Safe Abortion

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Showing support for the right to choose in Namibia. Photo: Gender Links

Key points

- Africa has the highest rates of abortion-related deaths of any region in the world. While Africa accounts for about one quarter of unsafe abortions globally, it accounts for about two thirds of abortion-related deaths.[1]
- Unmet need for contraception and maternal mortality ratio are both unacceptably high.
- The global and continental movement to decriminalise abortion is being countered by the resurgence of the anti-abortion movement.
- 11 SADC Member States have legislation that at least aligns to the Maputo Protocol, the first treaty in the world recognising abortion as a right.
- Many factors can hinder access to legally allowed safe abortion, including poverty; deep stigma and poor social support; insufficient information about the law among women, girls, health professionals and local level law enforcement bodies; lack of health sector guidance; and inadequate equipment or materials.
- Several international bodies, including associations of obstetricians and gynaecologists, are supporting innovative approaches to expanding access to safe abortion care.
- Women are exercising their agency in finding ways to access safe, or at least safer, abortion, including access to medication abortion.
- Grantees of the Voice and Choice Southern Africa Fund have initiated the Safe Abortion Alliance of Southern Africa (SAASA) to spearhead regional collaboration to advocate for legal review and expanded access to safe abortion.

[1] Population Reference Bureau (2021) Abortion facts and figures, Washington, DC. https://www.prb.org/wp-content/uploads/2021/03/2021-safe-engage-abortion-facts-and-figures-media-guide.pdf, accessed 18 August 2024

Introduction

Unsafe abortion is rife and is a major contributor to maternal mortality in SADC

Women from all walks of life, in every country in the world, seek abortions at some point in their lives. Africa was the first continent to adopt a protocol (the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, commonly known as the Maputo Protocol) recognising abortion, in some circumstances, as a human right. Yet, strong social stigma against abortion persists, driven by deeply held gender norms and fuelled by well-funded, international conservative groups. Many women in Africa and globally still struggle to access safe abortion, also referred to as termination of pregnancy.

Nine tenths of women in Africa live in countries that ban abortion completely, or only allow it to save the life of a woman, to preserve her mental or physical health, or in cases of rape, incest or fetal abnormality. Inability to access legal abortion does not reduce the number of abortions. Rather, it forces women and girls to seek any abortion measure available - most often unsafe. In contexts restricting access only about one quarter of abortions are safe, while in countries allowing abortion on request 90% are safe.

Thus, unsafe abortion is rife and is a major contributor to maternal ill health and mortality in SADC. It is estimated that eight million abortions occur in Africa every year, of which three quarters are not safe - with about a quarter unsafe and half least safe.[2] Unsafe refers to abortions carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. Least safe refers to abortions carried out by an untrained person using dangerous or invasive methods.[3]

Africa has the highest rates of abortion-related deaths of any region in the world. While Africa accounts for about one quarter of unsafe abortions in the world, it accounts for about two thirds of abortion-related deaths. The average death rate from unsafe abortion globally is 103 per 100 000 unsafe abortions. In developed countries it is 30 per 100 000 unsafe abortions, while in Africa it is 220 deaths per 100 000 unsafe abortions.[4] The toll of unsafe abortion is very high. For women and their families, complications and deaths from unsafe abortions can significantly affect psychosocial, physical and economic well-being. For health systems, there are financial costs of providing post abortion care (which is more expensive than providing safe abortion), as well as lost productivity.

This chapter highlights that despite global and continental movements for decriminalisation, there has been very little progress in SADC regarding reviewing and advancing abortion legislation. However, there has been action and progress towards ensuring women and girls are able to access abortion as allowed under national laws, as well as ensure this is good quality care. Across the region, there are examples of programmatic work seeking to change deeply entrenched perceptions of abortion; raise awareness about legal provisions and how these can be accessed; support development of guidelines for comprehensive abortion care; and share information about how to access services. These initiatives are critical to tackle barriers preventing women and girls from accessing safe abortions and seeking quality care that should be available according to legislation.

[2] Population Reference Bureau (2021) Abortion facts and figures, Washington, DC https://www.prb.org/wp-content/uploads/2021/03/2021-safe-engage-abortion-facts-and-figures-media-guide.pdf, accessed 18 August 2024
[3] WHO (2024) Abortion Fact Sheet https://www.who.int/news-room/fact-sheets/detail/abortion, accessed 19 October 2024.
[4] Population Reference Bureau (2021) Op Cit

Despite persisting barriers, women and girls are exercising their agency in finding ways to access safe, or at least safer, abortion. This includes traveling from all corners of SADC to access abortion in South Africa, which has one of the most liberal abortion laws in Africa. It also includes finding ways to access medication abortion.

There is continuing coordination and partnership between different actors working to broaden access to safe abortion. One such example is the collaboration initiated by grantees of the Voice and Choice Southern Africa Fund (VCSAF), highlighted in the following case study.

Safe Abortion Alliance of Southern Africa (SAASA)

VCSAF grantees initiated the Safe Abortion Alliance of Southern Africa (SAASA) at the Learning and Sharing Summit in November 2023. SAASA officially launched in a webinar on Safe Abortion and Gender-Based Violence (GBV) during 16 Days of Activism Against GBV on 6 December, 2023.

SAASA members met again in Harare on the occasion of the SADC Heads of State Summit where they made presentations to the SADC Gender Day meeting on 15 August 2024, as well as drafted an action plan and agreed to broaden their membership to all 16 countries in SADC.

In its short existence, SAASA has already achieved some milestones.

International Safe Abortion Day Dialogue
On International Safe Abortion Day, marked annually on 28 September, SAASA members hosted a dialogue on what needs to be done to improve women's access to safe abortion as prescribed by laws in SADC countries.

Lynette Mudekunye, author of the Safe Abortion chapter of the Voice and Choice SADC Barometer, noted that, "In every country in the world, women of all ages and socio-economic means, for many different reasons, take a decision they are not able to carry a pregnancy to term. Once a woman decides to have an abortion, she will find a way to do it."

Panellists from five countries with different abortion laws and interpretations described the persisting obstacles for women seeking access to safe abortion provided for under national laws.

In **Malawi**, Zaithwa Katherine Milanzi of the Young Women's Consortium on SRHR explained, one of the biggest challenges for women to access any SRH services is lack of resources - from the national health budget shortcomings to women's own resources. Milanzi highlighted climate disasters as a particular challenge in a country vulnerable to cyclones and drought. In disasters, SRHR competes for available resources amidst shortages of many essential goods and services. She lamented that the newly enacted Disaster Management Act 2023 does not specifically mention access to SRHR in disaster management.

According to Refiloe Harris of She-Hive Association, in **Lesotho**, stigma, stereotypes and religious, cultural and social norms are the biggest barriers for women and girls to access safe abortion. Applying existing laws, She-Hive Association successfully secured a court order for a 16-year-old to obtain a termination of a pregnancy that resulted from abuse (see case study found later in this chapter).

Hilda Dadu, from the Coalition for Women Human Rights Defenders, shared that in **Tanzania**, termination of pregnancy is prohibited, except to save a woman's life. Women and girls who become pregnant from sexual assault, rape or incest are forced to either keep the pregnancy or seek unsafe abortions. Both options can result in life-long physical and mental trauma. It is estimated that one million women have unintended pregnancies in Tanzania every year, of which 39% end in abortion.

South Africa is one of only two countries in SADC where abortion is legally available on request. However, women continue to die from unsafe abortions. Judiac Ranape, an abortion provider in the Western Cape, explained that the interplay between morals, ethics and legal duties for healthcare providers creates barriers for women to access safe abortion. She says, "The dearth of abortion providers undermines the availability of safe, legal abortion, making it easier for unscrupulous abortion providers to thrive."

The dialogue underscored the urgent need for a multi-sectoral and multi-pronged approach involving local partners, families, men and policymakers to advocate for decriminalising abortion and protecting women's right to access safe abortion services.

Presentation to the SADC Parliamentary Forum

Three young members of SAASA - Refiloe Harris (She-HIVE Association, Lesotho), Veronika Haimbili (Women of the South Speak Out (WOSSO) Fellow, Namibia) and Vimbai Nyika (Women's Action Group and WOSSO Fellow, Zimbabwe) - made a presentation to the SADC Parliamentary Forum on 23 October, calling for every member state to:

- Adopt progressive adolescent SRHR policies and ensure youth-friendly SRHR information and services like contraception.
- Promote community awareness to reduce stigma and protect adolescent SRHR rights.
- Ensure access to safe abortion by urging decriminalisation by parliaments and expanding quality, self-managed medication abortion options.

Movement building: growing SAASA

Since August 2024, SAASA has grown from 27 members to 43 members from eight SADC countries (DRC, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania and Zimbabwe), with the intention to recruit members from all 16 SADC countries. In collaboration with the Sexual and Reproductive Justice Coalition (SRJC), SAASA is planning a strategy convening in Johannesburg at the end of November 2024 to develop a collective vision for the alliance and strategies to advance safe and legal abortion access across Southern Africa.

Table 4.1: Key facts on abortion in Southern Africa

Country	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
Laws	Penal Code 2017	Penal Code 1991	Penal Code 1995	Maputo Protocol gazetted 2018	Constitution 2005	Penal Code 2010	Penal Code 1998, Criminal Procedure Law	Penal Code	Criminal Code Act 2012	Penal Code 2019	Abortion and Sterilisation act 1975	Termination of Pregnancy Act 1994	Choice of Termination of pregnancy Act (92/1996) amended in 2008	Penal Code	Termination of Pregnancy Act 2005 and Penal Code 2014	Termination of Pregnancy Act 1977
Abortion on request	Yes	Not specified	No	No	No	No	No	Not specified	No	Yes	No	Not specified	Yes	Not specified	Not specified	No
Compliance with Maputo Protocol	Yes	Yes	Partial	Yes	Yes	Yes	No	Partial	Yes	More than	Yes	More than	More than	Partial	More than	Partial
Unmet need for modern method of contraception																
% of unmarried women 15 - 49 with unmet need	16.9	8.3	6.2	21.7	10.2	5.5	12.2	10.1	4.6	14.9	9		10.2	12.8	11.7	4.4
% of married or in union women 15 - 49 with unmet need	39.0	12.1	36.8	39.7	18.1	16.5	21.6	16.7	36.9	26.8	18.2		14.9	26.9	22.4	11.6
Maternal mortality ratio (MMR)																
MMR 2020	222	186	217	547	240	566	392	381	84	127	215	3	127	238	135	357
Rate of reduction 2010 to 2020 %	40	-19	31	9	64	46	21	26	-53	61	55	63	42	51	50	42
Expected MMR at same rate reduction	134	222	149	498	86	308	309	283	128	50	96	1	74	117	68	206
Maternal mortality attributable to maternal abortion and miscarriage %	9.3	4.0%	11.9	10.1	7.7	No data	7.2	12.6	No data	13.8	8.8	No data	7.4	13.8	14.1	8.5
Guidelines																
Abortion care guidelines				Yes				Yes		Yes			Yes		Yes	Yes
Post-abortion care guidelines		Yes		Yes				Yes		Yes	Yes		Yes	Yes	Yes	Yes

Key for all tables Very good Medium Low Very low Insufficient data

Sources: Unsafe Abortions in Southern Africa: Current Status and Critical Policy Gaps. SAFAIDS 2019. WHO, Global Abortion Policies Database: https://abortion-policies.srhr.org/, accessed 15 April 2020. https://www.un.org/development/desa/pd/data/family-planning-indicators, accessed 17 September 2024 Trends in Maternal Mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division (2023), World Health Organization, Geneva https://data.worldbank.org/indicator/SH.STA.MMRT, accessed 17 September 2024

Matshalaga, N and N. Mehlo, Safe abortion policy provisions in the SADC region: Country responses, key barriers, main recommendations", (2022) South Africa Journal of Health;5(3):68-76. https://doi.org/10.7196/SHS.2022.v5.i3.133, accessed 26 August 2024.

