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THE GLOBAL GAG RULE AND ACCESS TO ABORTION:

Impact on law reform in Zimbabwe, Zambia,
Mozambique, Eswatini and Malawi

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SALC POLICY BRIEF

The Global Gag Rule and Access to Abortion: Impact on law reform in Zimbabwe, Zambia, Mozambique, Eswatini and Malawi

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The Southern Africa Litigation Centre (SALC), established in 2005, aims to provide support to human rights and public interest advocacy and litigation undertaken by domestic lawyers and human rights organisations in Southern Africa. SALC works in Angola, Botswana, Democratic Republic of Congo, Eswatini, Lesotho, Malawi, Mozambique, Namibia, Tanzania, Zambia and Zimbabwe.

Authorship and acknowledgments

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INTRODUCTION



Article 14(2) of the Protocol on the Rights of Women in Africa (called the Maputo Protocol)¹ recognizes the sexual and reproductive health rights of women in Africa. Article 14(2) (c) of the Maputo Protocol mandates African States to facilitate access to safe abortion in cases of sexual assault, rape, incest or where the pregnancy poses a risk to the physical or mental health of the woman, and where the pregnancy poses a risk to the life of the pregnant woman or the foetus. There is, therefore, recognition of the right to safe abortion under the African Charter.

Restrictive or unclear laws and negative attitudes make it difficult to realize the right to safe abortion. Their effect is to increase, rather than eliminate, the number of induced abortions, most of them unsafe. Unsafe abortion has been cited as a significant component in the high rates of maternal mortality in the Southern African region. There is therefore much need for advocacy for law reform to change and improve laws to ensure access to safe abortion, and for people to have access to sexual and reproductive health information to

1. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol Text) African Union; 2003.

make informed reproductive choices.

Many NGOs in Africa conduct activities to advocate for law reform and to raise awareness to improve access to Sexual and Reproductive Health (SRH) information, and thereby help to increase the ability of the State to improve public health. The ability of civic organizations to cover the gaps and carry out this work is hampered by the lack and loss of donor funding. The Protecting Life in Global Health Assistance (PLGHA) Policy prohibits US global health funding provision to foreign (non-US) Non-Governmental Organizations (NGO) that perform, advocate for, counsel or refer for abortion as a form of family planning in their own country, even if the funding for these activities is sourced from other sources that are not US government sources. In terms of the policy, as a condition for receiving US government global health funding, foreign (non-US) NGOs must agree not to perform or promote abortion as a method of family planning with any of their non-US funding.

This study was conducted in four Southern African countries that are recipients of large amounts of US global health funding and are potentially affected by the effects of the PLGHA; namely Zimbabwe, Zambia, Malawi, Eswatini and Mozambique. It provides an assessment of the legal and policy environment governing access to abortion in Zimbabwe, Zambia, Eswatini, Malawi and Mozambique, how this interacts with the policy and how this affects compliance with national and international obligations relating to providing access to safe abortion.

The study concludes that there are varying levels of restrictions and shortcomings within the law and policy. In these countries, to comply

with international law and afford women their sexual reproductive rights, there is a need for law reform, including clearly providing for instances where abortion is legal, expanding the legal grounds to access abortion, and simplifying the processes required to acquire a safe abortion. There is also a need to bring awareness on the law to the public and to decriminalize abortion to remove the barriers to access and reduce maternal mortality.

Much of the advocacy and awareness campaigns needed to reform the law and bring awareness of existing provisions to ensure access to safe abortion for women is done by NGOs. Partly because governments often have little capacity and has traditionally formed partnerships with NGOs. The efforts needed to achieve this reform may subject NGOs to the restrictions posed by the Global Gag Rule (GGR), and either limits their work due to what is required to comply or restricts their work due to loss of funding. The GGR has already harmed the viability of NGOs working on SRHR, including those advocating for safe abortion, and on African States' ability to comply with their obligations in terms of international law and their laws.

The right to safe abortion and international obligations

Article 14(2) of the Maputo Protocol provides that women in Africa have sexual and reproductive rights, consisting of the right to control fertility, decide on family-planning, and decide whether to bear children. In terms of article 14(2)(c), African Member States are required to put in place adequate measures, including laws and policies to ensure access to safe abortion at least in cases where the

pregnancy poses a danger to the mental and physical health of the pregnant woman; in cases where the pregnancy has resulted from rape or incest; where the continued pregnancy endangers the life of the woman or the foetus; or where the foetus is likely to have a severe disability or is not viable.

These provisions have become the content of the right to safe abortion in Africa.² African Union Member States thus should ensure access to safe abortion at the minimum in the circumstances outlined above.

The Committee of Experts on the Maputo Protocol has clarified what this entails in General Comment No.2, defining Member States' duties towards ensuring access to safe abortion as inclusive of the provision of information and informed consent to services. States must ensure that an enabling legal and policy framework is in place, inclusive of removal of legal barriers such as criminal sanctions.

Article 12 of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) requires the Member States to ensure equal access to health including reproductive health by removing barriers caused by discriminatory laws and practices. The CEDAW Committee in its General Recommendation No.24 states that creating legal barriers such as criminal sanctions to health services that only women need (such as safe abortion) is sex discrimination and that Member States must remove such barriers.

2. Ngwena, C.G., "Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa" (2010) 32 *Human Rights Quarterly* 32, 810.

THE PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE POLICY (GLOBAL GAG RULE)

The policy (then called the “Mexico City Policy”) was first introduced by Republican President Ronald Reagan in 1984.³ It is a US government policy that required foreign (non-US) non-governmental organizations (NGOs) to certify that they will not “perform or actively promote abortion as a method of family planning” with non-US funds as a condition for receiving financial assistance from the US government for family planning.⁴ It has been consistently repealed and reintroduced by succeeding Democratic and Republican presidents since its inception. It is colloquially known as the “Global Gag Rule” (GGR) for its chilling effect on freedom of expression and association.

On 23 January 2017, President Donald Trump signed an Executive Order reinstating and then expanding the policy to US global health assistance for the first time.⁵ The Protecting Life in Global Health Assistance Policy was introduced in May 2017 to manage implementation and

administration of US international health assistance.⁶ The policy expanded application and jurisdiction, prohibiting foreign NGOs from receiving US global health assistance if they perform, advocate for, counsel or refer abortion “as a form of family planning” in their own country, even if the funding for these activities is not sourced from the US government.⁷ The policy applies to approximately \$8.8 billion in global health financial assistance and affects a significant portion of such funding.

The scope and implementation of the policy

The PLGHA requires acceptance of and compliance by foreign NGOs with its terms as a condition for receiving global health assistance from the US government. It applies to HIV funding [including, the President’s Emergency Plan for AIDS Relief (PEPFAR)]; funding for tuberculosis, malaria [including the President’s Malaria Initiative (PMI)], pandemic influenza

3. Open Society Foundations, “What Is the Global Gag Rule?”, April 2019, <https://www.opensocietyfoundations.org/explainers/what-global-gag-rule>.
4. Henry J Kaiser Family Foundation, “The Mexico City Policy: An explainer”, <https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/>.
5. Fact Sheet, Office of the Spokesperson, Washington D.C, 15 May 2017, <https://www.state.gov/r/pa/prs/ps/2017/05/270866.htm>.
6. Fact Sheet, Office of the Spokesperson, Washington D.C, 15 May 2017, www.state.gov/r/pa/prs/ps/2017/05/270866.htm.
7. Protecting life in global health assistance, May 2017, Health and Human Services – Standard Provision; What you need to know about the Protecting Life in global Health Assistance Restrictions on US Global Health Assistance - An unofficial Guide, PAI, 30 September 2017, pg. 3.

and other threats; global health security; tropical diseases and other infectious diseases; non-communicable diseases; strengthening of health systems, maternal and child health; family planning and reproductive health; household and community sanitation, water and hygiene (WASH) and nutrition.⁸

The policy also regulates the transfer of funds (own funds) from a foreign NGO that has received US funds for global health purposes to another organization – known as the sub-recipient. The sub-recipient must certify that it does not perform or promote abortions and that it will not further pass those funds to an organization that participates in such activities.⁹

Acceptance of the provisions is required for funding and compliance with the policy is needed at the time of acceptance of the condition in the funding agreements.¹⁰ Suppose an organization bound by the terms of such an agreement breaches the prohibition on promoting or performing abortions. In that case, that organization must return any unused funds and repay the funds spent on the activity.

As stated, the policy relates to abortions as a method of family planning. This is defined as abortions used for spacing births, inclusive of when it is used to protect the physical and mental health of the pregnant woman or when it is performed when a foetus is likely to have a severe disability.¹¹ It excludes cases where a woman's life would be endangered if the foetus is carried to term, or where a woman becomes pregnant because of rape or incest.

The policy defines the performance of an abortion, as the operation of a facility where abortion as a method of family planning is provided.¹² Active promotion of abortion, in terms of the policy, is when the organization commits its material and other resources "in a substantial or continuing effort to increase the availability or use of abortion as a method of family planning".¹³

Promotion of abortion includes the provision of counselling services, advice and information provision on the benefits and accessibility of abortion for family planning purposes, lobbying government for the legalization of abortion as a family planning method and public advocacy

8. What you need to know about the Protecting Life in global Health Assistance Restrictions on US Global Health Assistance - An unofficial Guide, PAI, 30 September 2017.

