescents and young people in Zimbabwe.

**Toll free number: 577**



### Call Saru - Zimbabwe

- Saru (short for Sarudzo or choices) provides information to enhance access to SRHR services and information for youth, particularly in the Masvingo area.

**Number: 080 80617**



The **Zambia** Association of Gynaecologists and Obstetricians (ZAGO) partnered with the International Federation of Gynaecology and Obstetrics (FIGO) to enhance **the uptake of self-managed abortion** by identifying and addressing barriers<sup>42</sup>. The project worked with the Ministry of Health, community health volunteers and youth associations to collect

baseline and endline data from health providers and volunteers. It addressed barriers related to knowledge, skills and resources revealed by the baseline data by increasing health providers' awareness and application of national guidelines on self-managed abortion. The proportion of community health volunteers trained to provide health education on self-managed abortion

<sup>40</sup> The MAMA Network. <https://mamanetwork.org/> accessed 8 May, 2026

<sup>41</sup> MAMA Network. (2026) "Help lines": <https://mamanetwork.org/helplines/> accessed 18 May, 2026.

<sup>42</sup> World Health Organisation (2025) "From guidelines to implementation: increasing access to quality abortion care: How the international non-governmental community is translating evidence-based recommendations into real-life impact" 6 January. Available at <https://www.who.int/news-room/feature-stories/detail/from-guidelines-to-implementation-increasing-access-to-quality-abortion-care> accessed 8 May, 2026

increased from 25% to 93%. The project resulted in input into the revised Standards and Guidelines for Comprehensive Abortion Care in Zambia (2022). These specify that trained health providers

include midwives and nurses. The guidelines also provide for telehealth to get a prescription for medical abortion.

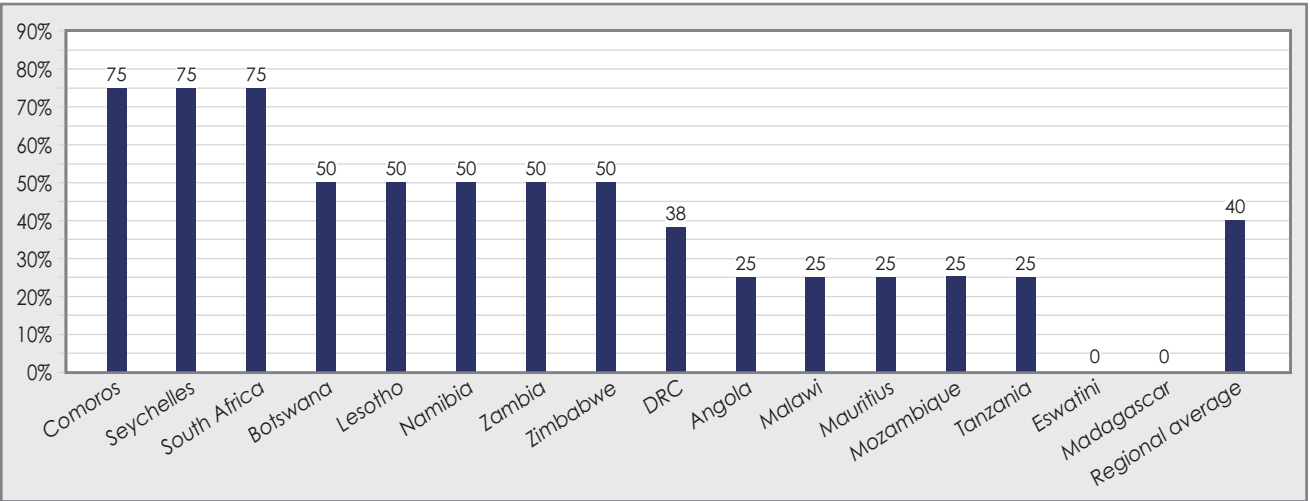
## Accessing abortion services available in the law

Service Providers can be a significant facilitator or barrier to service access. As all abortion access is time bound, provider awareness is a critical component of safe abortion. The question and five possible answers below determine the Provider awareness / support score in the Southern Africa abortion assessment:

Do providers (health, police and justice sectors) know under what circumstances abortion is allowed by law?

- (0) Most providers do not know under what circumstances abortion is permitted.
- (25) Some providers know under what circumstances abortion is permitted.
- (50) Most providers know under what circumstances abortion is permitted but are not supportive and do not facilitate access.
- (75) Most providers know, are supportive and generally facilitate access to services.
- (100) Most providers know, are supportive, actively facilitate access and there is evidence that women can access services without unnecessary barriers.