WHO Africa, Country Abortion Health Profiles as of 2019 https://staging.afro.who.int/pt/node/13767, accessed 17 July 2024

Table 4.1 shows that:

- Policy barriers in most SADC countries prevent women from seeking safe abortions when they make this decision as a personal choice. 11 of 16 Member States in SADC have legislation that at least aligns to the Maputo Protocol (abortion authorised in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the physical or mental health of the woman or the life of the woman or fetus).
- Unmet need for contraception ranges from a low of 11.6% in Zimbabwe to a high of 39.3% in the DRC. Several countries have a high unmet need, indicating access to SRH services is not ideal. Rates of unintended pregnancies are likely to be higher in these countries.
- Most of SADC is far from achieving the global sustainable development goal (SDG) target of a maternal mortality ratio (MMR) of 70 per 100 000 live births. Currently only Seychelles has an MMR lower than 70. All other countries

range between 84 and 547. Unsafe abortion leads to high levels of ill health and mortality, which increases overall maternal mortality. The contribution of abortion and miscarriage to the MMR varies between 4% in Botswana and 14.1% in Zambia (though there are differing estimates, some higher).

My Body, My Choice march in Johannesburg, South Africa, on International Day for Safe Abortion held annually on 28 September. Photo: Shamiso Chigorimbo

Abortion in Seychelles

According to the National Bureau of Statistics in the **Seychelles**, the number of legal abortions has remained fairly consistently 400 to 500 per year from 2008 to 2023, while the number of live births has also been quite consistent with about 1500 per year in the same period.

The following table shows the number of abortions per different age groups in 2021 and 2023.

Table 4.2: Abortion by age groups in Seychelles 2021 and 2023

Age group	Number of abortions 2021	Number of abortions 2023	Percentage of all abortions 2023
10 - 14	5	5	1%
15 - 19	49	53	13%
20 - 39	233	317	78%
40 - 49		30	7%

Source: Gender Links with data from Uzice, A, July 2024 and 'Youth voice out concerns'[5]

[5] Uzice, A. 2024. Abortions in Seychelles: Majority recorded among 20-39-year-olds - citing financial issues, failed relationships. http://www.seychellesnewsagency.com/articles/20488/Abortions+in+Seychelles+Majority+recorded+among-+year-olds-+citingfinancial+issues%2C+failed+relationships and Youth voice out concerns on laws, regulations on reproductive health September 2022. https://www.nation.sc/articles/14869/youth-voice-out-concerns-on-laws-regulations-on-reproductive-health accessed 19 July 2024.

Speaking to the media, a specialist consultant of gynaecology and obstetrics at the Seychelles Hospital expressed that Seychelles must invest more in SRHR education, especially about the availability of free contraceptives to prevent unwanted pregnancies. It is believed that there are many unsafe and unrecorded abortions taking place in Seychelles.[6] The Ministry of Youth and civil society organisations are concerned about the rate of teenage pregnancy, illustrated in Table 4.3.

Table 4.3: Adolescent pregnancy and abortion in Seychelles 2014 to 2021

Year	Adolescent girls (12 - 19) population	Reported adolescent pregnancy	Adolescent pregnancy rate per 1000 girls	% of reported abortion among adolescent pregnancy
2014	4555	188	41.3	58.5%
2015	4497	194	43.1	36.1%
2016	4150	211	50.8	37.0%
2017	3595	204	56.7	45.6%
2018	3800	217	57.1	36.4%
2019	4110	237	57.7	29.5%
2020	4203	193	45.9	39.9%
2021	5936	212	35.7	25.5%

Source: 'Youth voice out concerns on laws, regulations on reproductive health'[7]

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.[8]

6 Uzice, A. Op Cit.
7 'Youth voice out concerns on laws, regulations on reproductive health', Seychelles Nation, 1 September 2022, https://www.nation.sc/articles/14869/youth-voice-out-concerns-on-laws-regulations-on-reproductive-health accessed 19 July 2024
8 UNECA African Regional Conference on Women Beijing+25 Political Declaration and key messages and priority actions on the implementation of the Beijing Declaration and Platform for Action https://www.uneca.org/sites/default/files/uploaded-documents/Beijing25/e1902218-beijing25_declaration-english-.pdf, accessed 27 May 2020

Nairobi Statement on ICPD25: Accelerating the Promise[9]

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.[10]

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) was adopted by the African Union in 2003. It was the very first treaty anywhere in the world to recognise abortion, under certain conditions, as women's human right which they should enjoy without restriction or fear of being prosecuted. The SADC SRHR Strategy 2019 – 2030 calls for reduced rates of unsafe abortion. Other normative frameworks focus on the need for improved access to contraception to reduce the rate of unintended pregnancy which underlies most decisions to have an abortion. They also call for reduction in and even elimination of maternal mortality. Given the significant contribution of unsafe abortion to maternal mortality, it is clear that access to safe abortion is critical to achieve maternal mortality targets.

The Maputo Protocol turns 20

The status in SADC of signing and ratifying the Maputo Protocol, which turned 20 in 2023, is shown in the following table.

Table 4.4: Status of signing and ratification of the Maputo Protocol in SADC

Country	Signed	Ratified	Deposited
Angola	22/01/2007	30/08/2007	09/11/2007
Botswana	✗	✗	✗
Comoros	26/02/2004	18/03/2004	16/04/2004
Democratic Republic of Congo	05/12/2003	09/06/2008	09/02/2009
Eswatini	07/12/2004	05/10/2012	06/11/2012
Lesotho	27/02/2004	26/10/2004	05/11/2004
Madagascar	28/02/2004	No	
Malawi	19/12/2003	20/05/2005	29/06/2005
Mauritius	29/01/2005	16/ 06/2017	23/06/2017
Mozambique	15/12/2003	09/12/2005	30/12/2005
Namibia	09/12/2003	11/08/2004	26/08/2004
Seychelles	09/03/2006	08/03/2012	08/03/2012
South Africa	16/03/2004	17/12/2004	14/01/2005
Tanzania	05/11/2003	03/03/2007	05/09/2008
Zambia	03/08/2005	02/05/2006	07/06/2006
Zimbabwe	18/11/2003	14/04/2008	05/09/2008

Source: Gender Links with data from the Centre for Human Rights, University of Pretoria[11]

[9] https://www.nairobisummiticpd.org/content/icpd25-commitments, accessed 27 May 2020
[10] UNFPA (2020) Accelerating the Promise. The Report on the Nairobi Summit on ICPD25. New York.
https://www.nairobisummiticpd.org/sites/default/files/Nairobi%20Summit%20Report%20on%20ICPD25_0.pdf, accessed 31 May 2020
[11] Centre for Human Rights, University of Pretoria. Country Status. https://www.maputoprotocol.up.ac.za/countries/countries-table, accessed 15 August 2024.

When a state signs a protocol, it intends to adopt all the articles of the protocol and when it ratifies it has adopted all articles. To deposit a protocol means that a country formally submits its instrument of ratification or accession to the African Union's Secretary-General.

In SADC:

- 14 states are amongst the 44 that have ratified the Maputo Protocol.
- Madagascar is one of eight states in Africa that have signed but not ratified the Maputo Protocol.
- Botswana is one of three states in Africa have neither signed nor ratified the Maputo Protocol.

The following table provides an overview of legislation on abortion in SADC, categorised by whether legal provisions are more than, equal to, or less than required by the Maputo Protocol.

Table 4.5: Legal provisions regarding abortion in SADC[12]

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

Country	Law	Conditions under which an abortion may be granted										Gestational limits	Consent	Provided by	Penalties for an illegal abortion
		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[13]	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.	Right to terminate without consent of other parties apart from medical practitioners.		Yes, for the woman, provider, and person who helps a woman obtain abortion.
Mozambique	Amended Penal Code 2019	Available on demand.										On demand to 12 weeks; in the case of incest, 16 weeks; in the case of fetal anomalies, 24 weeks.	Parental consent for minors; a health unit committee determines legal grounds.[14]	A certified practitioner at designated facilities.[15]	Yes, for the woman, provider, and person who helps a woman obtain abortion.
Available on socio-economic grounds - more than required by the Maputo Protocol															
Seychelles	Termination of Pregnancy Act, 2012 Penal Code	✗	✗	✗	✗	✗		✗	✗	✗			If three medical practitioners agree in good faith, termination can be done at Victoria Hospital, Mahe		Imprisonment up to 14 years.
Zambia	Termination of Pregnancy Act, 1972, amended in 2005 and Penal Code	✗	✗				✗					Not specified.	Once three medical practitioners have agreed.		Seven years for person who administers; seven years for woman who administers own abortion.