9. <https://healthgap.org/press/secretary-pompeos-most-recent-expansion-of-the-global-gag-rule-places-access-to-hiv-services-for-women-worldwide-in-deeper-peril/>.

10. Fact Sheet, Office of the Spokesperson, Washington D.C, 15 May 2017, <https://www.state.gov/r/pa/prs/ps/2017/05/270866.htm>; Article I(5) and (6), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision

11. Article I(10)(i), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.

12. Article I(10)(ii), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.

13. Article I(10)(iii), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.

campaigns highlighting the benefits and propriety of abortion as a family planning method.¹⁴

The exceptions

Entities

The policy does not directly apply to foreign governments, parastatals, and multi-lateral organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as Gavi, the Vaccine Alliance.¹⁵ In general, the policy also does not bind US NGOs; however, they must ensure that any sub-recipients of their funds agree to its terms. Governments and parastatals that supply abortion as a method of family planning are required not to use US government funds for that purpose and to segregate US funds into a separate account so that no US funds are used for it.¹⁶

The exceptions also apply to government universities and hospitals and government-sponsored health advisory councils. They can conduct research, inform the public about abortion, unsafe abortion and take part in

national abortion policy development.¹⁷

The policy will also not apply to a foreign NGO that only receives US funding as a vendor of goods and services to a prime funding recipient or sub-recipient.¹⁸ The independent (prohibited) activities of an individual associated with an organization subject to the policy will not be imputed to the organization, provided the organization does not associate itself with or support the individual's activities in any way.¹⁹

Activities

US funding that is not subject to the policy includes funding for humanitarian assistance, inclusive of migration and refugee assistance; USAID and defence disaster and humanitarian relief; Food for Peace programmes; food assistance for emergency relief and development; basic health research; water and sanitation infrastructure spending for some households, schools, health facilities, industrial and commercial use; national policy development and governance activities; and the American Schools and Hospitals Abroad programme.²⁰

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14. Article I(10)(iii)(A), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.
 15. Fact Sheet, Office of the Spokesperson, Washington D.C 15 May 2017, <https://www.state.gov/r/pa/prs/ps/2017/05/270866.htm>; What you need to know about the Protecting Life in global Health Assistance Restrictions on U.S. Global Health Assistance - An unofficial Guide, PAI, September 30, 2017 p. 4; Article I(12), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.
 16. Article I (12), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.
 17. What you need to know about the Protecting Life in global Health Assistance Restrictions on US Global Health Assistance - An unofficial Guide, PAI, 30 September 2017, pg. 5.
 18. What you need to know about the Protecting Life in global Health Assistance Restrictions on US Global Health Assistance - An unofficial Guide, PAI, 30 September 2017, pg. 4.
 19. Article I(10)(C), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.
 20. What you need to know about the Protecting Life in global Health Assistance Restrictions on US Global Health Assistance - An unofficial Guide, PAI, 30 September 2017, pg. 3.

The prohibition of “abortion as a method of family planning” does not include circumstances where there is a danger to the life of the mother, rape or incest.²¹

Therefore, counselling and referral for abortion where there is a danger to life, rape or incest is permissible. There is also an exception in the case of supplying information to a pregnant woman who would have already decided to have an abortion.²²

The provision of post-abortion care (including treatment of complications from illegal abortions) is also exempted from the policy, and USAID funding may support post-abortion care training of health workers, with the proviso that the funding cannot buy specific equipment and medications used in post-abortion care.²³

US government funding may also be used for the provision of post-abortion contraceptive counselling and co-ordination with

organizations that provide abortion services to implement post-abortion contraception and reproductive health promotion.²⁴

The affirmative duty “defence”

The policy will not apply if the local governing law imposes an affirmative duty on health care workers to counsel or make a referral for abortion.²⁵ Thus, a health care worker who provides counselling and referral in terms of an affirmative duty provided for by law, would not be in breach of the policy if they do so. It is not clear precisely what the parameters of this defence are. Still, it can be assumed that the law should prescribe specific duties for health care workers in the extent of information they are required to provide patients to obtain informed consent for medical care. This “defence” however only applies to health care providers (not NGOs who are not designated as such) and only if the law is clear in terms of the affirmative duty.

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21. Article I(10)(i), Protecting Life in Global Health Assistance (May 2017) Health and Human Services – Standard Provision.
 22. Article I(6)(iii)(A)(II) “...(passively responding to a question regarding where a safe, legal abortion may be obtained is not considered active promotion if a woman who is already pregnant specifically asks the question, she clearly states that she has already decided to have a legal abortion, and the healthcare provider reasonably believes that the ethics of the medical profession in the host country requires a response regarding where it may be obtained safely and legally).”
 23. What you need to know about the Protecting Life in global Health Assistance Restrictions on US Global Health Assistance - An unofficial Guide, PAI, 30 September 2017, pg. 6.
 24. What you need to know about the Protecting Life in global Health Assistance Restrictions on US Global Health Assistance - An unofficial Guide, PAI, 30 September 2017, pg. 6.
 25. Article II (9) states, “For the avoidance of doubt, in the event of a conflict between a term of this paragraph (a) and an affirmative duty of a healthcare provider required under local law to provide counselling about and referrals for abortion as a method of family planning, compliance with such law shall not trigger a violation of this paragraph...” (the MCP).

THE IMPACT OF THE GLOBAL GAG RULE

The impact of the GGR policy has been extensively documented.²⁶ The policy has had wide-ranging and harmful effects on the ability of civil society to provide sexual and reproductive health services and information, and mainly on the ability of vulnerable groups, including adolescents and key populations, to access services and information. It has frustrated the work of NGOs working in family planning, reproductive health and other health care areas. It has prevented NGOs from expanding access and medical provision and posed challenges to NGOs seeking to maintain their output, worsening already existing problems such as high rates of unsafe abortions.

It has left NGOs in the region with an unconscionable choice- to access the funding and stop doing the work or decline the funding and risk collapse. This has affected partnerships with other organizations working on sexual and reproductive health as the policy has complicated cooperation and coalition-building in the NGO sector, among NGOs that elect to comply with the PLGHA and those that do not. This has resulted in a

fragmentation of the provision of sexual and reproductive health services.

The policy has had a chilling effect, resulting in either over-implementation due to fear and confusion over compliance issues, and/or breaking up of NGO collaborations due to fear of association by those subject to the policy and those that are not. The policy has meant that substantial sums of funding have been withdrawn from NGOs involved in performing or promoting abortion. This has impacted not only those services or advocacy efforts, but also the provision of HIV education and care, and maternal health services, as organizations have been unable to integrate these with other SRHR services.

A significant emerging effect, as outlined above, is that NGOs have been significantly hampered in advocacy work. Laws and policies play a huge role in at least creating an enabling environment to ensure access to safe abortion. The restrictions placed on NGOs have a considerable effect on the ability to use such advocacy.

26. Mavodza, C., Goldman, R. & Cooper, B. "The impacts of the global gag rule on global health: a scoping review" *Glob Health Res Policy* 4, 26 (2019) <https://doi.org/10.1186/s41256-019-0113-3/>.



ZIMBABWE

Legislative and policy framework

The law on abortion in Zimbabwe is primarily contained in three statutes: The Termination of Pregnancy Act of 1977, the Constitution of Zimbabwe (Amendment No. 20) of 2013, and the Criminal Law (Codification and Reform) Act [Chapter 9:23]. In addition to the statutes, several government policy documents cover management of post-abortion care and are relevant to the issue of safe abortion in Zimbabwe.

Constitution

Section 76 of the Constitution, provides that “every citizen and permanent resident of Zimbabwe has the right to have access to basic health care services including reproductive health care services.”

Section 52, which provides for the rights of women to personal security, states that subject to other provisions in the Constitution, a woman has the right to make choices concerning reproduction. This section is restricted by the provisions of section 48(3) of the Constitution which guarantees the protection of the right to life of “the unborn child” and explains that termination of pregnancy can only be done by the provisions of an Act of Parliament. This, therefore, is an internal limitation to the reproductive health rights provided for in sections 76 and 52.

In this context, the legal position is that a woman has the right to decide to have an abortion, but that this must be balanced with the right to life of the foetus. The right to have an abortion can only be exercised per the restrictions imposed by an Act of Parliament. The existing Act of Parliament, which predates the 2013 Constitution, is the Termination of Pregnancy Act.

Termination of Pregnancy Act

Section 3 of the Termination of Pregnancy Act of 1977 [Chapter 15:10] sets out the

restrictions on abortion:

“(1) No person may terminate a pregnancy otherwise than in accordance with this Act.

(2) Any person who contravenes subsection (1) shall be guilty of an offence and liable to a fine not exceeding level ten or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment.”