Figure 5.6: Provider awareness / support score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

Overall, the Southern Africa Safe Abortion Assessment 2026 shows that the region scored an average of 40% for service provider awareness, reflecting some knowledge but insufficient support for those seeking services. This ranges from 75% in Comoros, Seychelles and South Africa to 50% for Botswana, Lesotho,

Namibia, Zambia and Zimbabwe, to below 40% for six countries and zero for Madagascar and Namibia. These scores suggest that there is scope for training and awareness raising amongst providers. The cases below suggest that pharmacists are a category of service provider to collaborate with:



Following adoption of the Maputo Protocol as law in **DRC**, there have been many government and non-governmental efforts to ensure that women and girls are aware of the available services. This includes projects to increase access to self-managed medical abortion by collaborating with pharmacies.<sup>43</sup> Self-managed abortions are allowed in the DRC beyond the narrow confines of the Maputo protocol.



Research in **Mozambique** has shown that legislation is a necessary condition for the provision of safe abortion, but it is not a sufficient condition. A study on young people's access to Voluntary Termination of Pregnancy (VTP) in Nampula Province, Northern Mozambique found that:

- There has been a 77% increase in medical abortion use and a 23.5% reduction in complications from unsafe abortion between 2016 and 2021.<sup>44</sup>
- Safe VTP services are concentrated in urban areas, with rural young people still often resorting to unsafe practices. Further, there is insufficient availability of services in districts with high populations.
- Young women and men often seek VTP as their families force those that are pregnant to get married which they perceive as a punishment.<sup>45</sup> Young women and young men agree that young men are responsible for finding the money to procure VTP.
- Young people still often relied on unsafe abortion, even though safe services are available and should be free, due to limited awareness of the availability of safe services, inaccessibility of these services (either because they were too far away or because young people under the age of 16 require adult consent), illicit fees at government health facilities, stigma, and lack of social support.

- Midwives who provide abortion services are generally supportive, but some had experienced emotional distress from managing unsafe abortion complications. Many were overworked as not all health facilities provided VTP and they were stressed because of shortages of medicines. Midwives need emotional support for themselves as well as ongoing training<sup>46</sup>.

## Midwives who provide abortion services need emotional support

Even though **South Africa** has the most progressive legislation regarding abortion in SADC, many pregnant people fail to access safe services. The South African Choice on Termination of Pregnancy Act (CTOP) replaced the highly restrictive Abortion and Sterilisation Act of 1975 (the same law that still regulates abortion access in Namibia). The restrictive law made safe abortion inaccessible with the dangers of clandestine abortion disproportionately impacting Black women. Thirty years later, safe termination of pregnancy services in South Africa remains notoriously inaccessible. Abortion in the private healthcare sector is expensive and those seeking free termination of pregnancy services in public clinics and hospitals are beset by barriers. Those who do manage to access services have to navigate stigma and discrimination. Abortion in South Africa is still a dirty word. There is limited publicly available, updated, detailed information about how to safely and legally terminate a pregnancy. Several programmes seek to make information about services available to help people to identify where they can go.



<sup>43</sup> ACODAFEM, (2026) "Democratic Republic of Congo - Strengthening pharmacists' capacity to provide medical support during abortion", 8 May. Available at <https://www.safeabortionwomensright.org/news/democratic-republic-of-congo-strengthening-pharmacists-capacity-to-provide-medical-support-during-abortion/> accessed 12 April, 2026.

Lopepo, C., Kakesa, J., Spilotros, N. (2024) "Self-management of abortion in the eastern Democratic Republic of Congo", IRC. Available at <https://media.iawg.net/documents/IRC-DRC-Self-Management-of-Abortion.pdf?v=1638896599> accessed 14 April, 2026.

<sup>44</sup> Gondola Sifefane, G. et al. (2025) "Voluntary termination of pregnancy in the context of decriminalized safe abortion: a longitudinal study on the availability, coverage, and utilization of services during 2016-2021 in Nampula province, northern Mozambique", BMC Health Services Research (2025) 25:732 available at <https://doi.org/10.1186/s12913-025-12896-2>

<sup>45</sup> Gondola Sifefane, G. et al (2024). 'Better taking the risk than a lifetime punishment of early forced marriage': Young people's perceptions and experiences towards voluntary termination of pregnancy in northern Mozambique. Sexual & reproductive healthcare: official journal of the Swedish Association of Midwives, 41, 101007. <https://doi.org/10.1016/j.srhc.2024.101007>

<sup>46</sup> Gondola Sifefane, G., et al (2025). Navigating structural and personal dilemmas: a phenomenological study of midwives providing legal abortion care in Nampula, Mozambique. Sexual and reproductive health matters, 33(1), 2637328. <https://doi.org/10.1080/26410397.2026.2637328>

## GRIT Zuzi chatbot supporting access to safe abortion in South Africa



GRIT, who build technology-based interventions to address gender inequalities, has an AI chatbot called Zuzi which provides information 24/7 in multiple South African languages. Zuzi also offers a space for people to chat about things, such as abortion, that they might feel hesitant talking to a human about.