[12] 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
[13] https://www.afro.who.int/publications/who-african-regions-countries-abortion-health-profiles accessed 17 July 2024.
[14] http://www.parliament.gov.za/live/commonrepository/Processed/20140414/67169_1.pdf
[15] https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique
https://www.womenonwaves.org/en/page/5009/abortion-law-mozambique

Country	Law	Conditions under which an abortion may be granted										Gestational limits	Consent	Provided by	Penalties for an illegal abortion
		ES	FI	In	WD	Ra	WH	Wmh	Wph	WL	O				
Abortion available in specific circumstances - in compliance with the Maputo Protocol															
Angola	Penal Code 2019		✗					✗	✗	✗	✗	16 weeks to preserve health, fetal impairment no limit.	Parental consent for minors.	Licensed facility and one doctor.	Four to ten years in prison.
Botswana	Penal Code (Amendment) Act, 1991 - Section 160		✗	✗		✗		✗	✗	✗	✗	Termination must be performed before 16 weeks.[16]	Consent of parent or next of kin for minors; two doctors.	Licensed facility	Three years for procurement; seven years for aiding.
DRC	Act of Access to Maputo Protocol, 2018			✗		✗		✗	✗	✗	✗	Up to 14 weeks.	Parental consent for minors.		Yes, for the woman, provider, and person who helps a woman obtain abortion.
Eswatini	The Constitution, 2005		✗	✗		✗		✗	✗	✗	✗	Up to 14 weeks.	Two doctors.		Life imprisonment.
Lesotho	The Penal Code (2012)[17]		✗	✗		✗	✗					Up to 14 weeks.	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.
Mauritius	Penal Code 1983; Criminal Code Amendment Act 2012[18]		✗			✗		✗	✗	✗	✗	If a pregnancy is within 14 weeks and the girl is younger than 16.	Parental consent for minors.		Imprisonment of up to ten years.
Namibia	Abortion Sterilisation Act 2 of 1975		✗	✗	✗	✗		✗	✗	✗			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.
Partial compliance with the Maputo Protocol															
Comoros	Comoros-Penal-Code-1995	Very serious medical reasons.										Not specified.	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.
Malawi	Penal Code	Only to save a woman's life.													14 years for having an abortion; three years for supplying instruments to conduct an abortion.
Tanzania	Penal Code 1981[19]	Only to save a woman's life.													Seven years for procurement; three years for suppliers.
Zimbabwe	Termination of Pregnancy Act 1977, Chapter 15:10[20]		✗	✗		✗			✗	✗	✗		A magistrate must grant permission.		Five years in prison and/or fine not exceeding $5000.
Not compliant with Maputo Protocol															
Madagascar	Reproductive Health and Family Planning Law 2017	Abortion is prohibited.													Not explicit, but death, forced labour or life are most severe punishments.

[16] http://www.gov.bw/en/Citizens/Sub-Audiences/Women/Unsafe-Abortions, https://www.hsph.harvard.edu/population/abortion/BOTSWANA.abo.htm
[17] http://www.wipo.int/wipolex/en/text.jsp?file_id=238601
[18] https://lesotholii.org/ls/legislation/num-act/6
[19] https://srhr.org/abortion-policies/documents/countries/02-Mauritius-Criminal-Code-Amendment-Act-2012.pdf
[20] https://www.globalfinancingfacility.org/sites/gff_new/files/Tanzania_One_Plan_II.pdf
Termination of Pregnancy Act, http://cyber.law.harvard.edu/population/abortion/Zimbabwe.abo.html

Table 4.5 summarises legislation regarding abortions across SADC and compliance with the Maputo Protocol. It shows that there is a range of compliance in SADC countries.

- *Beyond compliance:* South Africa and Mozambique (abortion on demand in the first trimester) and Seychelles and Zambia (abortion on socio-economic grounds) are among 12 states which have ratified the Maputo Protocol and permit abortion beyond the circumstances listed in the Protocol's abortion provisions.
- *Fully compliant:* Angola, DRC, Eswatini, Mauritius, Lesotho and Namibia are among 11 states which have ratified the Maputo Protocol and permit abortion in all cases listed in the Protocol's abortion provisions. (Botswana is also compliant but has not ratified the protocol).
- *Partially compliant:* Comoros, Malawi, Tanzania and Zimbabwe (which only allows abortion if a woman's physical health is in danger and does not mention mental health) are among 16 states which have ratified the Maputo Protocol and that permit abortion in some but not all of the cases listed in the Protocol's abortion provisions.
- *Non-compliant:* Four states which have ratified the Maputo Protocol directly contravene the protocol by prohibiting abortion under all circumstances. (Madagascar is one of 22 countries in the world which prohibits abortions under all circumstances. It has not ratified the protocol).

The impact of access to legal abortion on selected SRH indicators

It is sometimes suggested that making safe abortion more easily available will result in abortions being used as a form of family planning. Rhodes University and the United Nations Population Fund (UNFPA) reviewed data, as well as peer reviewed articles regarding impact on SRH indicators of broadening grounds under which abortion is legal, for 27 countries globally (including Eswatini, Lesotho, Mauritius and Mozambique in SADC) that enacted change to their abortion legislation between 2000 and 2021.[21]

Table 4.6 summarises their findings.

Table 4.6: Selected SRH indicators for countries that broadened conditions under which abortion is legal since 2000

Key:	Acronym	
	MMR	Maternal Mortality Ratio, per 100 000 live births
	CPR	Contraception Prevalence Rate %
	ASFR	Adolescent Specific Fertility Rates per 1000 girls aged 15 - 19
	CBR	Crude Birth Rate - live births per 1000 population.

Country	MMR 2000	MMR 2015	Relative change in MMR (%)	CPR 2000	CPR 2019	Relative change in CPR (%)	ASFR 2000-2005	ASFR 2015-2020	Ratio ASFR (2015-2020/ 2000-2005)	Ratio CBR (2015-2020/ 2000-2005) compared to ratio ASFR
Australia	7	6	14	59	58	**-1**	16.9	11.7	0.69	1.01 (0.69)
Benin	520	421	19	20	16	**-20**	115.7	86.1	0.74	0.88 (0.74
Bhutan	423	203	52	20	38	93	69.2	20.2	0.29	0.71 (0.29)
Central African Republic	1280	912	29	19	22	19	148.0	129.1	0.87	0.84 (0.87)
Chad	606	550	9	4	6	56	209.7	161.1	0.77	0.84 (0.77)
Chile	31	14	55	43	62	45	57.0	41.1	0.72	0.81 (0.72)
Colombia	94	53.8	43	53	63	20	95.5	66.7	0.70	0.72 (0.70)
Eritrea	1280	518	60	6	8	51	82.4	52.6	0.64	0.88 (0.64)
Eswatini	580	435	25	29	53	87	104.7	76.7	0.73	0.84 (0.73)
Ethiopia	1030	446	57	5	27	407	106.0	66.7	0.63	0.79 (0.63)
Iran	48	17	65	49	58	20	32.8	40.6	1.24	0.70 (1.24)
Kenya	708	353	50	29	46	57	106.0	66.7	0.63	0.74 (0.63)
Lesotho	614	574	7	27	52	89	87.9	92.7	1.05	0.87 (1.05)
Luxembourg	10	5	50	No data	No data	No data	11.7	4.7	0.40	0.86 (0.40)
Mali	836	620	26	8	16	96	186.3	169.1	0.91	0.86 (0.91)
Mauritius	59	73	**-24**	46	42	**-8**	36.5	25.7	0.70	0.77 (0.70)
Mozambique	798	318	60	14	24	69	181.2	148.6	0.82	0.85 (0.82)
Nepal	553	236	58	28	42	50	104.9	65.1	0.62	0.70 (0.62)
Niger	813	555	31	9	15	80	215.5	186.5	0.87	0.88 (0.87)
Portugal	10	9	10	59	61	3	20.2	8.4	0.42	0.72 (0.42)
Saint Lucia	86	115	**-34**	39	48	23	54.6	40.5	0.74	0.76 (0.74)
Somalia	1210	855	29	7	15	108	127.4	100.1	0.79	0.88 (0.79)
Spain	5	4	20	57	60	6	10.2	7.7	0.75	0.84 (0.75)
Switzerland	7	5	29	72	72	0	5.3	2.8	0.53	1.02 (0.53)
Thailand	43	38	12	52	56	7	41.9	44.9	1.07	0.77 (1.07)
Togo	489	398	19	19	23	21	93.6	89.1	0.95	0.84 (0.95)
Uruguay	26	18	31	51	57	11	64.7	58.7	0.91	0.88 (0.91)

Source: Gender Links adapted from Macleod, C.I., Speciale, A., & Delate, R. (2021)[22]

The findings support the thesis that expanding access to safe abortion generally leads to reduction in maternal mortality and is associated with increased contraception prevalence, meaning that abortion is not being used as a means of family planning. Further, there was greater reduction in adolescent fertility than in fertility of all women.

Specifically:

- There was reduction in the maternal mortality ratio (MMR) between 2000 and 2015 in 25 of the 27 countries, of between 0 and 25% in eight countries; between 25 and 50% in nine; and of over 50% in eight (including Mozambique which had reduction of 60%).

[22] Macleod, C.I., Speciale, A., & Delate, R. Op Cit whose data is from Center for Reproductive Rights; MMR source: WHO Global Health Observatory and United Nations

- The contraception prevalence rate (CPR) increased in 23 of the 27 countries, 10 saw an increase of between 0 and 25%; two increased between 25 and 50%; while 11 were over 50%. The CPR in Eswatini increased from 29% to 53%.
- Adolescent specific fertility rates (ASFR) reduced between the period 2000-2005 and the period 2015-2020 in 24 of the 27 countries. Further the Crude Birth Rate also decreased in most of the countries. The decrease in ASFR was more than that of the CBR in 20 of 27 countries, indicating that fertility decreased more in adolescents than in all women of reproductive age in these countries.