The penalty for breach of section 3 is a fine not exceeding level 10 or to imprisonment for a period not exceeding five years or to both. Section 4 outlines several circumstances in which abortion is permitted. These are:

- Where the termination is necessary to prevent an endangerment to the life of the woman concerned or the pregnancy constitutes a serious threat of permanent impairment of her physical health.
- Where there is a serious risk that the child to be born will suffer from a physical or mental disability of such a nature that he or she will have a serious, permanent disability; and
- Where the pregnancy has resulted from unlawful intercourse. Unlawful intercourse includes rape (but not marital rape), incest and situations where a man has sexual intercourse with a woman with a mental disability, and she falls pregnant.²⁷

A medical practitioner may only conduct a termination in a designated institution and with the written consent of the

27. Defined as rape in terms of section 64(3) of the Criminal Code.

28. A designated institution is defined as a State hospital and any other institution designated by the Minister by Statutory Instrument.

Superintendent.²⁸ Further conditions of certification by a magistrate are imposed where the pregnancy is alleged to be the result of unlawful intercourse.²⁹ Additionally, where the termination is requested due to the threat to life or physical health of the pregnant woman or potential for disability of the foetus, certification of two physicians is required.³⁰ The Superintendent who permits the termination is liable for prosecution if he or she fails to abide by the strict requirements for certification set out in the Act or knowingly gives permission as a result of false information.³¹ Anyone who provides false information to obtain the certificates required is also liable for prosecution, with a penalty similar to the penalty prescribed for unlawful abortion.³²

In emergencies, any medical practitioner (presumably in any institution, designated or otherwise) can perform an abortion without obtaining the requisite permission but is required to submit a report of the procedure within 48 hours to the Secretary of the Ministry, failure of which he or she is liable for prosecution, with a penalty upon conviction of a Level 10 fine or

one-year imprisonment or both.³³ There is no clarification on what constitutes an emergency.

In the event of the Superintendent declining to permit an abortion, an appeal lies to the Secretary, who can authorize the abortion in the place of the Superintendent.³⁴

In terms of section 8 of the Act, the Secretary has monitoring and oversight powers over the process and may be furnished with the certification provided to the Superintendent for authorization of abortion for medical reasons.³⁵ The Secretary can compel anyone to disclose the circumstances of abortion carried out within an institution in contravention of the Act. The Secretary can make a referral to the Prosecutor General for prosecution if he or she forms the opinion that an offence was committed or direct the medical practitioner to the Medical and Dental Practitioners Council for disciplinary procedures for professional misconduct.³⁶ Punitive penal measures heavily underpin abortion law in Zimbabwe.

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29. If the pregnancy resulted from unlawful intercourse, the superintendent is not to provide written permission unless a Magistrate of a court in the jurisdiction where the abortion will be performed has furnished a certificate of satisfaction that a complaint about the alleged intercourse was lodged with the police; that, on the balance of probabilities the unlawful intercourse has taken place; and that the pregnancy is the result of such intercourse (in the case of incest, that the prohibited degree of relationship exists between the complainant and the alleged perpetrator).
 30. Section 5, Termination of Pregnancy Act of 1977 (Chapter 15:10). The certification is done after a thorough scientific investigation and production of written medical opinion.
 31. Section 5(5), Termination of Pregnancy Act of 1977 (Chapter 15:10).
 32. Section 6, Termination of Pregnancy Act of 1977 (Chapter 15:10).
 33. Section 7, Termination of Pregnancy Act of 1977 (Chapter 15:10).
 34. Section 6, Termination of Pregnancy Act (Chapter 15:10).
 35. The Superintendent must submit the information within 14 days of receiving it.
 36. Section 9, Termination of Pregnancy Act (Chapter 15:10).

Criminal Law

Section 60 of the Criminal Law (Codification & Reform) Act [Chapter 9:23] creates an offence for the termination of pregnancy other than in terms of the Termination of Pregnancy Act.

Section 60 provides as follows:

“Unlawful termination of pregnancy

(1) Any person who—

(a) intentionally terminates a pregnancy; or

(b) terminates a pregnancy by conduct which he or she realizes involves a real risk or possibility of terminating the pregnancy; shall be guilty of unlawful termination of pregnancy and liable to a fine not exceeding level ten or imprisonment for a period not exceeding five years or both.

(2) It shall be a defence to a charge of unlawful termination of pregnancy for the accused to prove that—

(a) the termination of the pregnancy occurred in the course of a “Caesarean section”, that is, while delivering a foetus through the incised abdomen and womb of the mother in accordance with medically recognized procedures; or

(b) the pregnancy in question was terminated in accordance with the Termination of Pregnancy Act [Chapter 15:10].”

The law on termination of pregnancy in Zimbabwe, whilst seemingly allowing abortion under some circumstances, is highly restrictive and imposes onerous conditions and sanctions on all parties involved, with the real possibility of imprisonment.

Case law

The courts have, in some circumstances, interpreted the provisions of the Termination of Pregnancy Act and the criminal law.

In *Ex parte Miss X* 1993 (1) ZLR233(H), a pregnant woman who had alleged that her pregnancy was a result of rape applied to a Magistrate for a certificate which would have allowed her to have the pregnancy terminated. The Magistrate declined to issue the certificate stating that he was not satisfied that there was a reasonable possibility that the pregnancy was the result of rape. On review, the High Court upheld the Magistrate’s decision. It stated that the

issuing of the certificate is a matter within the discretion of the Magistrate and that the Court could only interfere if the Magistrate's decision were grossly unreasonable.

In the case of *S v Maposa* 1994 (2) ZLR, the High Court refused to certify on review the proceedings of the Magistrates Court because the Magistrate had cautioned and discharged a woman who had been convicted of abortion, because it was too serious an offence for caution and required a sentence of a fine or a suspended prison term and that cautions, and discharges were only for petty and technical offences.

In *Mildred Mapingure v The Minister of Home Affairs*,³⁷ the plaintiff was raped and intended to have the pregnancy terminated. To obtain a lawful abortion in line with the provisions of the Act, she needed a certificate issued by a Magistrate confirming that the rape had indeed taken place. However, she was informed by the prosecutor and the Magistrate that she could only get the certificate when the criminal court case had been completed. By the time she was able to get the certificate, Mapingure was six months pregnant, and the medical professional declined to terminate the pregnancy on the basis that it was unsafe to do so. She

sued the Ministries of Home Affairs, Justice and Health and demanded damages for the failures of the State to prevent the pregnancy and terminate the subsequent pregnancy. The damages she claimed included money for the maintenance of the child that was born. The High Court dismissed the entire claim.

On appeal, the Supreme Court found that the obligations of the State authorities did not extend to the duty to initiate abortion proceedings before the Magistrates Court on behalf of the complainant. Therefore, the Magistrate and prosecutor could not be found liable for negligence. The police and doctor (and vicariously the Ministry of Health and Ministry of Home Affairs) involved were found liable:

*"...in respect of the failure to avoid the pregnancy. Although the originating cause of the appellant's pregnancy was the rape, its proximate cause was the negligent failure to administer the necessary preventive medication timeously. But for that failure, the appellant would not have fallen pregnant."*³⁸

These cases illustrate some of the difficulties faced by women seeking to terminate a pregnancy leading to calls to amend the Termination of Pregnancy Act.³⁹

37. Minister of Health and Child Welfare and Minister of Justice, Legal and Parliamentary Affairs HH-452-12 (unreported case)

38. Feltoe, G., "Case note on the case of *Mapingure v Minister of Home Affairs & Ors*" S-22-14, https://zimlil.org/zw/journal/2017-zelj-01/%5Bnode%3Afield_jpubdate%3Acustom%3AY/case-note-case-mapingure-v-minister-home.

39. *Ibid*, "The Mapingure case clearly points to the urgent need to amend the Termination of Pregnancy Act as soon as possible to place the duty squarely upon the police and other authorities dealing with rape victims to guide and assist rape victims through the processes necessary to obtain contraception to avoid pregnancy or, where the victims wish this, to obtain termination of pregnancies. The amendment should require the authorities to act with expedition in this sort of case."

Access to safe abortion, informed consent and medical ethics

Access to safe abortion is affected, in addition to the legal provisions in the Termination of Pregnancy Act, by the attendant duties or requirements on health care workers to provide such, and whether the law and policy make such a provision. Even though the Public Health Act, Patient's Charter and medical ethics and guidelines create general duties of care for medical practitioners to require informed consent for access to health care, it is not clear whether this extends to counselling, referral or provision of a safe abortion.

No duty to perform an abortion

Section 10 of the Termination of Pregnancy Act absolves medical practitioners, nurses, and any other health officials from any obligation to perform, participate in or assist in the termination of pregnancy notwithstanding any legal or contractual obligation to do so. In effect, there is, therefore, no affirmative duty on medical personnel to perform an abortion. This is like the "conscientious objection" exclusions common to other laws, but it does not require there to be a reason for the objection. This creates the real possibility that, regardless of fulfilling all the criteria for safe abortion, a pregnant woman may still not be able to access a safe abortion in the face of objecting practitioners.

The Masingure case illustrates the existence of an affirmative duty of care on medical professionals to inform and assist, but this does not go beyond options for obtaining emergency contraception to prevent pregnancy. Once there is a pregnancy, there is no duty to provide or facilitate an abortion.