GRIT is conducting research on the abortion landscape in South Africa to curate a dataset that Zuzi draws on to answer questions about abortion. The research has exposed many obstacles inhibiting women's choices. For example, in one town, women cannot access abortion because of the personal views of one powerful man. An internationally renowned organisation is prohibited from putting up signage in and around the private hospital they operate from because management are 'unhappy'. One of the more resourced provinces has only one doctor who provides surgical abortions in the public sector.

GRIT has built a knowledge base with a level of detail that is seldom available through other digital offerings (like South African government or other websites). Through mapping of currently available materials, consultation with key informants, and in the chatlogs with Zuzi, GRIT has observed a key but less mentioned knowledge gap and access barrier. There is very little consolidated information on the various 'textures' about the process of accessing different ToP services in South Africa. The dearth of this data contributes to misinformation and leaves abortion-seekers with unclear access pathways that can amplify anxiety about already mistrusted processes and institutions. There is insufficient publicly available information about how abortion providers operate across the public, private, and non-profit sector. With the backing of intensive research- Zuzi can offer information about (amongst others) how the different provision facilities work, how gestational limits and facility capacity impact the amount of time between when the patient first engages the healthcare provider and is assisted.



Zuzi chatbot.

Photo: GRIT

GRIT is continuing to collect data that responds to knowledge gaps that hamper access so that Zuzi can be a novel intervention that supports safe abortion. Zuzi can provide responses to questions to encourage and support a user to seek services safely.

Source: Ronel Koekemoer, GRIT (Gender Rights in Tech), 2026



Another source of information is the SRJC (Sexual and Reproductive Justice Coalition) website. The Abortion page (<https://srjc.org.za/focus-area/abortion/>) covers: an overview of abortion; types of abortion; how and what to expect; legal assistance for getting an abortion; how to identify an illegal abortion clinic; abortion and HIV; abortion when queer; abortion and sexual assault; post abortion care; advocacy and resources.

# Attitudes and public discourse on abortion

The Afrobarometer survey round 10 included questions on attitudes towards abortion and access to contraception. This survey is conducted by a network of partners across 45 countries in Africa, including 15 in SADC. The survey in each

country interviews a nationally representative sample. A summary of the responses about attitudes to abortion and access to contraception for the SADC countries surveyed is presented in Table 5.4.

Table 5.4: Attitudes to termination of pregnancy and contraception from Afrobarometer Round 10 reports

| Country                                                                                                                     | Angola |    | Botswana |    | Comoros |    | Eswatini |    | Lesotho |    | Madagascar |    | Malawi |    | Mauritius |    | Mozambique |    | Namibia |    | Seychelles |    | South Africa |    | Tanzania |    | Zambia |    | Zimbabwe |    |  |
|-----------------------------------------------------------------------------------------------------------------------------|--------|----|----------|----|---------|----|----------|----|---------|----|------------|----|--------|----|-----------|----|------------|----|---------|----|------------|----|--------------|----|----------|----|--------|----|----------|----|--|
|                                                                                                                             | F      | M  | F        | M  | F       | M  | F        | M  | F       | M  | F          | M  | F      | M  | F         | M  | F          | M  | F       | M  | F          | M  | F            | M  | F        | M  | F      | M  | F        | M  |  |
| Women / girls in your community often terminate pregnancy -                                                                 | 35     | 36 | 20       | 21 | 30      | 32 | 35       | 33 | 30      | 28 | 26         | 20 | 50     | 50 | 6         | 4  | 22         | 23 | 18      | 17 | 23         | 15 | 16           | 24 | 23       | 23 | 32     | 30 | 26       | 26 |  |
| For each of the following situations, percent who think it can always be justified for a woman to terminate a pregnancy if: |        |    |          |    |         |    |          |    |         |    |            |    |        |    |           |    |            |    |         |    |            |    |              |    |          |    |        |    |          |    |  |
| a. pregnancy is result of rape /incest                                                                                      | 35     | 30 | 40       | 35 | 14      | 12 | 29       | 27 | 37      | 34 | 12         | 11 | 10     | 7  | 54        | 51 | 36         | 37 | 29      | 28 | 35         | 34 | 48           | 44 | 10       | 9  | 10     | 9  | 41       | 39 |  |
| b. her health / life is in danger                                                                                           | 36     | 36 | 43       | 38 | 24      | 26 | 26       | 26 | 34      | 27 | 21         | 20 | 21     | 18 | 60        | 54 | 38         | 41 | 36      | 34 | 51         | 48 | 51           | 44 | 26       | 23 | 17     | 17 | 32       | 30 |  |
| c. going through economic hardships                                                                                         | 18     | 14 | 10       | 9  | 12      | 11 | 12       | 17 | 15      | 14 | 6          | 6  | 5      | 6  | 25        | 23 | 21         | 21 | 17      | 17 | 10         | 7  | 25           | 25 | 5        | 4  | 3      | 4  | 4        | 3  |  |
| d. any reason                                                                                                               | 15     | 15 | 7        | 6  | 11      | 11 | 7        | 6  | 11      | 12 | 5          | 4  | 3      | 2  | 5         | 8  | 20         | 16 | 17      | 15 | 5          | 6  | 23           | 29 | 4        | 3  | 2      | 3  | 3        | 3  |  |
| Percent who agree or strongly agree to following statements:                                                                |        |    |          |    |         |    |          |    |         |    |            |    |        |    |           |    |            |    |         |    |            |    |              |    |          |    |        |    |          |    |  |
| Contraceptives should be available to everyone                                                                              |        |    |          |    |         |    |          |    |         |    |            |    |        |    |           |    |            |    |         |    |            |    |              |    |          |    |        |    |          |    |  |
| a. regardless of marital status                                                                                             | 60     | 63 | 85       | 90 | 53      | 58 | 87       | 84 | 87      | 75 | 76         | 72 | 58     | 52 | 63        | 72 | 75         | 71 | 81      | 74 | 89         | 92 | 93           | 85 | 42       | 31 | 51     | 45 | 70       | 70 |  |
| b. who is sexually active regardless of age                                                                                 | 52     | 51 | 72       | 69 | 47      | 51 | 74       | 73 | 79      | 75 | 57         | 56 | 44     | 44 | 53        | 59 | 66         | 65 | 77      | 71 | 52         | 51 | 82           | 80 | 24       | 21 | 34     | 33 | 48       | 45 |  |
| Girls should be allowed to continue their education even if they become pregnant or have a child                            | 77     | 77 | 92       | 91 | 76      | 78 | 89       | 85 | 90      | 86 | 83         | 84 | 92     | 92 | 67        | 65 | 86         | 86 | 86      | 83 | 88         | 84 | 90           | 83 | 59       | 59 | 97     | 92 | 75       | 68 |  |