A movement for the total decriminalisation of abortion

In June 2022, the United States Supreme Court, in the Dobbs v. Jackson Women's Health Organisation decision, overturned the Roe v. Wade ruling, which had legalised abortion in the United States in 1973. The global environment post the Dobbs decision has been very unfriendly to any efforts to liberalise abortion legislation. This decision has emboldened anti-abortion groups like Family Watch International, which has a focus on Africa, to increase their attacks on possible legal change.[23]

Nonetheless, there is still a global call for complete decriminalisation of abortion founded in notions of gender equality and human dignity, and challenging legal restrictions to women's bodily autonomy. Legal campaigns for decriminalising abortion embrace criminal, health, constitutional and international law.[24]

The World Health Organisation (WHO) 2022 Abortion Care Guidelines calls for "the full decriminalisation of abortion."[25] The guidelines say that decriminalisation:

- Means removing abortion from all penal/ criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.
- Would ensure that a woman who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care.
- Does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute serious assaults as these would be non-consensual interventions.[26]

FIGO (the International Federation of Gynaecology and Obstetrics) called for "the total decriminalisation of safe abortion, and for the promotion of universal access to abortion, post-abortion care and evidence-based, non-biased abortion-related information, free of force, coercion, violence and discrimination. Abortion should be removed from criminal law and regulated by laws consistent with every other medical procedure, and with the well-being of women and girls placed at the centre of their care."[27]

The African Union Special Rapporteur on the Rights of Women, Honourable Commissioner Maria Teresa Manuela, has called on States to *decriminalise abortion*[28] and empower women and girls to make their own choices about their reproductive health."[29]

[23] Roe fallout: Religious conservatives rally to curb abortion in Africa, Rédaction Africanews, 3 July 2023. https://www.africanews.com/2023/07/03/post-roe-fallout-religious-conservatives-rally-to-curb-abortion-in-africa/, accessed 30 June 2024.
[24] Malagodi M, Gender Equality and the Complete Decriminalisation of Abortion, Int'l J. Const. L. Blog, Nov. 10, 2021, at:http://www.iconnectblog.com/2021/11/gender-equality-and-the-complete-decriminalisation-of-abortion/, accessed 30 June 2022.
[25] WHO (2022) Abortion care guidelines, Geneva, World Health Organization https://apps.who.int/iris/handle/10665/349316, accessed 21 June 2022
[26] Ibid
[27] nternational Federation of Gynecology and Obstetrics (2022) FIGO Calls for the Total Decriminalisation of Safe Abortion. Available from: www.figo.org/resources/figo statements/figo calls total-decriminalisation safe abortion
[28] Emphasis Gender Links.
[29] "Statement of the Special Rapporteur on the Rights of Women on the Occasion of the Global Day of Action for Access to Safe and Legal Abortion", African Commission on Human and Peoples' Rights, 28 September 2021 https://www.achpr.org/pressrelease/detail?id=602, accessed 6 July 2022.

Lobbying and advocacy in SADC for improved access to safe abortion

In June 2024, the chairperson of **Zimbabwe**'s Parliamentary Portfolio Committee on Health and Child Care, Hwange Central legislator Daniel Molokele, called for repealing the country's Termination of Pregnancy Act, saying the Termination of Pregnancy Act of 1977 is outdated, violates the current Constitution's promotion of gender equality and places women in dangerous situations.[30]

The Justice, Legal and Parliamentary Affairs Minister, Ziyambi Ziyambi, acknowledged the need for reforming the Termination of Pregnancy Act which only permits abortion in three specific scenarios:

- Continuation of the pregnancy endangers the woman's life or poses a serious threat of permanent impairment to her physical or mental health.
- Child may be born with serious physical or mental defects.
- Fetus was conceived as a result of rape or incest.

Molokele contends that safe abortion is available in Zimbabwe to those that can pay for it, but that poverty deprives many women of what should be a right. He further believes that if a revised Act is aligned to the Zimbabwe 2013 constitution, which has a robust Bill of Rights, it will be very different. He believes that each generation should move the process towards decriminalisation.[31]

Civil society organisations working on safe abortion in Zimbabwe, including VCSAF grantee Women's Action Group (WAG), have formed the Safe Abortion Coalition to coordinate advocacy. They are negotiating with the Minister of Health and Child Care, Dr. Douglas Mombeshora, regarding expanding the circumstances under which safe abortion can be accessed; complete review of the Termination of Pregnancy Act (1977); access to comprehensive quality SRHR services and increased budget allocation to the Ministry of Health and Childcare.[32]

There is ongoing advocacy for legal reform in **Malawi**. The case study below highlights work to mobilise communities to demand safe abortion.

Traditional leaders as champions for safe abortion in Malawi

In a bold step toward advancing reproductive health rights, VCSAF grantee the Malawi Human Rights Resource Centre (MHRRC), in collaboration with other civil society organisations (CSOs), conducted an impactful campaign in Kasungu, in Malawi's Central Region, on International Safe Abortion Day. This event, aired on national television, sparked critical discussions about the urgent need to enact the Termination of Pregnancy (ToP) Bill, which is crucial to address unsafe abortions and safeguard the reproductive rights of women and girls.

A panel discussion brought together influential stakeholders, traditional leaders, Members of Parliament, young people, service providers and members of CSOs. The discussion focussed on how the ToP Bill could address the widespread challenges faced by women and girls in accessing safe abortion services, which is essential for reducing maternal deaths and ensuring reproductive rights.

During the discussion, Traditional Authorities Lukwa and Njombwa passionately advocated

[30] Moyo, S. 'Lawmaker pushes for easier access to safe abortion", June 2024 https://www.chronicle.co.zw/lawmaker-pushes-for-easier-access-to-safe-abortion/#google_vignette
[31] Personal Communication, 7 August 2024.
[32] Masiyiwa, E. Presentation to the SADC Gender Day, 15 August 2024

for the passage of the ToP Bill. As respected leaders in their communities, they emphasised the critical need for Parliament to take immediate action. Both leaders highlighted how unsafe abortions continue to claim the lives of women, especially those from impoverished backgrounds who are forced to resort to unsafe methods due to lack of access to safe medical procedures.

Senior Chief Lukwa pointed out the glaring disparity in abortion access, noting, "The issue is that those with financial means can access safe abortion services because they can afford them, while those without money are forced into dangerous backstreet procedures, risking their lives."

Senior Chief Lukwa speaking on the panel discussion in Kusungu, Malawi on International Safe Abortion Day. Credit: Lyness Soko, MHRRC

Senior Chief Njombwa reinforced the urgent need for Parliament to act, stating that continuing to deny women access to safe abortion only deepens their vulnerability. He called for lawmakers to enact the ToP Bill, which could save the lives of many women and girls.

The panel included young people and women from the community. Many lamented the fact that women and girls continue to die from unsafe abortions, yet society, religious leaders and the law seem indifferent. One young woman shared her concerns, "We are dying, and it feels like no one cares. People hide behind religion and the law, but women and girls are raped every day, and some are forced to carry the pregnancies of their rapists. How is that justice?"


Honourable Dr. Ngwale, Chairperson of the Parliamentary Health Committee, speaking during the International Safe Abortion Day in Kasungu, Malawi. Credit: Lyness Soko, MHRRC

These powerful testimonies highlighted the real-life struggles faced by women and girls, who endure not only sexual violence but also the burden of carrying unwanted pregnancies resulting from rape. For them, the ToP Bill represents more than just a legal reform - it is a lifeline that could restore their dignity and protect their health.

Young people called for an end to the silence around sexual violence and unsafe abortions, urging Members of Parliament to listen to the lived experiences of survivors and take action to prevent more deaths.

Matthew Ngwale, Chairman of the Parliamentary Health Committee, attended the event. Ngwale committed to bringing the stalled Termination of Pregnancy Bill back to parliament and said he plans to initiate community consultations about the Bill.

Coverage in the national print media and on television sparked a national conversation on reproductive rights, amplifying the voices of women, young people, and traditional leaders who support enacting the ToP Bill. It reinforced the role of traditional leaders, Members of Parliament, and community stakeholders in the fight for reproductive justice. The collective call for the ToP Bill sends a strong message to lawmakers that the lives and rights of women and girls must be prioritised, ensuring that no one is left behind due to outdated laws and harmful social norms.

Source: MHRRC report

Chitete, S. "Chiefs demystify safe abortion," The Nation, Blantyre Malawi. 21 October 2024

Accessing abortion services available in the law

In all Member States many circumstances keep women from realising safe abortion rights that should be made possible in law. This includes in South Africa and Mozambique, which have the most liberal legislation. Some of these circumstances are:

- Limited knowledge or understanding of what is legally allowed and poor access to information among women, girls, their partners, health providers and legal practitioners.
- Lack of guidelines for the health sector to ensure they do provide what should be available. Many health facilities do not have the correct medicines or equipment, especially so in rural areas.
- Many laws have unreasonable requirements e.g. approval by two doctors in countries where doctors are few and far between, and especially not available in rural and other underserved areas.
- Delays, for instance in determining that a pregnancy was the result of rape or incest, which pushes pregnancies beyond the time limit which is allowed for an abortion.
- Stigma, rooted in moralistic religious, cultural and traditional gender norms.
- Attitudes of health professionals, and conscientious objection by health professionals.
- Poor social support for a woman to seek an abortion.
- Poverty and insufficient money to pay to access a safe abortion. This may include money for transport to get to a facility that provides abortions and, quite often, to go back to that facility if a woman or girl cannot receive the service when they initially go.

The following section of the chapter presents information from different countries of barriers for accessing safe abortion services that should be available under national laws, as well as action being taken and innovations introduced to ensure women and girls are able to access these services.

Operationalising legislation to improve access to abortion care in the DRC

Until 2018, the **DRC** had one of the most draconian laws against abortion of any nation while also curtailing access to contraceptives. Low levels of contraceptive prevalence and high levels of sexual violence in the ongoing conflict are two factors that contributed to high levels of unsafe abortions in the DRC. In 2017, Médecins Sans Frontières (MSF) reported that 13% of all abortion related complications they treated in the 75 countries where they work were in the DRC (2,800 cases).[33]

Although the DRC ratified the Maputo Protocol in 2008, it only nationalised the protocol's provisions in 2018 with publication in the *Journal officiel edition spécial du 5 Juin 2018* (National Gazette), enabling it to become the law of the land. Abortion is now legally allowed in the DRC through 14 weeks in cases of sexual assault, rape, incest, fetal abnormalities, and when continuing the pregnancy endangers the mental or physical health or life of the pregnant woman.

Independently of the process to have the Maputo Protocol gazetted, another process resulted in the passage of a Public Health Law also in 2018. This law allowed access to contraception for all persons of reproductive age and provided for legal abortion to preserve the life of the mother and in cases of fetal malformations. The provisions of the Public Health Law and Maputo Protocol were not the same, but DRC law provides that the provisions of international protocols take precedence over national law.[34]

In 2020, the Ministry of Health (MOH) developed standards and guidelines for woman-centred abortion care aligned to the WHO standards. The standards determine who may perform abortions, where they can be performed, what

[33] Glover, A L., JC Mulunda, P Akilimali, D Kayembe & JT Bertrand (2023) Expanding access to safe abortion in DRC: charting the path from decriminalisation to accessible care, Sexual and Reproductive Health Matters, 31:1, 2273893, DOI: 10.1080/26410397.2023.2273893 Accessed 20 July 2024
[34] Ibid

methods can be used and to whom abortion can be offered.