The need for law reform

Although the Termination of Pregnancy Act, was enacted to clarify the law on abortion, replacing the common law, it has been said to be "lacking in transparency".⁴⁰ The Act fails to clarify the practical steps by which women who qualify in terms of the law can obtain an abortion, and their

40. Cook, R.J. & Erdman, J.N, "Abortion Laws in Transnational Perspective: Cases & Controversies", Pennsylvania Studies in Human Rights 2014, pg. 171.

rights and the remedies where they are denied a legal abortion. This lack of clarity also applies to health professionals as there are no guidelines to inform them of the practicalities of providing legal abortion.⁴¹

Also, the language used to describe the instances where abortion would be legal are restrictive, for example, where there is "...a serious threat of permanent impairment of physical health". The Act also impliedly does not include danger to a woman's mental health as a ground for abortion. This, and the odious requirements for certification are deterrents to obtaining and providing a legal abortion as even health care professionals are discouraged from providing legal abortion for fear of flouting the law and being prosecuted.⁴² The law has thus served as a deterrent to accessing safe abortion and is therefore connected to a high incidence of unsafe abortions, which have affected the mortality rates of pregnant women. It is estimated that 16 per cent of maternal deaths are due to unsafe abortions, half of which occur among adolescents.⁴³ This has

led to calls among some in Zimbabwe for the modernization of anti-abortion laws to ensure that they address the plight of women.⁴⁴

The absence of an affirmative duty to assist in an abortion, even in the absence of a conscientious objection, hinders for access to safe abortion in instances where the law allows it. In other countries, like South Africa, the unregulated exercise of conscientious objection has led to increasing obstacles for access to a safe abortion even in the presence of very liberal abortion laws.⁴⁵ There is thus a case for reform of the provision.

Some studies have suggested several obstacles contributing to instances of unsafe abortions in Zimbabwe, including a "lack of adequate information and knowledge on sexual reproductive health rights (SRHRs) including issues to do with contraception among the unmarried young women."⁴⁶ The fear of falling foul of the law, coupled with a lack of provision within the law for safe abortions, is another reason for resorting to unsafe abortions. This

41. Cook, R.J. & Erdman, J.N, "Abortion Laws in Transnational Perspective: Cases & Controversies", *Pennsylvania Studies in Human Rights* 2014, pg. 172.

42. Cook, R.J. & Erdman, J.N, "Abortion Laws in Transnational Perspective: Cases & Controversies", *Pennsylvania Studies in Human Rights* 2014, pg. 172.

43. Chipunza, P. "MPs Clash on Abortion Law" *The Herald*, 13 June 2017, <http://allafrica.com/stories/201706130715.html>. Sachiti, R. "Zim's abortion dilemma: it's the women who suffer", *The Herald*, 20 June 2017, <http://www.herald.co.zw/zims-abortion-dilemma-its-the-women-who-suffer/>; Phiri, M. "Zimbabwe teen pregnancies fuel demand for illegal abortions", *Reuters*, 26 June 2015, <http://www.reuters.com/article/us-rights-zimbabwe-abortion/zimbabwe-teen-pregnancies-fuel-demand-for-illegal-abortions-idUSKBN0P61W820150626>.

44. "Our ugly secret: Abortion in Zimbabwe; illegal but thriving" *Pambazuka News*, 16 May 2012, <https://www.pambazuka.org/governance/our-ugly-secret-abortion-zimbabwe-illegal-thriving>.

45. Harries, J., Cooper, D., Strebel, A. et al. "Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study" *Reprod Health* 11, 16 (2014), <https://doi.org/10.1186/1742-4755-11-16>.

46. Universal Periodic Review of Zimbabwe: 26th Session, Submission by Katswe Sistahood and Sexual Rights Initiative, 2016; Hwenjere, V.G., "Understanding unsafe abortions among young women in Zimbabwe: A Socio-legal study on Reproductive Rights" *Research Paper*, International Institute of Social Studies, 2016.

fear of arrest also leads to a reluctance to seek medical assistance. The incidence of mortality and morbidity due to unsafe abortions has grown so alarming that government policy towards post-abortion care has shifted from enforcing the criminal sanctions (doctors were required to report anyone presenting suspected of having had an illegal abortion), to instituting a policy where patients are provided with post-abortion care with no questions asked.⁴⁷ Predictably, this means that a large percentage of public health funds is spent on post-abortion care, which arguably could be avoided with more permissive laws or policies.

Other factors contributing to unsafe abortions are not necessarily legal. For instance, Zimbabwe's traditional and religious communities and their discourse on abortion also play a part in depicting abortion as a sin. This influences the thinking of society as well as those individuals who require an abortion.⁴⁸

There is a need for law reform relating to the simplification and clarification of the process leading to legal abortion. Also, there is a need to raise public awareness on the possibility of obtaining a legal abortion where it is appropriate and required, such as in cases of rape.

The Termination of Pregnancy Act predated the new Constitution and was therefore enacted before reproductive health rights were part of the Bill of Rights. A process of alignment of the Constitution with the law regarding termination of pregnancy ought to result in relaxation of the provisions and the addition of further grounds for lawful termination in line with the progressive realization of the right to freedom of choice and reproductive health protected under sections 76 and 52 of the Constitution. It remains to be seen, however, how far this could go considering the restriction to those rights in section 48 of the Constitution which protects the right to life of the "unborn child".

47. "Zimbabwe relaxes abortion laws" <http://www.africareview.com/news/Zimbabwe-relaxes-abortion-laws/979180-1470854-ac97vy/index.html>

48. Hwenjere, V.G. "Understanding unsafe abortions among young women in Zimbabwe: A Socio-legal study on Reproductive Rights" Research Paper, International Institute of Social Studies, 2016 pg. 33.

International obligations on access to abortion

Zimbabwe has ratified both CEDAW and the Maputo Protocol. It is accordingly obligated to ensure health access to women, remove discriminatory barriers, and ensure access to abortion.

Zimbabwe's law, as outlined above, is substantially compliant with article 14(2)(c) of the Maputo Protocol in providing for abortion on the grounds of health, rape, incest or foetal viability. However, it still falls short in that it does not provide for abortion on mental health grounds, and its procedures are not straightforward and streamlined enough to ensure access. The criminalization of those who seek an abortion and those that may seek to provide it, creates a barrier to accessing safe abortion.

In its Concluding Observations on Zimbabwe's 6th periodic report, the CEDAW Committee recommended that Zimbabwe should decriminalize abortion in all circumstances and ensure access to safe abortion and post-abortion care.⁴⁹ Thus law reform and active policies to provide access to safe abortion must be put in place for Zimbabwe to fulfil its obligations.

The Global Gag Rule and law reform efforts

The GGR has impacted significantly on access to health care, and SRHR services in Zimbabwe, from previous iterations of the GGR to the ongoing impact felt with its current implementation. Some NGOs that have accepted the terms of the GGR have ceased to work on abortion-related projects, for example, the Zimbabwe National Family Planning Council in Zimbabwe.⁵⁰ This has impacted collaboration with other organizations that provide family planning like MSF, leading to a scaling down of the provision of reproductive health care. Another organization, SafAIDS, declined to accept the terms of the policy and had to give up implementation of a programme serving vulnerable children affected by HIV, thereby losing a significant portion of their budget.⁵¹

It is clear, therefore, that NGOs working to liberalise the law and improve access face significant barriers created by the implementation of the GGR.

49. Concluding observations on the sixth periodic report of Zimbabwe Committee on the Elimination of Discrimination against Women, CEDAW/C/ZWE/CO/6.

50. Population Action International, *Access Denied: The Impact of the Global Gag Rule in Zimbabwe*, published and updated in 2005.

51. <https://globalpressjournal.com/world/u-s-pulls-funding-plug-reproductive-health-providers-proceed-reprohealth/>.



ZAMBIA

Legislative and policy framework

The legal framework relating to abortion in Zambia is underpinned by the provisions of the Constitution of Zambia of 1996,⁵² the Termination of Pregnancy Act (Chapter 304 of the Laws of Zambia), and the Penal Code (Chapter 87 of the Laws of Zambia). The Gender Equality and Equity Act No. 22 of 2015 and the Standards and Guidelines for Comprehensive Abortion Care in Zambia⁵³ provide additional support and clarity to the law.

52. Although the Constitution of Zambia was amended in 2016, the Bill of Rights in the 1996 Constitution is still applicable as it was not expressly repealed by the Constitution of Zambia (Amendment) Act No. 2 of 2016.

53. Standards and Guidelines for Comprehensive Abortion Care in Zambia (MOH, 2017).

Constitution

Article 12(2) of Part III of the Constitution of Zambia of 1996 protects the right of the unborn child to life and stipulates that termination of pregnancy may only be done in accordance with conditions specified in an Act of Parliament. This means that abortion is restricted. The legislation that provides the requirements for legal abortion is the Termination of Pregnancy Act.

The Termination of Pregnancy Act

In terms of section 3 of the Termination of Pregnancy Act, a pregnancy may only be terminated by a registered medical practitioner. The medical practitioner and two other registered medical practitioners should have reached the opinion in good faith that:

1. The continuance of the pregnancy would involve –
 - a. Risk to the life of the pregnant woman; or
 - b. Risk of injury to the physical or mental health of the pregnant woman; or
 - c. Risk of injury to the physical or mental health of any existing children of the pregnant woman; greater than if the pregnancy were terminated; or
2. There is a substantial risk that if the child were born, it would suffer from serious mental or physical disability.