Source: Gender Links with data from 15 Afrobarometer Round 10 country Summary of Results reports<sup>47</sup>

Table 5.4 shows that public attitudes in many SADC countries are not very supportive of safe abortion. Only in Mauritius did more than 50 percent of respondents agree that it is always justified for a woman to terminate a pregnancy that is a result of rape or incest while ten percent or less agreed to this in Malawi, Tanzania, and Zambia. Fifty percent or more agreed that it is justified for a woman to terminate a pregnancy if her life or health are in danger in Mauritius and South Africa. The highest rate of those who believe it is always justified for a woman to terminate a pregnancy if she has economic problems and is not able to care for the child was 25% in Mauritius and South Africa while fewer than ten percent believed it is always justified in Botswana, Madagascar, Malawi, Seychelles,

Tanzania, Zambia and Zimbabwe. The rates of agreement are slightly higher for women than men, but the differences are small.

Access to contraceptives is crucial to reduce the rate of unintended pregnancies. More than 80% of respondents agree or strongly agree that "Contraceptives should be available to everyone regardless of marital status" in Botswana, Eswatini, Lesotho, Namibia, Seychelles, and South Africa, while fewer than 50 percent agree or strongly agree with this in Tanzania. There is lower rate of agree and strongly agree in all countries to "Contraceptives should be available to everyone who is sexually active regardless of age". The agreement was only over 80% in South Africa and between 70% and 80% in Botswana,

<sup>47</sup> Afrobarometer Summary of Results Afrobarometer Round 10. Country reports Available at <https://www.afrobarometer.org/publications/?select-publication-subtype%5B%5D=summary-of-results&select-survey-rounds%5B%5D=survey-round-10&hidden-current-page=1> accessed 30 June, 2026

Eswatini, Lesotho and Namibia. Only 24% of women and 21% of men agreed or strongly agreed in Tanzania.

More than 80% of female and male respondents in Botswana, Eswatini, Lesotho, Madagascar,

Malawi, Mozambique, Namibia, Seychelles, South Africa, and Zambia strongly agreed or agreed "Girls should be allowed to continue their education even if they become pregnant or have a child". Less than 60% agreed or strongly agreed with this statement in Tanzania.