Though the gazetting of the Maputo Protocol should have provided an avenue for increased access to abortion care, a study in 2021 found that 19% of women in Kinshasa were unaware of the legal conditions for abortion.[35] Health providers are also unsure of the legal provisions and often lack skills in providing abortion care, as well as the necessary equipment or medication.

Misoprostol was on the essential medicine list and should have been available in hospitals to treat postpartum haemorrhage and manage post-abortion complications. However, a Service Provision Assessment (SPA) conducted in 2017 found that only 13.4% of DRC health facilities had misoprostol on hand.[36] The MOH has since authorised mifepristone-misoprostol medication abortions and added mifepristone to the essential medication list. Further, the MOH has authorised providers to give prescriptions for Mifepak (the combination package of mifepristone 200 mg and misoprostol 200 mcg tablets) that women can access in pharmacies. Medication abortion has significant potential to expand safe abortion care. NGOs, healthcare providers and some community agents can provide access to medication abortion through community facilities.

The 2017 SPA found that only one third of health facilities in the DRC were ready to provide safe abortion care and that readiness varied considerably between provinces. Since then, training curricula and tools such as guide sheets and wall posters for providers have been developed and disseminated. Clinical training in safe abortion care has been added to nursing and medical schools' curricula.

High levels of stigma, ostracisation and rejection towards both women who procure an abortion as well as those that provide abortions are still prevalent throughout the DRC.[37] It is difficult for women to access accurate information. The study in Kinshasa found that women valued confidentiality and therefore prioritised seeking information from a very small circle of trusted female relatives or friends. They sometimes entrusted their partners, who were able to seek information more widely, and rarely directly approached health care providers. Some partners shared information with the affected women, allowing them to make their own decisions. Others used the information to make decisions on behalf of their partners, thereby denying them the agency to make their own decisions. Women still often resort to unsafe abortions, which are more confidential, to avoid stigma.

Some of the recommendations to improve access to safe abortion care in the DRC are:

- Wide awareness campaigns for women, men, local authorities, religious authorities, traditional leaders and health providers on the current provisions of the law. The campaigns should include:
  - Risks of unsafe abortions.
  - Availability of post-abortion care and need to access this to save women's lives, without stigma.
  - Availability of legal reproductive health services, including abortion care, to reduce the risks.
  - Address stigmatisation of abortion.
  - Any minor's pregnancy is automatically eligible for safe abortion if the minor wishes it as sexual intercourse before the age of 18 is rape.
- Advocacy for further change of legal policies for abortion and sexuality based on a human rights perspective.
- Consider task shifting in the provision of legal abortion care, especially training pharmacists who are popular contact points for women.
- Improve service provision in health centres through:
  - Replacing use of sharp curettage with manual and electric vacuum aspirators.
  - Training health providers in provisions of the law, as well as safer medical abortion.
  - Improve collection of national statistics on provision of abortion care.

[35] Ngondo D, Karp C, Kayembe D, Basile KS, Moreau C, Akilimali P, et al. (2024) Abortion information-seeking experiences among women who obtained abortions in Kinshasa, DRC: Results from a qualitative study. PLOS Glob Public Health 4(2): e0002383. https://doi.org/10.1371/journal.pgph.0002383, accessed 20 July 2024.
[36] Glover at al. Op Cit.
[37] See for instance, Collective of Youth Organizations for Solidarity in the Democratic Republic of Congo (COJESKI-DRC), (5 April 2024). Public Debate on Reducing Abortion stigma in Goma. https://www.safeabortionwomensright.org/news/democratic-republic-of-congo-very-first-public-debate-on-reducing-abortion-stigma-in-goma/ accessed 20 July 2024.
Also Ngondo et al Op Cit.

Social change in Mozambique needed for legal changes to make a difference

At a national level, **Mozambique** has been a leader in reviewing legislation to make abortion care more available to girls and women. Review of the abortion law in 2014 was followed by revision of the outdated Penal Code in 2019. Legal abortions are allowed on demand in the first trimester (up to 12 weeks gestation). In cases of rape or incest abortions are legal to 16 weeks and until 24 weeks in cases of fetal anomaly. The law stipulates that abortions must be performed at designated facilities by qualified practitioners.[38] The Ministry of Health developed clinical guidelines on abortion and post-abortion care in 2017.

At local level, however, entrenched gender norms lead to deep stigma regarding abortions. This often deters women, and particularly unmarried, younger women, in rural areas where services are not as easily accessible and who have less accurate information, from accessing safe abortions. Thus, the number of unsafe abortions, with accompanying complications and mortality, is still high.

A study to assess adolescents', young women's, informal abortion providers', and other adult community members' knowledge, attitudes, practices, and preferences related to abortion, with a focus on gender values and norms found four major themes:[39]

1. *Gender norms and expectations put girls at increased risk of unintended pregnancy*. These norms are rooted in beliefs that a woman's primary role is procreation. Such norms promote child marriage and adolescent pregnancy within these marriages. They also limit girls' agency in negotiating safe sex with male partners and their agency to discuss access to contraception with their parents. Poor socio-economic situations may push girls into transactional sex, at times encouraged by their parents or caregivers, with limited protection from pregnancy or sexually transmitted infections.
2. *Gender norms and stigma around adolescent pregnancy affect pregnancy decisions.* Even while girls' role in procreation is valued, it is only valued in the context of marriage. There is enormous stigma against sexual activity and pregnancy outside of marriage. Some girls who become pregnant are afraid of disappointing their parents, or that their parents will insist they must marry the man. Others fear they will be rejected by family, not allowed to continue school, or be cut off from their faith community.
3. *Gender norms contribute to abortion stigma and influence choice of provider.* There is still considerable stigma associated with having an abortion. A general perception is that girls and young women that have abortions are "loose," with many partners, such that they do not know who the father of the child is. Health providers often exhibit stigmatising attitudes, and may publicly chastise young woman seeking an abortion for engaging in sex while young and unmarried. Fears of stigma encourage girls to seek abortions which will be secret, which often means an unsafe abortion, outside a health facility. For these girls social safety is more critical than medical safety.
4. *Men, family members, and others have a strong influence on pregnancy and abortion decision-making.* Some young women discuss the pregnancy with male partners. Many partners express that they are not able to care for a child or are already married and strongly encourage the girl to have an abortion, with some contributing the costs. Some girls also consult their parents or other female relatives, who may be supportive, especially when they are still studying, and assist them to access abortions.

[38] IPAS. March 26 2020. In recent penal code review Mozambique recognizes legal right to abortion. https://www.ipas.org/news/in-recent-penal-code-review-mozambique-recognizes-legal-right-to-abortion/ accessed 20 July 2024.
[39] Griffin, S.; Melo, M.d.; Picardo, J.J.; Sheehy, G.; Madsen, E.; Matine, J.; Dijkerman, S. The Role of Gender Norms in Shaping Adolescent Girls' and Young Women's Experiences of Pregnancy and Abortion in Mozambique. Adolescents 2023, 3, 343-365. https://doi.org/10.3390/adolescents3020024 accessed 20 July 2024.

The study concluded that legal change alone was not sufficient to ensure women access to safe abortion, social change is also needed. Accurate information, supportive healthcare providers and peer or family support are all critical enabling factors for the necessary social change. Further, programmes need to mobilise communities, including men, parents and community leaders, as well as health providers, to challenge current gender norms.

Supporting expanded access to abortion in Mozambique:

Several organisations, including IPAS, Pathfinder and MSF are supporting the Government of Mozambique to expand access to safe abortion. For instance, MSF runs clinics in Beira, in central Mozambique, focusing on the most marginalised women - adolescents and sex workers. Most of the abortions are medication abortions using a combination of misoprostol and mifepristone. Women take one pill at the clinic and the others at home. Women who access abortions from these clinics comment on the confidentiality and support from staff.[40]

As previously discussed in this chapter, abortions are legal in **South Africa** on request in the first trimester. The following case study illustrates how technology can be a powerful force to provide information around abortion services which are legally available, yet often socially difficult for marginalised women such as sex workers.

Harnessing technology to provide information to sex workers

GRIT (Gender Rights in Tech), formerly known as Kwanele - Bringing Women Justice, is a VCSAF grantee based in South Africa. The GRIT Mobile App was initially developed to assist women reporting violence, guiding women through the process of collecting essential evidence and throughout the reporting process, as well as court appearances. This app is now being refined for wider use, including related to abortion service information. In addition to the app, GRIT is developing an AI-assisted chatbot named Zuzi, designed with the persona of a friendly African Aunt.

One of the key workshops during Zuzi's development was run with sex workers to test, refine, and co-create the technology. This particular session focused on access to abortion services, as many sex workers expressed a need for reliable information and access to safe abortion options. Participants shared concerns about visiting formal providers due to anxiety over the procedure, fear of judgment related to their occupation, as well as of stigma and discrimination. These concerns often led to delays in seeking care, until they were beyond the safe period for accessing abortion services.

Through a participatory discussion, the GRIT team explored how the Zuzi chatbot could offer relevant advice and support, including options for self-managed abortions. While the response to at-home abortion was mixed, most participants agreed that Zuzi could make abortion services more accessible. They noted that being able to discuss their fears and receive unbiased information from Zuzi would make them more comfortable seeking safe, legal services.

Since the initial workshop, dataset collection has expanded, with further input from sex worker teams across three provinces. This data was critical in refining the chatbot and enhancing its functionality. It is crucial to conduct dataset collection with sex workers in South Africa to ensure that technology solutions, like the Zuzi chatbot, are informed by their unique experiences and needs. This makes the solutions more effective in addressing issues such as stigma, discrimination and access to safe services. The

[40] Rajaonary, M. (2023). Stories of safe abortion care in Mozambique Women share their diverse experiences with safe abortion care in the nation with one of the most liberal abortion laws in Africa. MSF. Mozambique. https://www.doctorswithoutborders.org/latest/stories-safe-abortion-care-mozambique accessed 21 July 2024.

ChatGBV is a chatbot simplifying access to information, resources, and assistance for GBV survivors navigating the justice system. Credit: GRIT

chatbot is currently in beta mode for additional testing and growth, with full deployment planned for the middle of 2025.

The GRIT app, however, is fully deployed and now has over 10,000 users, including sex workers from all of South Africa's nine provinces. Moving forward, GRIT plans to expand its training with sex workers nationwide, leveraging insights from the chatbot's development and the app's success to make the technology more inclusive. This initiative will also explore ways to enhance the reporting of incidents, including those involving police misconduct, to provide a more comprehensive and supportive platform for sex workers.