In terms of the requirements, one of the medical practitioners providing the recommendation for termination should be a specialist in the field. Further, the medical practitioners may take account of the pregnant woman's actual and reasonably foreseeable environment or her age. Additionally, in emergencies, where it is determined that the termination is urgently necessary to save life or prevent grave injury to the physical or mental health of the woman the opinions of the two medical practitioners may be dispensed with.

The above-stated provisions suggest that abortion is allowed on socio-economic as well as medical grounds, which is relatively progressive.

Criminal law

Section 151 of the Penal Code criminalizes abortion by penalizing "procuring miscarriage" by the intentional administering of poison or other noxious substance, force or any other means to a pregnant woman or child. The sentence upon conviction is imprisonment for a term not exceeding seven years.

Further, section 152 provides for a penalty of fourteen years' imprisonment for a woman who carries out an abortion or allows another person to perform an abortion on

her. In the case of a female child, the penalty is community service or counselling, as determined by a court in the best interests of the child. There is a proviso, however, that where a female child is raped or “defiled” and becomes pregnant, the pregnancy may be terminated per the Termination of Pregnancy Act.

Section 153 of the Penal Code penalizes the provision of means for abortion by anyone and attracts a sentence of 14 years’ imprisonment.

Section 221 states that any person who, with intent to destroy the life of a child capable of being born alive, wilfully causes a child to die before it has an existence independent of its mother, shall on conviction be sentenced to life imprisonment. For a person to be convicted under this section, it must be proved that the act which caused the death of the child was not done in good faith to preserve the life of the mother.

As is clear from the text, the exceptions do not include pregnancies arising from incestuous relations with the women concerned and only refer to girl children, and impliedly excludes adult women who may need to terminate a pregnancy after being raped.⁵⁴

The Gender Equity and Equality Act

The Gender Equity and Equality Act is aimed at fostering and achieving gender equality in the various sectors of Zambian society, and access to services, goods for men and women on an equal basis. It states in the preamble that the purpose of the Act is to give effect to Zambia’s international obligations on gender equality in terms of CEDAW and the Maputo Protocol as well as the SADC Protocol on Gender and Development.

54. Mushabati, N., “Abortion in Zambia”, BUWA! A Journal on African Women’s Experiences, 23 October 2012.

Section 21 spells out the sexual and reproductive health rights of all individuals, inclusive of the right to choose family planning methods, fertility and child spacing. Section 21(2) mainly provides for the woman's right to "choose whether or not to have a child" subject to other laws, which is an indirect reference to the right to have an abortion.

Section 32 spells out the duties of health service providers, which include the obligation to provide necessary information on sexual and reproductive health services and procedures and obtain informed consent. Also, it imposes an affirmative duty to provide information, counselling and referrals on sexual and reproductive health (in line with section 21 this includes information and referral for an abortion).

The Act, therefore, reinforces the provisions of the Termination of Pregnancy Act in terms of access to safe abortion in terms of the law.

Standards and guidelines for comprehensive abortion care in Zambia

The Standards and Guidelines, first developed in 2009 and updated in 2017, provide principles and guidelines for the prevention of unsafe abortion and its effects on women through a tiered system (primary, secondary, tertiary and quaternary).

Primary prevention entails prevention/mitigation of unsafe abortion due to unintended pregnancies through comprehensive sexuality education, improving contraceptive access (including emergency contraception) and prevention of sexual assault. Secondary prevention is to be achieved through early detection of unintended pregnancy and the provision of safe abortion to the full extent of the law. This also includes counselling and provision of ante-natal services and adoption services for women opting to carry through with the pregnancy. Tertiary prevention involves dealing with abortion complications (including unsafe abortion) through the provision of post-abortion care to prevent permanent disability and death. Quaternary prevention involves post-abortion counselling and provision of contraceptives and linkage to other SRH services like STI screening and management.

The Guidelines emphasize the importance of respecting a woman's right to know and choose available options, equitable access to services and high quality of such services.

Case law

In the *People v Gulshan, Smith, Finlayson*,⁵⁵ a case concerning three doctors charged with procuring an abortion contrary to sections 151 and 394 of the Penal Code, the Court held that abortion was lawful where it was done in good faith and with reasonable

55. (1971) High Court [Criminal] HP. 11/1971 (Zambia).

knowledge to save the life and prevent grave permanent injury to the physical or mental health of the mother. This case went on to form the basis of the Termination of Pregnancy Act of 1972 and still stands as good authority for abortion law in Zambia.

The need for law reform

Zambia's abortion law has been described as ambiguous, being either liberal or restrictive depending on political/cultural persuasion.⁵⁶ Despite the existence of the relatively permissive law and policies on abortion, research on access to abortion and post-abortion care shows that in 2014–15 abortion complications accounted for 13.3% of maternal deaths in Zambia, 33.3% of health facilities provided post-abortion care [and], yet only 5% performed the abortion.⁵⁷ Several factors have been attributed to the low take up of legal abortion procedures, including:

“provider bias, limited information among women and girls about the Termination of Pregnancy Act, legal requirements, the limited number of sites that perform the procedure, and social and religious sentiments against abortion – all of which lead an unknown number of women and girls to opt for unsafe and illegal abortions at the hands of untrained people in unsanitary and unsafe conditions.”⁵⁸

Further factors include:

- The cost of conducting legal abortions compared to unsafe ones;
- The requirement that three medical practitioners must authorize an abortion;
- The requirement that one of the medical practitioners must be a specialist in the branch of medicine that the pregnant patient needs to be examined in;⁵⁹

56. Haaland, M.E.S., Haukanes, H., Zulu, J.M. et al. “Shaping the abortion policy – competing discourses on the Zambian termination of pregnancy act” *Int J Equity Health* 18, 20 (2019), <https://doi.org/10.1186/s12939-018-0908-8>

57. Population Council, UNFPA, Government of Zambia Human Rights Commission, WLSA, and United Nations in Zambia, “The Status of Sexual and Reproductive Health and Rights in Zambia: Contraception and Family Planning, Preventing Unsafe Abortion and Accessing Post-abortion Care, and Maternal Health Care” Lusaka, Zambia, 2017.

58. Mushabati, N., “Abortion in Zambia” *BUWA! A Journal on African Women's Experiences*, 23 October 2012.

59. *Ibid*, “In rural areas where clinics are far away and may not even have three medical practitioners, this is a virtually impossible requirement to comply with.”

- The lack of safe abortion procedures in rural areas;⁶⁰ and
- The reluctance of some medical practitioners to sign the forms for religious and personal reasons.⁶¹

In addition, there are gaps in the law that might require law reform, such as the extension of the criminal exception of rape as a ground for abortion to adult women.

Interventions are required to deal with these problems that might involve advocacy and lobbying by NGOs and government departments to:

- Simplify procedures and dispense with the certification requirements, or at least reduce the number of practitioners required for it;
- Improve on the availability of health services by mitigating the shortage of doctors and training and utilizing mid-level health care professionals to perform an abortion, at least in the first trimester;
- Reform the criminal law to decriminalize abortion, or at least to increase the exceptions and include adult women; and

- Raise awareness about lawful abortion and the requirements to address ignorance and the belief that it is illegal.

International obligations

Zambia is a signatory to and has ratified the CEDAW and the Maputo Protocol. The State is therefore obliged to ensure access to health care for women on an equal basis as men in line with article 12 of CEDAW, inclusive of reproductive health care, in addition to the obligations to ensure access to safe abortion outlined in article 14(2) of the Maputo Protocol.

The legal provisions on abortion are substantially in compliance with the Maputo Protocol, as abortion is allowed on therapeutic as well as socio-economic grounds. However, there are still gaps like the legal unavailability of abortion for adult women who have been raped. However, there are barriers affecting access, as outlined above, including onerous procedural conditions, problems with provider access, societal attitudes and criminalization.

In its Concluding Observations to Zambia's State Report in 2011, the CEDAW Committee recommended that the Government raises

60. Mubita-Ngoma, C.A. et al "Abortion Policy in Zambia: Implementation Challenges" *JOJ Nurse Health Care*, 2017; 3(1): 555602. "In Zambia safe abortion services are available only within Provincial government hospitals and in private clinics."

61. *Abortion Policies: A Global Review*, United Nations Population Division, Department of Economic and Social Affairs, 2002, www.un.org/esa/population/publications/abortion/doc/zambia.doc.

awareness about the law providing access to safe abortion and ensure equitable access to abortion and post-abortion care services.⁶²

Impact of GGR on law and policy reform

The GGR policy has affected organizations that provide abortion and other reproductive health services, such as the Planned Parenthood Association of Zambia (PPAZ). Formerly, PPAZ offered programs which provided HIV testing for the community, access to contraceptives and family planning and other advice in schools. Yet much of that work – and PPAZ's staff – have been scaled-back by the reintroduction of the GGR, as PPAZ lost a substantial portion of its funding when it declined to comply with its terms. In 2017, it was estimated that PPAZ lost half of its annual operating budget,⁶³ not only imperiling its work on reproductive and abortion rights but also on HIV and other areas of health. PPAZ's work in Zambia takes on pronounced importance, as the only NGO which provides reproductive health clinics in Zambia.⁶⁴

Since the exceptions to the GGR do not include abortion on the grounds of socio-economic reasons, and mental health or physical health issues which do not amount to danger to life, Zambian law does not strictly fall within the exceptions. Thus, even advocacy to bring public awareness to the provisions of the law may violate contractual terms for a gagged organization and affect any collaborations with other organizations.