## Public discourse on abortion

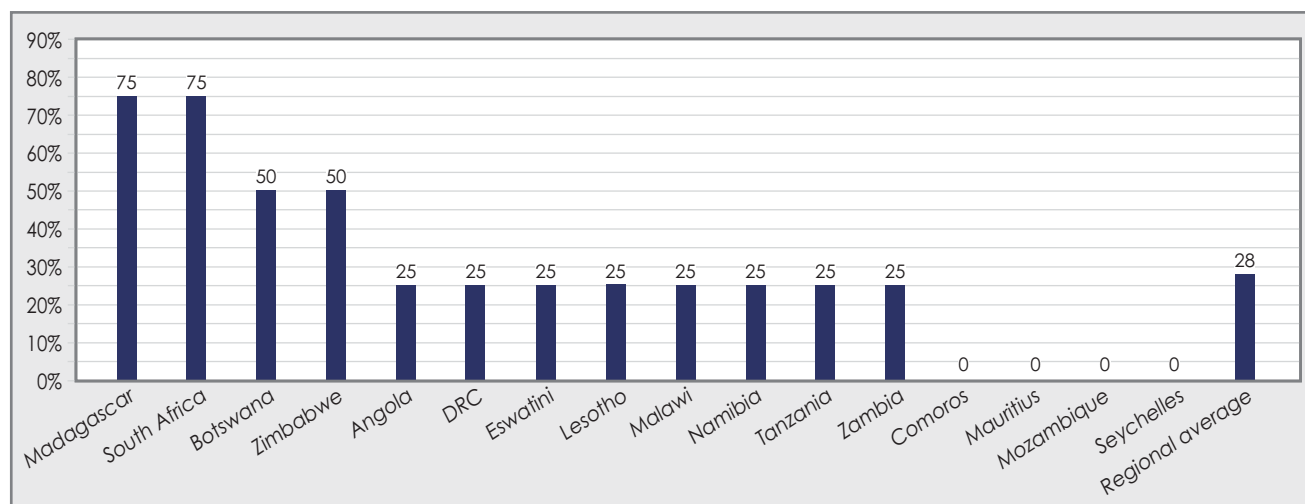
The Southern Africa abortion assessment considered public discourse. The question asked and five possible responses which determined the score are:

Is there public discussion about the impact of unsafe abortion on maternal mortality and morbidity?

- (0) No public discussion.
- (25) Limited discussion through a small number of media reports, interviews or public forums.

- (50) Widespread public discussion, but coverage is often sensationalist or inaccurate.
- (75) Widespread public discussion with balanced, evidence-based and gender-sensitive coverage.
- (100) Widespread public discussion with sustained, evidence-based and rights-based coverage that contributes to public awareness and policy dialogue.

Figure 5.7: Public discourse score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

The regional average score of 28% (Figure 5.7) suggests limited debate of this crucial topic. However, this ranges from 75% in Madagascar and South Africa to 50% in Botswana and Zimbabwe, to 25% in eight countries and zero in Comoros, Mauritius, Mozambique and Seychelles. The Afrobarometer reports suggest that there is need for intensive public engagement on the issue of girls' and women's reproductive rights, even in countries where the legislation is relatively

supportive. There is scope for much more to be done in this regard.

Media can play a critical role in shaping public perception. Writing for Health Times in **Zimbabwe**, Memory Kadau explains how media narratives build public understanding of safe abortion. Media headlines such as "Zimbabwe: Our Ugly Secret - Abortion, Illegal but Thriving" contribute to misinformation and



stigma. These discourage women from seeking abortions which are legal and service providers from providing the service. At the other extreme media exaggeration of small legal wins and clarification of the law can fuel moral panic which also encourages stigma. She concludes, "Every narrative carries consequences. It either reduces stigma or reinforces it. It either expands access or restricts it. If Zimbabwe is serious about saving lives and strengthening reproductive justice, our public communication must reflect that commitment. Our media must report with accuracy, compassion, and responsibility. The story we tell determines the lives we save."<sup>48</sup>

## Every narrative... reduces stigma or reinforces it

"Beyond Borders: Uniting for Reproductive Justice"<sup>49</sup> is an example of newer media formats. The limited podcast series highlights the work of the Sexual and Reproductive Justice Coalition (SRJC) and the Safe Abortion Alliance of Southern Africa (SAASA) regarding safe abortion access, adolescent health, and LGBTQI+ rights in Southern Africa. The six episodes cover:

- She Hives' fight: Tackling GBV (Gender Based Violence) and reproductive justice in Lesotho with Refiloe Harris.
- Stories and solutions: Zimbabwean activists working to normalise safe abortions with Edinah Masiyiwa.
- From stigma to justice: Advancing reproductive rights in Malawi with Lyness Soko.
- Morality vs rights: Addressing stigma and unsafe abortions in Southern Africa with Neo Kitso.

- Ending stigma, supporting women: Reproductive justice in action with Mandia Macuacua.
- Activism, abortion and equality: Inside the SRJC's mission Sihle Motha.

The media covered a dialogue hosted by *One Billion Rising, Journey of Hope for Girls and Women and SAFAIDS* with traditional leaders, religious leaders, community members and partners. The dialogue presented the results of a study on sexual reproductive health rights focused on access to safe abortion for women and girls in **Eswatini**. The partners emphasised the nexus between GBV and unintended pregnancies. Leaders and the community agreed that women and girls should not be forced to risk their lives from unsafe abortion. They also called for education on this topic for local leaders<sup>50</sup>.