Source: GRIT (Kwanele) VCSAF Report, July 2024 with additional information

Review of the comprehensive abortion care guidelines

The Ministry of Health and Child Care with support from WHO, UNFPA, the Making Abortion Safe (MAS) programme, and other partners, finalised an expanded and updated third edition of the National Guidelines for Comprehensive Abortion Care (CAC) in **Zimbabwe**. These updated guidelines include the provisions of the current Termination of Pregnancy (ToP) Act and cover procedures to follow to provide abortion allowable under the Act (instances of unlawful sexual intercourse, specifically rape and incest; severe fetal abnormality; or danger to the mother's life). They also include updated information on post-abortion care.[41]

Communities need to be aware of abortion services that can be offered at local health centres

Edinah Masiyiwa, director of WAG, a VCSAF grantee in Zimbabwe, said of the CAC guidelines, "Popularisation of the CAC guidelines by the Ministry of Health and Child Care and non-governmental organisations to communities must occur so that they are aware of the abortion services that can be offered at health centres. Awareness raising should also include the provisions of the current Termination of Pregnancy Act and highlight the gaps. There should be continuous information dissemination in communities to allow those who need abortion services to receive it. This way we will be able to fight the stigma associated with abortion."[42]

The MAS programme was supported by the Royal College of Obstetricians & Gynaecologists (RCOG) as a multi-country programme, of which only Zimbabwe was in SADC. In addition to supporting the guidelines, the programme supported research and sensitisation of health care providers and others, such as magistrates, on the provisions of the ToP Act.[43]

[41] Ministry of Health and Child Care (2022) National Guidelines for Comprehensive Abortion Care in Zimbabwe, Harare. MOHCC
[42] Masiyiwa, E. Hope on the horizon for Zimbabwe as health Ministry signs Comprehensive Abortion Guidelines, 10 January 2024, Health times. https://healthtimes.co.zw/2024/01/10/hope-on-the-horizon-for-zimbabwe-as-health-ministry-signs-comprehensive-abortion-care-guidelines/
[43] De Vries, I et al. 2024. RCOG Making Abortion Safe Project - final evaluation. Amsterdam, KIT Royal Tropical Institute.

The following case study is of an organisation in **Tanzania** that is engaging in public interest litigation on issues of abortion as one way to raise the issue nationally.

New commitment for SRHR public interest litigation

Sophia Sushi is the Executive Director and one of the founders of Teens Corridor, an organisation promoting adolescent sexual reproductive health and rights (SRHR), as well as a member of the Coalition of Women Human Rights Defenders (CWHRD). Sushi has a new perspective on advocacy for SRHR. Sushi is from the remote Mwanza region in the northern part of Tanzania, about 1000 kilometres from the capital city, Dar es Salaam.

Sophia Sushi. Credit: CWHRD

She says, "I now understand that there are challenges of service availability, accessibility, affordability, acceptability and quality. A large part of the government budget on SRHR comes from development partners, we need to create even larger movements from the grassroots level to advocate for SRHR issues including budget allocation and legal transformation."

Sushi is one of the WHRDs in Tanzania who have been engaged in the "Building vibrant repro rights movement in Tanzania" project, implemented by the Coalition for Women Human Rights Defenders with support from Gender Links, with funding from Amplify Change. The project aims to reduce discrimination, stigma and legal barriers for safe abortion and post-abortion services in Tanzania. It is working to building a joint sense of ownership over a common agenda that is inclusive and mutually understood, enhancing cross-generational feminist solidarity and knowledge transfer around selected SRHR issues in order to keep movements strong, active and alive.

Sushi participated in a training on public interest litigation, where she learned about using public interest litigation as an advocacy tool to address SRHR challenges facing women and girls in Tanzania. "I have been following public interest litigation cases, but I did not understand the whole process, such as the stages to follow in developing cases, and how to file cases in court," she said. "I have also been transformed in terms of existing myths and perception around SRHR"

She said that through participating in various activities, she now has a positive attitude towards advocacy on SRHR as a fundamental human rights issue. She committed to using the knowledge and skills to enhance advocacy on SRHR in her organisation, as well as sensitise her staff who have negative myths and perceptions about SRHR issues, particularly sensitive issues such as safe abortion. Sushi believes, "It is essential for Women Human Rights Defenders to start movements on SRHR at the grassroots level to advocate for legal transformation."

Source: Coalition for Women Human Rights Defenders report to Gender Links, October 2024

Unintended pregnancy, access to contraception and abortion: assessments in Botswana, Eswatini, Lesotho and Namibia

WHO and the UNFPA supported the Ministries of Health in Botswana, Eswatini, Lesotho and Namibia to engage in strategic assessments on unintended pregnancies, contraception, abortion, sexual and gender-based violence and HIV through the 2gether 4SRHR programme. Comparative analysis of the background papers developed in the four countries showed:[44]

- All have high abortion-related contribution to the MMR.
- All have good but not optimal contraceptive prevalence.
- All have restricted access to abortion, but it is available in certain circumstances (in compliance with the Maputo Protocol) and is not completely banned.
- Women, in general, as well as other key stakeholders, including men, have poor knowledge of contraception that is available, including emergency contraception, as well as the provisions of the abortion laws.
- Only Botswana has post-abortion care guidelines, and none have guidelines for the abortions allowed in the law.

The study in **Eswatini** examined unintended pregnancy as well as abortions.[45] The Ministry recognised that progress to address maternal mortality was not on track to achieve the SDG target. The study found that a key driver of unintended pregnancy was poor provision of SRHR programmes for certain populations. This includes people with disability; in and out of school adolescents, where the adolescent unmet need for contraception is double that of the general population; and men, whose knowledge of contraception methods, availability and use was very poor.

A key driver of unintended pregnancy was poor provision of SRHR programmes

This was coupled with sub-optimal awareness about contraceptive availability in general. It was also exacerbated by lengthy stock outs of contraceptives at public facilities, as well as poor use of opportunities to engage with women in post-natal or post abortion care about contraception. Other drivers were poverty which drove women into transactional or commercial sex, without adequate protection, and rampant gender-based violence.

The study noted that the constitution of Eswatini allows abortion under certain constrained circumstances, including to preserve the life, physical and mental health of the woman; when the pregnancy is the result of incest or rape; and in cases of fetal abnormalities. However, neither the general public nor health professionals are aware of these provisions. Further, the constitution requires two doctors to agree and to be present for the termination. These conditions are difficult to provide, and many determinations of rape take so long that the pregnancy has advanced beyond the allowed gestational period for a legal abortion. Furthermore, many women and girls seek abortions for other reasons, particularly poverty and the inability to care for a child; when the paternity of the child is in doubt or a father denies responsibility for the pregnancy; or to be able to continue with her education. As a result, many women still seek clandestine abortions, many of which are unsafe. Methods used include misoprostol, which is widely available on the black market, inserting a foreign object into the vagina, various traditional concoctions and going to South Africa where abortion is legal.

The study reported that women of all ages accessed abortions, but few came to health facilities for post-abortion care as they believed that they would be reported to the police and face imprisonment. It is believed that those that do access health care have serious complications, and they report spontaneous miscarriage. Health care workers decried the lack of post-abortion care guidelines.

[44] Macleod, C. I., Reuvers, M., Reynolds, J. H., Lavelanet, A., & Delate, R. (2023). Comparative situational analysis of comprehensive abortion care in four Southern African countries. Global Public Health, 18(1). https://doi.org/10.1080/17441692.2023.2217442 https://www.tandfonline.com/doi/full/10.1080/17441692.2023.2217442#d1e1999 Accessed 8 September 2024.

[45] Ministry of Health (2023). Strategic Assessment on Unintended Pregnancies, Contraception and Post Abortion Care 2023. Mbabane, Eswatini. Ministry of Health.

The **Botswana** assessment of unintended pregnancy, access to contraception and unsafe abortion was conducted in 2020[46] and has been followed by discussion and deliberation throughout the country. Similar to Eswatini, there is sub-optimal uptake of contraception, with an emphasis on long-acting reversible contraceptives (LARCs) which are implants or intrauterine devices. Comprehensive sexuality education (CSE) is not taught as well as it could be. There is poor community awareness of contraception which is available and of the legislation on abortion (with the general perception being that all abortion is banned).

There is suboptimal awareness and uptake of available contraception

Health workers need guidance and training on safe abortion as well as on insertion of contraceptive implants and intrauterine devices. GBV is rife and there is need for community dialogue to address this scourge, as well as support for survivors. There are extremely high levels of stigma in relation to sexuality, contraception and abortion.

The most common methods of clandestine abortion are: cytotec (misoprostol) which is readily available on the black market; insertion of objects (feathers, pen cartridges, straws, etc), traditional medicine taken orally or placed in the vagina.

The recommendations are to:

- Expand access to contraception by improving supply and information to girls, women, men and the general population.
- Increase uptake of services through broad awareness and discussion about contraception and abortion to address the low levels of awareness and the stigma.
- Have wide discussions and community dialogue to reduce GBV.

Though legislation allows for abortion in certain circumstances, specific situations must often be argued in the courts and within twelve weeks of the first trimester. The following case study is of a situation in Lesotho that was successfully argued in court.

Test court case to access abortion care available within the law in Lesotho

She-Hive Association, a VCSAF grantee in Lesotho, persisted until a court order was granted by the Children's Court in 2024 allowing the termination of a sixteen-year-old girl's pregnancy. Lesotho's Penal Code of 2010 allows abortion in compliance with the provisions of the Maputo Protocol, including to prevent significant harm to the health of the pregnant person. In most cases this refers to physical health. However, in this instance it was a mental health issue, which is not easy to prove due to the subjective and intangible nature of mental health conditions. Though physical health conditions often have obvious signs, mental health struggles typically require more nuanced evidence and evaluations. Eventually, the court order was issued just before the end of the first trimester, which was in time to conduct the legal termination. The girl was first referred to She-Hive by her aunt in March 2024. The aunt was concerned that the girl was being abused by her paternal grandfather with whom she lived, as the aunt was abused by her own father and had a child by him. She came to She-Hive because she said she did not want her niece to go through the same nightmare. The girl's mother passed on when she was only three months old, and her father is working in South Africa. She-Hive's investigations found that she was being abused and arranged for her to be removed and placed

[46] Rakareng, T. et al. Assessment of unintended pregnancies, contraception, and abortion in Botswana. Int J Gynecol Obstet. 2024;164(Suppl. 1):51-60. DOI: 10.1002/ijgo.15336

in the Department of Gender's emergency shelter, to receive psychosocial support (PSS) while the grandfather was prosecuted. While at the centre, she was impregnated by a security guard. As the girl said that sex with the guard was consensual, the Child and Gender Protection Unit denied the initial She-Hive request for the pregnancy to be terminated.