The problems highlighted require concerted action, including advocating for law and policy reform, in contravention of the policy.

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62. Committee on the Elimination of Discrimination Against Women (CEDAW), Concluding observations of the Committee on the Elimination of Discrimination against Women - Zambia, 19 September 2011, CEDAW/C/ZMB/CO/5-6 <https://www.refworld.org/docid/4eeb489a2.html>
 63. Ratcliffe, R., "People will end up dying': Trump's cuts devastate clinics in Zambia" *The Guardian*, 21 January 2019, <https://www.theguardian.com/global-development/2019/jan/21/trump-cuts-devastate-clinics-zambia>.
 64. Population Action International, *Access Denied: The Impact of the Global Gag Rule in Zambia*, 2006.



MOZAMBIQUE

Legislative and policy framework

The laws governing abortion in Mozambique are the Penal Code, the Constitution, and Ministerial Guidelines on Abortion. The former Penal Code of 1886 was inherited during colonial times and adopted at independence in 1975. The Code criminalized abortion in article 358, with penalties varying from two to eight years of imprisonment. Abortion could only be provided to save the life of the pregnant woman.

Despite the criminalization of abortion, because of the high prevalence of complications and mortality arising from unsafe abortions, the Ministry of Health in the early 1980s and 1990s issued directives authorizing abortion, firstly in the central hospitals and later covering provincial hospitals, to include instances of contraceptive failure and upon request by the pregnant woman up to 12 weeks gestation.⁶⁵

In terms of article 18 of the Constitution, international treaties and agreements ratified by the State enter automatically into force in the country after publication in the Official Gazette and have the same legal value as domestic legislation.

New provisions on abortion were therefore applicable following the approval at the regional level of the Maputo Protocol. This Protocol was ratified by the State in 2005.⁶⁶

The ratification of the Protocol required that legislators harmonize the Penal Code of 1886 that criminalized abortion with the Maputo Protocol that had become domestic law by ratification and that allowed access to safe and legal abortion under broad conditions.

The Penal Code

New provisions on abortion are contained in the new Penal Code, which was enacted in

July 2014. These new provisions broadened the circumstances under which abortion is allowed. Although the new Penal Code still criminalizes abortion in its article 166, it establishes in article 168 conditions for a lawful abortion.

Article 168 allows abortion when performed by a doctor or other trained health professional, or under his or her direction, in an official or officially recognized health facility and with the consent of the pregnant woman, when, following the provider's expert medical opinion:

- a. There is a danger of death or of a severe and irreversible injury to the mental or physical health of the pregnant woman;
- b. It is recommended to avoid the danger of death or a severe and lasting injury to the body or to the mental or physical health of the pregnant woman and is performed in the first 12 weeks of pregnancy;
- c. In the case where, as proven by ultrasound or other appropriate means, the foetus is likely to suffer from any incurable severe disease or congenital disability, and if the abortion is carried out in the first 24 weeks of pregnancy;
- d. The foetus is not viable;
- e. It is recommended in case of chronic-degenerative diseases;

65. Usta, M.B. et al, Situational Analysis of Unsafe Abortion in Mozambique <http://www.who.org>.

66. Resolution of the National Assembly No. 28/2005, 13 December.

- f. The pregnancy is a result of rape or incest, and the abortion takes place within the first 16 weeks of pregnancy; and
- g. On request of the pregnant woman up to 12 weeks of pregnancy.

Ministerial guidelines on abortion

Following the amendment of the Penal Code, the Minister of Health passed the Ministerial Decree n. ° 60/2017, which authorize the Medical and Ethical Guidelines on Safe Abortion Post Abortion Care and defines the conditions in which the voluntary termination of pregnancy can be performed in the Health Units of the National Health Service ("S&Gs").

Apart from reaffirming the provisions of the Penal Code on the conditions and the procedure for abortion, the S&Gs regulate other aspects like the duties of health providers to obtain informed consent, professional secrecy, conscientious objection, and the responsibility of the Government to offer free services.

As provided for in terms of article 168(2) of the Penal Code, the circumstances authorizing an abortion must be certified by a medical certificate, written and signed with the intervention of two health professionals other than the one under whose direction the abortion will be performed. This requirement, however,

seems not to be applicable in the case of abortion on request of the pregnant woman, as the medical condition of the woman does not need to be certified.

*Conscientious objection*⁶⁷

Medical doctors or health professionals with a conscientious objection to the termination of pregnancy are not compelled to perform it, except when the procedure is necessary to save the life of the pregnant woman or to prevent serious risk to her health. The objector should refer the woman to another health professional who can perform the service.

It is the duty of the management of the health unit where the objector is allocated to refer to another doctor in case the objector does not do so. However, if there is no other health professional available in the unit, the pregnant woman should be transferred to another health unit, without any costs to her.

The S&Gs further impose on the medical doctor and all health professionals the duty to inform the pregnant woman about her rights in the case of conscientious objection, to guarantee that she can be assisted by another professional who is not an objector.

67. Article 5 of the Ministerial Decree n. ° 60/2017, of 20 September that approved the S&Gs.

*State obligations*⁶⁸

The S&Gs provide that safe abortion and post-abortion care services should be free of charge.

They further establish that the Ministry of Health must ensure that users of the health system are offered a range of reproductive health services, including the voluntary termination of pregnancy in cases allowed by the law. The Ministry has the responsibility to train the managers for the implementation of those services in hospitals and public health centres.

The case for improvement in access and further law reform

Despite the relatively liberal abortion policy in Mozambique before the change in law, touted as being “one of the most liberal de facto systems of abortion on request in Sub-Saharan Africa”,⁶⁹ like the situation in Zambia, this has not eliminated unsafe abortions, mortality, and strain on the public health system.

In 2011, according to Maputo City Health Director Pascoa Zualo, the capital’s hospitals recorded 9,400 admissions due to complications from illegal abortions, with eight resulting in deaths.⁷⁰ These figures exclude Maputo Central Hospital, the country’s largest. Further, a report by the WHO in 2015 concluded that 11% of maternal deaths in Mozambique were due to unsafe abortions.⁷¹

Some of the factors leading to this include insufficient knowledge about access to safe and lawful abortion services and limited technical capacities of abortion services where they are legal.⁷² Access to safe abortion and post-abortion care in rural areas is also a significant challenge.⁷³ Despite

68. Article 7 and 8 of the Ministerial Decree n. ° 60/2017, of 20 September that approved the S&Gs.

69. Agadjanian, V., “‘Quasi-Legal’ Abortion Services in a Sub-Saharan Setting: Users’ Profile and Motivations”, *International Perspectives on Sexual and Reproductive Health*, Vol 24, Issue 3 September 1998, <http://www.guttmacher.org>.

70. Sayagues, M. “Op-ed: Progressive new abortion law shows Mozambique’s commitment to women’s reproductive rights”, *Daily Maverick*, 1 October 2014, <https://www.dailymaverick.co.za>; Sayagues, M. “Unsafe Abortion Makes News, as Mozambique Prepares for a Change in Law”, *International Centre for Journalists*, 25 July 2012, <https://www.icfj.org>.

71. Vieira, A. “Sweden gives Mozambique \$5,2 million for safe abortion”, *Africa Review* 5 March 2017, <http://www.africareview.com>.

72. Agadjanian, V., “‘Quasi-Legal’ Abortion Services in a Sub-Saharan Setting: Users’ Profile and Motivations”, *International Perspectives on Sexual and Reproductive Health*, Vol 24, Issue 3 September 1998 available at <http://www.guttmacher.org>.

73. Sayagues, M. “Unsafe Abortion Makes News, as Mozambique Prepares for a Change in Law”, *International Centre for Journalists*, 25 July 2012, <https://www.icfj.org>.

the Ministry of Health's directives to allow for safe abortion in the main hospitals, rural women have not been able to access abortion services due to distance from facilities, criminalization, and hospital directors refusing to provide abortion services.⁷⁴ The cost of legal abortion services is also a factor, with abortion having become a significant source of revenue for health institutions.⁷⁵

With the change in the law, some of these challenges remain, in addition to other difficulties which impact women's access to safe abortions. A survey by Pathfinder International in May 2016 in 4 provinces with 164 health providers found that only 53% of the providers were knowledgeable about the new law and that only 57% would be willing to provide a legal abortion, clearly showing challenges in implementation.⁷⁶ Because of the above, it is important to consider the following:

- The need to further streamline and simplify procedures to realize the gains of the law, for example, removal of the provision requiring the intervention of multiple providers to certify an abortion on medical grounds. It has been shown that laws that are too restrictive are likely to lead to women failing to access safe abortions and then resorting to unsafe abortions outside hospital. Also, this procedure might prevent rural women from obtaining assistance where there is a shortage of medical practitioners.
- In the light of the very liberal laws allowing abortion, the maintenance of criminalization for abortion is unnecessary; instead, there is a need to raise awareness of the dangers of unsafe abortions and the availability of safe alternatives.
- The need for investment in capacity-building and training for health workers to be able to provide abortion care and counselling within the law, and especially in rural areas; and
- The need to raise public awareness of the provisions of the law to enable women to take advantage of it when needed.