Other news coverage in Eswatini is much more sensational. This includes an article about so called "street abortions" where women, who are labelled as "sex workers", are said to travel to Manzini where they procure abortion pills<sup>51</sup>. Other reporting was about a case in which a woman was fined E5000 for procuring an abortion<sup>52</sup>.

The media in **Lesotho** has had several articles on safe abortion. One reported on a study conducted by Rhodes University, with the WHO and UNFPA on abortion care in Botswana, Eswatini, Lesotho and Namibia<sup>53</sup>. The study identified the absence of comprehensive national guidelines in all the countries and over-reliance on donor funding, for SRHR programmes, particularly in Eswatini and Lesotho, as barriers to sustained comprehensive abortion care. The article recommended that Lesotho should



<sup>48</sup> Kadau, M. (2025) Why media narratives matter for safe abortion and reproductive justice in Zimbabwe. Health Times, 4 December. Available at <https://healthtimes.co.zw/why-media-narratives-matter-for-safe-abortion-and-reproductive-justice-in-zimbabwe/> accessed 7 December, 2025.

<sup>49</sup> "Beyond Borders: Uniting for reproductive justice". Available at <https://iono.fm/c/9374>

<sup>50</sup> Simelane, T. (2026) Call for action against unsafe abortion. Times of Eswatini, 21 April. Available at <https://www.pressreader.com/eswatini/times-of-eswatini/20260421/281487872934880> accessed 5 May, 2026.

<sup>51</sup> Zwane, S. (2025). Street abortions plague Manzini. Times of Eswatini, 21 July. Available at <https://www.pressreader.com/eswatini/times-of-eswatini/20250721/281625311339806> accessed 5 May, 2026.

<sup>52</sup> Tsabedze, S. (2025) Woman sentenced to five years for abortion. Eswatini Observer, 26 November. Available at <https://eswatiniobserver.com/woman-sentenced-to-five-years-for-abortion/> accessed 10 May, 2026.

<sup>53</sup> Motaung, N. (2025) "Addressing systemic barriers to abortion care", Newsday Online, 20 January. Available at: <https://newsdayonline.co.ls/health-2/> accessed 4 May, 2026.

prioritise domestic funding for SRHR with public education to combat stigma.

Another article focused on teenage pregnancy and unsafe abortions.<sup>54</sup> The article promoted protection from unsafe abortions through

education, prevention, and access to proper healthcare. It also called for open and inclusive dialogue about existing laws to ensure that they are aligned with international human rights standards, so that the health and dignity of women in Lesotho are protected.

## Abortion and post-abortion care guidelines

Several countries in SADC have abortion and post abortion care guidelines or include guidance on abortion care in other guidelines. Several countries have updated guidelines to

clarify when abortions are allowed in the law and to include guidance on medication abortion.

Table 5.5: Abortion, post abortion care and other guidelines which discuss abortion

| Country      | Abortion/<br>post-abortion<br>guidelines | Any related policies and/or guidelines                                                                                                                                                             |
|--------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Botswana     | Y                                        | Comprehensive Post Abortion Care Reference Manual, Ministry of Health; Botswana Essential Drug List 2012; Botswana Sexual and Reproductive Health Policy Guidelines.                               |
| DRC          | Y                                        | Standards and Guidelines for Comprehensive Women Centred Abortion Care in the DRC, 2020; Essential Medicines List 2020.                                                                            |
| Malawi       | Y                                        | Standards and Guidelines for Post Abortion Care, 2020; National Reproductive Health Service Delivery Guidelines, 2019; Malawi Standard Treatment Guidelines 2015.                                  |
| Mozambique   | Y                                        | Clinical guidelines on abortion and post abortion care, 2017; Ministerial Decree on abortion, 2017; National Medicines Form 2007.                                                                  |
| South Africa | Y                                        | National Guideline for Implementation of Choice on Termination of Pregnancy Act, 2019; South Africa Standard Treatment Guidelines and Essential Medicines List, 2020.                              |
| Tanzania     | Y                                        | Comprehensive Post Abortion Care Guidelines 2020; Comprehensive Post-Abortion Care Guideline Training Manual 2016; Standard Treatment Guidelines and Essential Medicines List, 2017.               |
| Zambia       | Y                                        | Standards and guidelines for comprehensive abortion care in Zambia. September 2022 revised edition. Lusaka: Ministry of Health; 2022.                                                              |
| Zimbabwe     | Y                                        | National Guidelines for Comprehensive Abortion Care in Zimbabwe, 2022; Essential Medicines List and Standard Treatment Guidelines for Zimbabwe, 2011; Register for Approved Human Medicines, 2015. |
| Angola       | N                                        | Angola Medical Ethics Code 2000; National List of Essential Medicines, 2021.                                                                                                                       |
| Comoros      | N                                        | Essential Medicines List, 2014.                                                                                                                                                                    |
| Eswatini     | N                                        | National Policy on Sexual and Reproductive Health 2005; Standard Treatment Guidelines and Essential Medicines List of Common Medical Conditions.                                                   |
| Lesotho      | N                                        | Lesotho Essential Medicines List 2005.                                                                                                                                                             |
| Madagascar   | N                                        | Health Code 2011; Reproductive Health Norms and Procedures 2006; List of Medications 2014; List of Medications 2014; National Family Planning Policy 2008-2012.                                    |
| Mauritius    | N                                        | Medical Council Act, 1999.                                                                                                                                                                         |
| Namibia      | N                                        | Namibia Essential Medicines List; Namibia Standard Treatment Guidelines 2011 - First ed.                                                                                                           |
| Seychelles   | N                                        | Termination of Pregnancy Act; Seychelles List of Basic Essential Medicines Ministry of Health 2010.                                                                                                |