She-Hive's psychosocial team assessed that the sex was in the context of a trauma bond (when a deep attachment develops from a cycle of physical and/or emotional abuse. Trauma bonds most commonly develop in romantic relationships, and leaving these relationships can be very hard). They therefore pursued the case and took it up in court. This resulted in the issuance of the court order for termination.

She-Hive approached the Department of Social Development seeking a social grant for the young girl. The Ministry of Home Affairs needed family members to write a letter asking for their assistance to issue the girl with a birth certificate or granting She-Hive permission to apply on her behalf. Most family members were afraid to sign the letter, because they did not want to appear to be siding with the young girl against the prosecuted grandfather. The children's welfare section of the Department of Social Development is now seeking a court order granting issuance of the birth registration documents. She-Hive and Social Development are also trying to find a long-term shelter where the girl will live. The family is so afraid of the grandfather that none of them wants to be associated with the girl.

Source: She-Hive Association presentation to SADC Gender Day, 15 August 2024, with updates.

Situation in Namibia regarding legislation and practice

There has been on-going debate and discussion about review of the **Namibia**n legislation on abortion since 1996 when the first minister of Health and Social Services introduced a bill to oppose the Abortion and Sterilization Act of 1975, inherited from apartheid-era South Africa.[47] The intention in 1996 was to make abortion available on demand within a specified time period. This bill was opposed and did not pass. Recently there has been further debate and discussion following the tabling in 2020 of a petition with 63 000 signatures calling for review. However, there is no timetable for when parliament will resume debate on the issue.

In the meantime, there are continuing media stories of unwanted babies being "dumped" with the police acknowledging 234 of these between 2016 and 2022. There is media coverage of back street abortions, most of which are unsafe. There are also now stories of women who fly, when they can afford it, or take a long bus trip to neighbouring South Africa to access safe abortions.[48]

Supporting abortion providers in South Africa

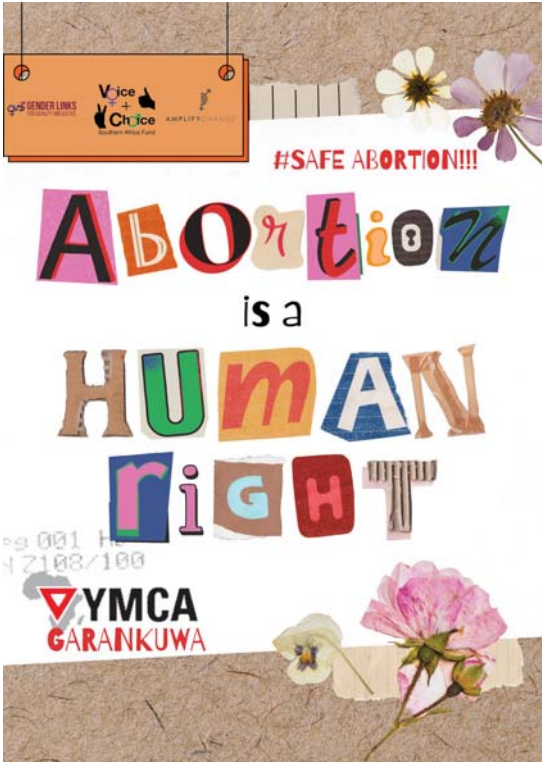
Research conducted by the SRJC, a VCSAF grantee in **South Africa**, found that abortion providers in South Africa experienced low levels of support from the Department of Health at district, provincial or national level. This includes poor supervision, provision of necessary equipment and medication, continuing training or recognition. Abortion providers also receive low levels of collegial support and mentorship. At the same time, abortion providers experience

[47] Rauna Namukwambi, R, L. Sheehama, Justice EK. Sheehama, H N. Nakambale. 2023, Exploring Women's Perspectives on Abortion Legalization in Namibia: Insights from Residents of Gereres, Keetmanshoop. medRxiv preprint doi: https://doi.org/10.1101/2023.07.20.23292972 accessed 22 July 2024
[48] 'Women are risking their lives': Abortion reform debate splits Namibian opinion, News 24, 29 May 2023 https://www.news24.com/news24/africa/news/women-are-risking-their-lives-abortion-reform-debate-splits-namibian-opinion-20230529, accessed 24 July, 2024

high levels of societal stigma and facility-based discrimination. This situation leads to isolation and burn out with poor levels of service provision. However, the providers see themselves as champions for women's reproductive rights. When the official services are struggling, illegal backstreet operators mushroom and flourish.

The research recommended that government should:

- Enhance public sector SRH services and invest more in services and staff development.
- Improve alignment of legislation and policy to ensure that requisite materials and support is available.
- Foster collaboration and development of support networks to combat stigma and make accurate information about the law as well as services available.[49]



Poster advocating for Safe Abortion by VCSAF grantee, YMCA Garankuwa, near Pretoria, South Africa. Credit: YMCA Garankuwa

Exercising agency to access safer options

Women are exercising agency, within the means available to them, to find safer abortion options. This includes traveling to South Africa where abortion is legal, which is discussed in the case study below. It also includes accessing medication abortion, which may be legal and safe or is also available on the black market with variable levels of safety.

Women are finding ways to make abortion safer - travelling to South Africa or accessing medication abortion

Abortion services provided in South Africa to clients from other SADC countries

The Sexual and Reproductive Justice Coalition (SRJC), a VCSAF grantee, is collaborating with Gender Links and SAASA to survey abortion providers in South Africa. The goal is to collect information and collaborate with and support providers to improve services. Consolidated data from this survey is being used to advocate for greater access to safe choice of termination of pregnancy, including through this Barometer. The SRJC conducted a rapid survey amongst a network of abortion providers that the SRJC works with in South Africa.

[49] Rucell, J. Presentation to the SADC Gender Day meeting, 15 August 2024

The survey had 30 responses within the first month. The respondents were from:
- Limpopo (11.37%)
- Gauteng (8.27%)
- Western Cape (5.17%)
- KwaZulu Natal (3.10%)
- Mpumalanga (3.10%)

The abortion providers were:
- Midwife (17)
- Registered Nurse (10)
- Medical Doctor (2)
- Other - Online information service provider (1)

Preliminary findings show that 60% of surveyed providers are based at a public clinic or hospital and 37% at a private facility, while one respondent is providing information. In terms of abortion services, 26 provide first-trimester surgical abortions; 25 first-trimester medication abortions; six second-trimester surgical abortions; and five support self-managed abortions. All providers also offer contraception counselling and various SRHR services - 25 provide treatment for STIs and 24 counselling, testing for HIV and referral for ARV access.

The research shows that women from most SADC countries, and beyond, seek abortion services in South Africa, one of only two countries in SADC where abortion is legal on demand.

Abortions were provided to people from:

Country from which clients come	Number of providers that see clients from this country
South Africa (my province)	28
South Africa (another province)	14
Zimbabwe	11
Lesotho	9
Mozambique	8
Malawi	7
Eswatini	7
Botswana	5
Others	4
Nigeria	4
Namibia	4
DRC	3
Zambia	1
Angola	1

Providers based in Gauteng reported seeing 480 clients from other countries in the last quarter, Limpopo 104 clients, Western Cape 60 clients, Mpumalanga 15 and KwaZulu Natal three. A total 528 clients from other countries were seen in public facilities while 104 were in private facilities.

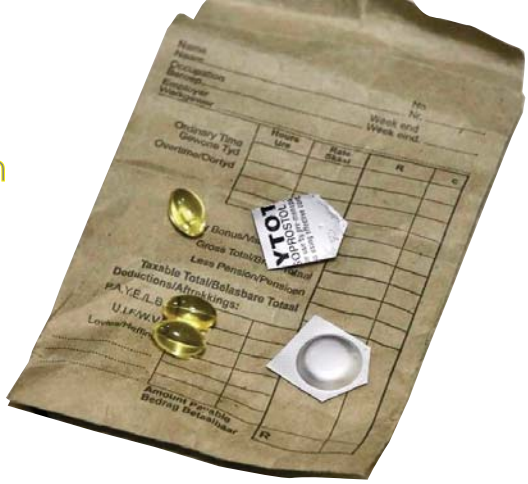
These results underscore that women who have decided to have an abortion will find a way to do so. Women who can afford it, will travel to South Africa from neighbouring countries, and even farther afield, to access safe abortion. This raises the question of why such services are not available to them and to the many other women who cannot afford to travel, within their own countries.

Source: SRJC presentation to SADC Gender Day, 15 August 2024

Increased access to medication abortion

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

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



Abortion Pills, the common name medical abortion using mifepristone and misoprostol to end a pregnancy. Credit: Keletso Serowe

Support from national associations of obstetricians and gynaecologists

The Livingstone Safe Abortion Care Charter was drafted at a learning and sharing meeting of national associations of obstetricians and gynaecologists, convened by FIGO. The charter was signed by the Presidents of 12 National Associations of Obstetricians and Gynaecologists,[50] including Malawi, Mozambique and Zambia in SADC, in January 2023.[51]

The Charter reaffirms the commitment of obstetric and gynaecological societies to strengthen access to safe abortion care for women and girls, including self-managed abortion care. This includes creating enabling environments within which health systems function and health care professionals are empowered to meet the needs and entitlements of women and girls. The signatories pledged to leverage clinical expertise and resources to address the scale of unsafe abortion in Africa through advocacy and addressing stigma. They also pledged to advocate for decriminalising abortion care and urging their governments to regulate it like any other health care provision.

The Self-Management of Abortion (SMA) project (2023 to 2024) was a collaboration between FIGO and the **Zambia** Association of Gynaecologists & Obstetricians (ZAGO).[52] The project aimed to identify and remove barriers to self-managed abortion in the country. It worked with 30 healthcare facilities in ten districts of three provinces.

The project developed training curricula, a reference manual for self-managed medical abortion (SMA), protocols and job aids to support health care professionals. These are available for use in other health facilities and districts. It raised awareness of and created demand for SRH including SMA through radio programmes and working with youth advocates and community health volunteers.

The project promoted a culture of openness and acceptance to create an enabling environment for women and girls to seek safe abortion care without fear. It raised awareness about the legal framework on abortion in Zambia as many people did not know that abortion is legal in the country, and that self-managed abortion is an option.