International obligations

Mozambique, as a State Party to CEDAW and the Maputo Protocol, must eliminate laws and practices that obstruct equal access to reproductive healthcare and to ensure access to safe abortion. The law on abortion in is relatively liberal, and in substantial compliance with the Maputo Protocol, providing for abortion on extensive grounds, restricted only by gestation periods. However, the existence of the law does not necessarily ensure actual access, as issues

74. Sayagues, M. "Op-ed: Progressive new abortion law shows Mozambique's commitment to women's reproductive rights", Daily Maverick, 1 October 2014, <https://www.dailymaverick.co.za>.

75. Agadjanian, V. "'Quasi-Legal' Abortion Services in a Sub-Saharan Setting: Users' Profile and Motivations", International Perspectives on Sexual and Reproductive Health, Vol 24, Issue 3 September 1998, <http://www.gutmacher.org>.

76. Mozambican Coalition for Sexual and Reproductive Rights, "Now what? Challenges of implementing a new law that decriminalises abortion", International Campaign for Women's Right to Safe Abortion, 28 September Report, <http://www.safeabortionwomen'sright.org>.

77. Concluding Observations and Recommendations - Mozambique: Initial and Combined Periodic Reports, 1999-2010 available at <https://www.achpr.org/states/statereport?id=89>.

like lack of awareness of the law, societal and provider attitudes, economic issues affecting access, and availability of providers (facilities and health workers), limit the ability of women to benefit effectively from the law.

The CEDAW Committee in its Concluding Observations to Mozambique State Reports (1999-2010)⁷⁷ recommended, after commending the State for the liberalization of the law on abortion, that the State should put more effort towards improving access to safe abortion through increasing the number of health facilities and health personnel in rural areas and to ensure confidential access to abortion and post-abortion care. In addition, the State was urged to intensify awareness, especially amongst rural women and girls, of their sexual and reproductive health rights.

Impact of GGR on abortion access, law, and policy reform

The GGR has undoubtedly established substantial barriers to access to health care and reproductive health services in Mozambique. It has primarily affected NGOs with a focus on women's health care and reproductive rights. One of those is Associação Moçambicana para Desenvolvimento da Família (AMODEFA),

identified as Mozambique's oldest NGO specializing in sexual and reproductive health.⁷⁸ AMODEFA declined to agree to the terms of the policy. It has lost approximately US \$2 million, 60 per cent of its operating budget.⁷⁹

In the province of Gaza, two-thirds of health care clinics dedicated to young people have been closed; 95% of AMODEFA's peer sexual health educators were laid off, and over half of its staff are no longer employed.⁸⁰ Its school clinic closed – there is only one other, located in the country's capital, Maputo.

The provisions of Mozambique law on abortion, like in the case of Zambia go beyond the exceptions in the PLGHA policy, in that the instances where abortion is allowed are quite extensive, including abortion upon request and apparently for family planning purposes. Thus, activities aimed at eliminating or mitigating the effects of the weaknesses highlighted above, like raising public awareness of the provisions of the law and advocating for further liberalization of the law to ensure access may most likely fall foul of the policy, stifling 'gagged' organizations.

78. Abrahams, J. "Mozambique's teenage pregnancy challenge" Devex, <https://devex.shorthandstories.com/mozambique-teenage-pregnancy-challenge/index.html>.

79. International Planned Parenthood Federation, "The Global Gag Rule (GGR) cuts deep into sexual and reproductive healthcare in Mozambique" International Planned Parenthood Federation, 6 December 2017, <https://www.ippf.org/blogs/global-gag-rule-ggr-cuts-deep-sexual-and-reproductive-healthcare-mozambique>.

80. Abrahams, J. "Mozambique's teenage pregnancy challenge" Devex, <https://devex.shorthandstories.com/mozambique-teenage-pregnancy-challenge/index.html>.

81. Mavundla, S. & Ngwena, C., "Access to Abortion for Rape as a Reproductive Health Right: A Commentary on the Abortion Regimes of Swaziland and Ethiopia", Ngwe and Durojaye (eds.) in *Strengthening the Protection of Sexual*



ESWATINI

Legislative and policy framework

The official law on abortion and reproductive rights in Eswatini is contained in the Constitution of 2005, although the common law still applies in effect. Before the establishment of its 2005 Constitution, legal access to abortion was solely governed by the common law.

Common law

Under the common law, abortion was not entirely illegal but heavily restricted.⁸¹ Abortion was only permitted in circumstances where it would save the life of the pregnant woman. In other words, it covered the “physical and mental health” of a woman.⁸²

The Constitution

For the first time in Eswatini’s history, the governing law on abortion and women’s reproductive matters was codified in the Constitution, expanding the scope of circumstances in which a woman could have an abortion. Section 15 of the Constitution deals with the “protection of the right to life”. In this context, the general prohibition of abortion is presented as an issue of “life”, not in terms of a woman’s right to attend to her reproductive health. Here, abortion is stated to be “unlawful” but that it “may be allowed” on specific grounds. Abortion is legally permitted “on medical or therapeutic grounds”. Suppose a doctor certifies that a continued pregnancy will endanger or pose a serious threat to a woman’s physical or mental health, or where there is a serious risk that the child would suffer from a serious and irreparable physical or mental disability. In that case, an abortion can be legally performed.

Abortion is also permitted where the pregnancy results from rape, incest, or unlawful sexual intercourse with a person with a mental disability. In terms of section 15(5)(c), abortion may be legal on “such other grounds” as determined by Parliament. Eswatini’s legislature, however, has yet to provide any more grounds upon which a woman can have a legal abortion.

National policy on sexual and reproductive health

This policy, published in 2013, expounds government policy statements on access to safe abortion. It states as goals and objectives the provision of comprehensive information and quality health services to manage and reduce abortion and prevent complications from unsafe abortion. The State pledges to strengthen access to safe abortion and post-abortion care services within the precepts of the law, which includes providing technical guidelines for health service providers.

Criminal law

Abortion is an offence in terms of the common law and has been consistently prosecuted. Cases include prosecution of women and girls for having an abortion,⁸³ or their parents,⁸⁴ or health workers or other unlicensed individuals.⁸⁵ Many such

and Reproductive Health and Rights in the African Region Through Human Rights, Pretoria University Law Press, 2014, pg. 68.

82. R v Bourne 1 Kings Bench 687 (Central Criminal Court, London).

83. “Teacher, Form 5 pupil arrested for abortion” Swazi Observer, <https://new.observer.org.sz/details.php?id=10955>

84. Matimba Elizabeth & Another v Rex (9/2001) [2001] SZSC 28 (01 November 2001).

85. Mkhululi v R (13/10) [2011] SZSC 55 (30 November 2011), <https://swazilii.org.sz/judgment/supreme-court/2011/55>.

86. “Swaziland: Death of Swaziland Schoolgirl After Illegal Abortion Highlights Suffering of Women in Kingdom” Report, <https://allafrica.com/stories/201904010949.html>.

prosecutions relate to complications that would have arisen because of unsafe abortion, like death. The sentences imposed vary from 5 years to life imprisonment.

The need for law reform

Even though the common law has officially been superseded by the constitutional provisions expanding the grounds upon which an abortion can be lawfully obtained, Parliament has not enacted a law to make the provisions effective. Thus, in effect, the common law is still operational, and awareness of the constitutional provisions is deficient. In addition, health providers lack guidelines in terms of offering abortion services in terms of the law.

As a result, it is challenging for women to obtain safe abortions. As an alternative, women often get abortions in unsafe and unregulated situations, at times leading to death and morbidity.⁸⁶ There is also a high unmet need for contraceptives in Eswatini, especially among adolescents,⁸⁷ in part because of problems such as social and cultural stigma and want of access in rural areas, and therefore a high probability of unplanned pregnancies.

In 2012, it was reported that over 1,000 women were treated in a Manzini clinic for “abortion-related complications” – the result of unsafe abortions administered in a non-professional setting, such as at home.⁸⁸ Similarly, in 2012, 16 per cent of female deaths at the largest hospital in Eswatini’s main city, Mbabane, were due to unsuccessful terminations of pregnancy. The causes related to haemorrhaging, and delays in receiving medical treatment for “other complications”. The Health Ministry in Eswatini has previously estimated that 19 per cent of maternal mortality annually is due to “unsafe and illegal” abortions.⁸⁹

International obligations

Eswatini is a State Party to CEDAW and the Maputo Protocol and thus has obligations to remove barriers to effective access to reproductive healthcare for women, and, also to provide for effective access to safe abortion in line with article 14(2)(c) of the

87. <https://eswatini.unfpa.org/en/topics/family-planning-2>.