Source: Matshalaga, N and N. Mehlo,<sup>55</sup> updated by the Global Abortion Policy Database<sup>56</sup>

<sup>54</sup> Motaung, N. (2025) "Lesotho's hidden crisis: Unsafe abortions and the shadow of concealed births", Newsday online, 28 April, Newsday online. Available at: <https://newsdayonline.co.ls/lesothos-hidden-crisis-unsafe-abortion-and-the-shadow-of-concealed-births/> accessed 4 May, 2026.

<sup>55</sup> Matshalaga, N and Mehlo, N (2022) "Safe abortion policy provisions in the SADC region: Country responses, key barriers, main recommendations", South Africa Journal of Health;5(3):68-76. Available at: <https://doi.org/10.7196/SHS.2022.v5.i3.133>.

<sup>56</sup> WHO, Global Abortion Policy Database, <https://abortion-policies.srhr.org/>, accessed 20 September 2024

The question and five possible responses for the Abortion or Post Abortion Care guidelines score in the Southern Africa abortion assessment are:

Does your country have safe abortion and/or post-abortion care guidelines?

(0) No guidelines exist.

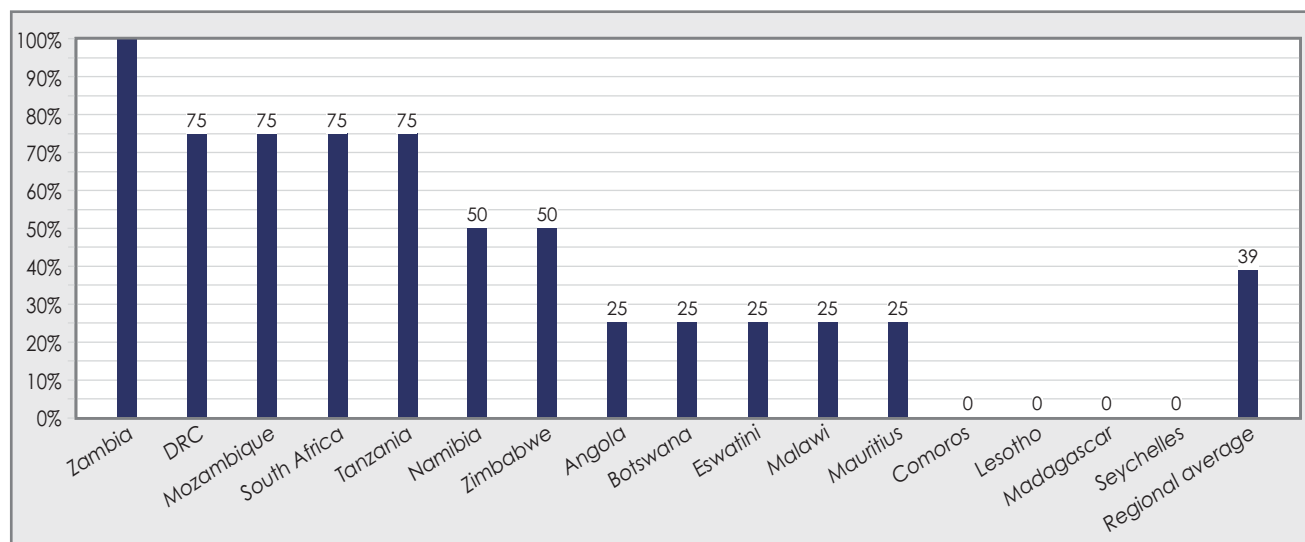
(25) Only post-abortion care guidelines exist.

(50) Safe abortion guidelines exist but do not include medication abortion.

(75) Safe abortion guidelines include medication abortion but not self-managed abortion.

(100) Safe abortion guidelines include self-managed abortion and reflect current WHO guidance.