Though the pilot project has ended, the health-care facilities are continuing to provide SMA and ZAGO is working with the Ministry of Health to

[50] Benin, Burkina Faso, Cameroon, Cote d'Ivoire Kenya Mali, Mozambique, Rwanda, Uganda, Zambia. Ethiopia, Malawi.
[51] FIGO, Livingstone Safe Abortion Care Charte https://www.figo.org/resources/figo-statements/livingstone-safe-abortion-care-charter
[52] Removing barriers to access Safe Abortion through Self-Management Zambia https://www.figo.org/news/removing-barriers-access-safe-abortion-through-self-management-zambia accessed 22 July 2024. and
The Long Lasting Impact of the Self-Management Abortion Project https://www.figo.org/news/long-lasting-impact-self-management-abortion-project accessed 23 September 2024

integrate SMA within existing repro-ductive health services. This involves training more healthcare providers, raising awareness about safe abortion and strengthening monitoring and evaluation.

The WHO multi-country survey on abortion (MCS-A) studied post abortion care provided to 15 671 women at 210 facilities in 11 sub-Saharan African countries (including DRC, Malawi and Mozambique in SADC) in 2017 - 18.[53] The study found that the most common complications were different forms of bleeding or haemorrhage which suggested that more women may be accessing medication abortion. There were: 2.6% severe maternal outcomes, 7% potentially life-threatening complications, 58.2% with moderate complications and 32.4% with mild complications. Women with lower educational achievement (no education or primary) were more likely to experience potentially life-threatening complications. Factors associated with severe abortion-related complications were being single, having a prior pregnancy and late gestational age (over 13 weeks).

Only 20% of the women who participated in an exit interview admitted to inducing an abortion. The most common methods reported were misoprostol (54.3%), other medicines either orally or vaginally (40.5%) and procedures that cleared out contents from the uterus (38.7%). However, 18.7% reported using herbs, anti-malarial drugs, bleach, gasoline or detergents and 14.3% reported using traditional abdominal massage. The study concluded that more women seem to be accessing safer medical abortion. However, they may not have full information about expected complications and when they need to seek medical intervention.

About one tenth of the women reported accessing information on social media or the internet, indicating potential to utilise social media to share information to more women and thus reduce the burden on both the women and the health care system. The high percentage still using unsafe approaches, with tragic results, is indicative of a continuing gap in access to safer methods.

There is need for correct information about dosages and timing of medication abortion

Availability of misoprostol: A qualitative study conducted in Dar es Salaam, in a context of severely constrained legal avenues for safe abortion,[54] found that misoprostol was widely available through formal and informal pharmacies and could quite easily be purchased without a prescription. The WHO issued guidelines for the use of misoprostol alone for abortion in 2012. "Miso," as the drug is commonly known in Dar es Salaam, is heat stable, cheaper and a more available drug than mifepristone. With good quality drugs and correct usage, it is 85-90% effective. The WHO stresses the need for post abortion care in instances such as incomplete abortion. Other methods known to have been used for unsafe abortions include concentrated teas, washing detergents, wood ashes, anti-microbial drugs in high doses and uterine insertion of sharp objects. Medical practitioners have also made surgical abortions available.

The study identified three main themes:

- "Miso is common" - known, widely accessible and in demand.
- "It's your secret" - using misoprostol for an abortion from a pharmacy is more private, simple and safe, which was valued by women.
- "It's a business" - respondents viewed many suppliers to be opportunistic, who provided poor information and resulted in incomplete abortions. There were real concerns about the quality of the misoprostol that is available and the poor advice about dosage and when to take the pills. The study found that even many health care professionals did not have accurate information about dosage. Thus, many girls and women purchase and take fewer tablets than is recommended or at incorrect time intervals.

[53] Qureshi Z, Mehrtash H, Kouanda S, et al. Understanding abortion-related complications in health facilities: results from WHO multicountry survey on abortion (MCS-A) across 11 sub-Saharan African countries. BMJ Global Health 2021;6:e003702. doi:10.1136/bmjgh-2020-003702. Accessed 8 Sept 2024. The 11 countries included in the study are: Benin, Burkina Faso, Chad, DRC, Ghana. Kenya, Malawi, Mozambique, Niger, Nigeria, Uganda

[54] Solheima I.H et al (2020) Beyond the law: Misoprostol and medical abortion in Dar es Salaam, Tanzania. Social Science & Medicine 245 (2020) 112676 https://doi.org/10.1016/j.socscimed.2019.112676

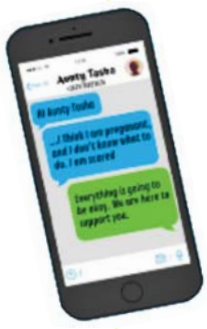
The MAMA (Mobilising Activists around Medical Abortion) Network

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 the potential of 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.[55] There are three MAMA affiliated hotlines in SADC:[56]

Aunty Sissy Hotline

24 hours a day,
7 days a week in
English and Chichewa
Hotline numbers:
0987 873 001 or
0884 678 303

Aunty Tasha is an e-service platform in Zambia.



Toll free line: 0213 325 325
WhatsApp line: 0955 325 325
Email: info@auntytasha.com
Instagram: @auntytashahotline
Twitter: @Aunty_Tasha
Facebook:
https://www.facebook.com/pages/category/Local-Service/Aunty-Tasha-Hotline-105138391207162/

Tantine Marthe - DRC

The line is open 24 hours a day, 7 days a week.
Numbers: (+243) 89 87 92 002, (+243) 99 66 55 418, (+243) 82 84 02 772
Auntie Marthe is based in Uvira, South Kivu and covers the provinces of South Kivu, North Kivu, Tanganyika and Maniema.

Post-abortion care

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

Most countries provide some access to post abortion care

My body, my choice art display in South Africa. Credit: Thato Phakela

[55] The MAMA Network. https://mamanetwork.org/ accessed 19 October 2024
[56] Help lines. https://mamanetwork.org/helplines/ accessed 19 October 2024

Table 4.7: Abortion/post-abortion guidelines and policies for SADC Member States

Country	Abortion/ post-abortion guidelines	Any related policies and/or guidelines
Angola	N	Angola Medical Ethics Code 2000; National List of Essential Medicines, 2021
Botswana	Y	Comprehensive Post Abortion Care Reference Manual, Ministry of Health; Botswana Essential Drug List 2012; Botswana Sexual and Reproductive Health Policy Guidelines
Comoros	N	Essential Medicines List, 2014
DRC	Y	Comprehensive Abortion Care Guidelines, 2020; Essential Medicines List 2020
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
Malawi	Y	Standards and Guidelines for Comprehensive Abortion Care, 2020; National Reproductive Health Service Delivery Guidelines, 2019; Malawi Standard Treatment Guidelines 2015;
Mauritius	N	Medical Council Act, 1999
Mozambique	Y	Clinical guidelines on abortion and post abortion care, 2017; Ministerial Decree on abortion, 2017; National Medicines Form 2007
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
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 Guideline Training Manual 2016; Standard Treatment Guidelines and Essential Medicines List, 2017
Zambia	Y	Zambia Standards and Guidelines for Comprehensive Abortion Care 2017; Register of Marketing Authorisations, 2015; Standard Treatment Guidelines, Essential Medicines List and Essential Laboratory Supplies
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

Source: Matshalaga, N and N. Mehlo,[57] updated by the Global Abortion Policy Database[58]

The **Zimbabwe** National Comprehensive Abortion Care Guidelines highlight the following challenges with post-abortion care in the country, identified by a study conducted in 2016:[59]

- Many women experiencing complications from unsafe abortion or miscarriage face delays in obtaining post-abortion care. On average, nearly two full days elapse between experiencing complications and receiving completed treatment. Common reasons for delays include lack of money, lack of transportation and distance to a health facility.
- Post-abortion care is not offered at most primary health centres, which are the facilities most accessible to rural women. Nearly half of post-abortion care patients had to seek care at more than one facility to get complete treatment.
- One-fifth of public facilities asked women to pay for post-abortion care prior to treatment, causing delays in treatment, even though these facilities are supposed to provide the service at no cost.
- A substantial proportion of first trimester post-abortion cases were treated using surgical procedures not recommended by WHO or national guidelines for this type of care. These procedures are more expensive and carry greater risk for further complications than medically recommended methods such as manual vacuum aspiration and use of recommended medicines such as misoprostol, mifepristone and letrozole.

[57] Matshalaga, N and N. Mehlo Op Cit
[58] WHO, Global Abortion Policy Database, https://abortion-policies.srhr.org/, accessed 20 September 2024
[59] Ministry of Health and Child Care (2022) Op Cit.

Next steps

Key recommendations include:

- Governments of SADC Member States must stop "hiding behind religion and law," and start caring about the high levels of unsafe abortion and resulting high maternal mortality and act to address these. Assessments done in Botswana, Eswatini, Lesotho and Namibia show that Governments need to act with urgency to address unintended pregnancy, particularly amongst younger women. This can be achieved by adopting progressive ASRHR policies which enable young people to access youth friendly SRHR information and services, including:
  - Increasing investment in high quality comprehensive sexuality education for boys and girls - in and out of school.
  - Expanding access to modern contraception for all, especially women in groups that governments often overlook, such as sex workers, those in remote communities, the disabled, and poorest and address stock outs of contraceptives.
  - Improving protection from sexual violence and work with communities to build safe communities that do not tolerate gender norms which perpetuate such violence.
- SADC Member states must pay attention to calls for decriminalisation of abortion from the AU Special Rapporteur on the Rights of Women, WHO and FIGO and critically consider why they believe it is necessary to keep such laws which are denying girls and women their right to self-determination over their own bodies. Governments and activists should be wary of the activities of well-funded groups that are opposed to abortion.
- Governments and activists should promote access to self-managed medication abortion as a safe method of abortion care. This must be accompanied by accurate information regarding dosage and timing, with access to post abortion care if needed.
- Community leaders and health care professionals need to pay attention to overwhelming levels of stigma that prevent young and other marginalised women from accessing SRH services. There should be community dialogues to engage traditional and religious leaders, men, women and all stakeholders to challenge gender norms that promote stigma.
- To save lives, all SADC Member States should provide post-abortion care to all women with abortion complications and train staff in the safest and most up to date approaches as well as provide the necessary equipment and drugs.
- Activists and political leaders need to work together to share information about the conditions under which abortion can be accessed and ensure that both those that need abortions and those that provide abortions are aware of these circumstances.
- There is an urgent need for much better data to inform decision-making on the issue of abortion. Data needs to include access (or lack of access) to contraception by all who need it (not only women and men in marriage); rate of legal abortions performed; demand for abortion and reason for the demand; rate of illegal abortions performed; and rate of unsafe abortions.

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