Figure 5.8: Abortion or Post Abortion Care guidelines score



Source: Gender Links and SAASA, Southern Africa Abortion Assessment 2026

Figure 5.8 shows that overall, the region scored 39% on Abortion and Post Abortion care guidelines. Zambia scored 100% on this scale with DRC, Mozambique, South Africa and Tanzania scoring 75%, Namibia and Zimbabwe scoring 50%, Angola, Botswana, Malawi and Mauritius have scores of 25%, and all other countries scored zero, meaning they do not have stand-alone guidelines. Countries that do not have stand-alone guidelines but scored higher than zero have limited provisions elsewhere.

Guidelines are critical to give life to legislation, and especially to support how women can access services which should be available to them. As discussed in other parts of this chapter, NGOs working with pharmacists in the DRC are able to support women to access medication

abortion that is allowed in the guidelines; Zambia's guidelines have been reviewed to include wider access to medication abortion and the High Court in Malawi has instructed the Ministry of Health to update guidelines to make safe abortion accessible to survivors of sexual violence.

Even though post abortion care is provided for in many countries, uptake is often low. Speaking on the sidelines of a training workshop for journalists, Vimbai Nyika of Alliance partner Women's Action Group in **Zimbabwe**, noted that poor information, stigma, fear, and cultural barriers were keeping women from accessing lifesaving treatment on time. However, she commented that there were some promising signs, "in communities you now hear village



health workers, health service providers, even religious and traditional leaders talking about sexual and reproductive health issues. At parliamentary level, these matters are also being raised. When the law says someone can access a service, they should be able to do so without barriers"<sup>57</sup>.



The National Department of Health in **South Africa** is revising the National Clinical Guideline for the Implementation of the Choice on Termination of Pregnancy Act (2019). The revised guideline is designed to provide clear, evidence-based guidance to health care providers and facilities, based on the WHO Abortion Care Guideline (2022), FIGO (International Federation of Obstetrics and Gynaecology) recommendations and other evidence. It includes guidance on self-managed abortion. The guideline provides for medical abortion up to 12 weeks 6 days to be provided at all primary health facilities on the same day the request is made unless there is need for an ultrasound and this is unavailable on that day.

Individuals may conduct some or all elements of such medical abortion on their own:

- self-assessment of eligibility;
- self-administration of medicines;
- self-assessment of the success of the abortion.

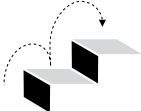
Self-management involves interactions with trained health workers in the community, online through telemedicine, or at a health-care facility, including at a pharmacy. Anyone engaging in self-management of medical abortion must have access to accurate information, quality-assured medicines including 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. Complications which may be experienced with medical abortions are pain, bleeding, fever or chills, nausea and vomiting, diarrhoea, and pelvic infection. Medical abortions for pregnancies that are over 13 weeks' gestation should be provided in facilities.



Abortion Law reform movement in Namibia.

Photo: Ndilokelwa Nthengwe

<sup>57</sup> Gukutikwa, T. (2025) Uptake of post-abortion care still low despite Government efforts, Herald online, 28 November available at: <https://www.heraldonline.co.zw/uptake-of-post-abortion-care-still-low-despite-government-efforts/> accessed 9 May, 2026.



## Next steps

Article 26 of the SADC Gender protocol on Sexual and Reproductive Health and Rights has a target to eliminate maternal mortality. This can only be achieved with much better access to safe abortion across the region. In most countries abortion is governed by outdated colonial penal codes, long abandoned in their countries of origin. Legislation needs to be aligned to contemporary human rights commitments that SADC countries have made and values of self-determination, equality and dignity which SADC member states subscribe to.

We therefore call on **SADC Parliaments** to decolonise abortion legislation and decriminalise abortion altogether. Changes to legislation need to be accompanied by community engagement, involving those affected, the media, traditional and religious leaders.

We call on **SADC governments** to:

- Update the SADC Gender Protocol, whose targets are aligned to the 2030 Sustainable Development Goals, to decriminalise safe abortion altogether; or at a minimum provide at least as much protection as the Maputo Protocol, to which all SADC members are signatory.

- Improve access to SRH information and services, especially contraception, to reduce the high rates of unintended pregnancy. This includes services for women and girls who are often poorly served such as younger, rural, poorer women, and women with disability. This is especially important now, when deep cuts in international aid are stressing health services across the region.
- Make safe abortion drugs available and provide quality post abortion care, with sensitisation of service providers on the circumstances under which safe abortion is allowed and on the provisions for post abortion care.
- Adopt guidelines aligned to the most up-to-date WHO guidance available; and disseminate guidelines to service providers so that they are aware of the circumstances under which safe abortion is legal and act to provide the services.

**Civil society** organisations and the **media** should support governments in destigmatising abortion, sharing information about the availability of post abortion care and the need to access this timeously.



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