88. “Illegal abortions endangering lives” The New Humanitarian, 14 November 2012, <https://www.thenewhumanitarian.org/news/2012/11/14/illegal-abortion-endangering-lives>,

89. Id.

90. Concluding observations on the combined initial and second periodic reports of Swaziland CEDAW/C/SWZ/CO/1-2.

Maputo Protocol. In 2014, the CEDAW Committee recommended, in its Concluding Observations,⁹⁰ that Eswatini should step up efforts to reduce maternal mortality through provision of safe abortion and post-abortion care

The provisions of section 15 of the Constitution, legalizing abortion are mainly in line with article 14(2)(c) of the Maputo Protocol. However, because this has not been legislated by an Act of Parliament and is generally unknown by the public and duty-bearers, it has not translated into the State putting in place adequate measures to ensure access to safe abortion. Thus, to be compliant with its obligations, Eswatini must put in place legislation bringing into effect the constitutional provisions and provide practical guidelines for duty-bearers like law enforcement, the judiciary and health care workers.

Besides, in line with CEDAW Committee and African Commission recommendations, Eswatini should decriminalize abortion to remove barriers to safe abortion, coupled with measures to improve access.

The effect of the GGR on law reform and access to abortion

Eswatini has a high HIV rate, and many of its NGOs receive funding from the President's Emergency

Plan for AIDS Relief (PEPFAR).⁹¹ The application of the PLGHA has stripped NGOs of crucial funding sources and compelled others to cease sexual and reproductive health programmes. It is estimated that 57% of PEPFAR's partners were forced to make alterations to their programs and services because of the implementation of the policy. Youth-focused organizations have been significantly impacted by the policy, and many have had to reduce their outreach efforts to educate and raise awareness of sexual health. These include having less capacity to provide contraceptives, cervical cancer screening, HIV testing, counselling, and referrals.⁹² NGOs are thus highly restricted from advocacy for law reform due to lack of resources, or restricted activities due to signing on to the GGR.

As shown above, the need for law reform for access to abortion in Eswatini is great, and a lot of advocacy and lobbying is required for the enactment of abortion law in line with the provisions of the Constitution.

NGOs lobbying and assisting the State in law reform and public awareness-raising will almost certainly fall foul of the policy, or at the very least are restricted.

91. Sherwood, J. and Roemer, M., "Opinion: The 'global gag rule' hits PEPFAR implementers, study shows" Devex, 16 April 2019, <https://www.devex.com/news/opinion-the-global-gag-rule-hits-pepfar-implementers-study-shows-94656>.

92. Id.

93. Daire, J., Kloster, M.O., and Storeng, K.T., "Political Priority for Abortion Law Reform in Malawi: Transnational and

MALAWI

Legislative and policy framework

In general, Malawi's abortion law is restrictive.⁹³ The Constitution of 1994 is silent on whether abortions are permitted or not. The law is primarily governed by the Penal Code of 1930,⁹⁴ which emulates British laws on abortion at that time (Britain has since reformed and considerably liberalized its abortion laws). There have been recent attempts in Malawi – both within civil society and the legislature – to introduce more progressive, and thus less restrictive, abortion laws.⁹⁵

Criminal law

There are various provisions in the Penal Code which outline the legal status of abortion in Malawi. Penalties are attached to conduct by a pregnant woman or another party – whether a friend or medical practitioner. A pregnant woman who intends to bring about her abortion, called “miscarriage” – whether by administering drugs, using force or any other way – or permits others to act in such a way as to produce an abortion, is guilty of an offence and liable to seven years’ imprisonment.⁹⁶ A third party with the intent to induce an abortion – by any means, including administering a drug or by force – is also guilty of a criminal offence. The stipulated period of imprisonment for such action is 14 years.⁹⁷ Any person who “supplies to or procures for” another person drugs or other substances or instruments intended to be used to bring about abortion has committed a criminal offence and must be imprisoned for three years.⁹⁸

However, a person acts without criminal liability if they perform a surgical operation in good faith and with reasonable care on another for their benefit, or on an unborn child. Such an operation on an unborn child – that is, an abortion procedure – must be for

the preservation of the mother’s life. The procedure must also be reasonable in the relevant circumstances.⁹⁹

The need for law reform

Malawi does not have a stand-alone law authorizing safe abortion, except for the exception in the Penal Code. As a result, there is no direct provision for safe and legal abortion for young girls who fall pregnant as a result of sexual assault (rape or defilement in terms of the Penal Code). Even though there are One-Stop Centres where victims of sexual violence can obtain emergency medical, and socio-legal services like post-exposure prophylaxis, emergency contraception or access to safe abortion or counselling on abortion are not available for cases where pregnancy results from the sexual violence. It becomes an issue of interpretation of the law whether a health worker is willing to decide that providing abortion in those instances amounts to good faith intervention to “preserve life”. Such decisions are likely to be arbitrary, being, as they are, unregulated by any guidelines in the law. This is worsened by the lack of clarity in the archaic provisions of the Penal Code. There have therefore been repeated calls for law reform. A lengthy process of advocacy

National Influences (2018) Health and Human Rights Journal 20(1), <https://www.hhrjournal.org/2018/03/political-priority-for-abortion-law-reform-in-malawi-transnational-and-national-influences/>.

94. Penal Code of 1930, Chapter 7:01 of the Laws of Malawi.

95. “Abortion law reform bill in Malawi supported by religious leaders – again”, International Campaign for Women’s Right to Safe Abortion, 27 February 2019, <https://www.safeabortionwomensright.org/malawi-abortion-law-reform-bill-in-malawi-supported-by-religious-leaders-again/>.

96. Penal Code, s 150.

97. Penal Code, s 149.

98. Penal Code, s 151.

99. Penal Code, s 243.

100. <https://www.hhrjournal.org/2018/03/political-priority-for-abortion-law-reform-in-malawi-transnational->

resulted in the Termination of Pregnancy Bill in 2015, which sets out the instances where abortion is legalized, in clear terms.¹⁰⁰ However, the Bill has not yet been debated or passed by the legislature, largely because of opposition from religious and traditional leaders.

Advocates have called on the State to implement the law as it is, whilst awaiting the legislative process, and clarify its terms, to enable health workers and other service providers to be able to help women and girls who may be in need.¹⁰¹ The inability of the law to enable safe abortion access has resulted in a high mortality and morbidity rate in Malawi because of unsafe abortion.

International obligations

Malawi, as a state party to the CEDAW and Maputo Protocol is obligated to eliminate discriminatory barriers to reproductive healthcare, and also ensure access to safe abortion in line with article 14(2) (c) of the Maputo Protocol. This means that a reform of its laws is imperative, at least to make the law clear, certain, and transparent, and to eliminate barriers caused by highly punitive measures against both providers and seekers of abortion services.

The CEDAW Committee in its Concluding Observations to Malawi's 7th periodic report recommended the liberalization of the law to ensure access to safe abortion without undue

procedural restrictions to women and young girls.¹⁰² The African Commission for Human and People's Rights also made extensive recommendations for Malawi to deal with the problem of high maternal mortality rates, in its Concluding Observations to Malawi's Initial and Combined periodic report of 2015,¹⁰³ including urging the completion of the abortion law reform process to align the law with the Maputo Protocol. The Commission also urged Malawi to increase education and awareness-raising measures to enable access to safe abortion in terms of the current law and improve the availability, knowledge, and access to contraception for adolescent girls and women in rural areas. In addition, Malawi was encouraged to improve provision of post-abortion care and put measures in place to prevent the victimization of women and girls by health providers and the criminal justice system.

The Global Gag Rule, abortion law reform and access to safe abortion

According to SRHR advocates in Malawi, the Global Gag Rule and the rising conservative "anti-gender" movement, inclusive of religious leaders, have had a direct effect on efforts to reform abortion law in Malawi. According to a CHANGE report,¹⁰⁴ citing NGO representatives in Malawi, the enactment and operationalization of the GGR in 2017 made Government reluctant

and-national-influences/

101. Kangaude, G.D., Mhango, C., "The duty to make abortion law transparent: A Malawi case study", <https://doi.org/10.1002/ijgo.12630>.

102. Concluding observations on the 7th periodic report of Malawi: Committee on the Elimination of Discrimination against Women, CEDAW/C/MWI/CO/7.

103. https://www.achpr.org/public/Document/file/English/concluding_observations__initial__combined_state_report_malawi.pdf

104. "A Powerful Force: US Global Health Assistance and sexual and reproductive health and rights in Malawi" <https://srhrforall.org/a-powerful-force-u-s-global-health-assistance-and-sexual-and-reproductive-health-and-rights-in-malawi-2/>.

105. Penal Code of 1930, Chapter 7:01 of the Laws of Malawi.

to table the Bill in Parliament, for fear of falling foul of the US administration. This, even though the GGR does not officially apply to government funding.

The GGR has also made it difficult for SRHR advocacy organizations to coalesce, particularly where organizations have accepted US health assistance funding and signed on to the GGR.

In Malawi's already highly restricted environment, the policy has had a large role to play in further restricting the activities of NGOs providing abortion-related services. There are reported cases of local health clinics closing because of the introduction of an expanded policy, meaning that women – especially poor and in rural areas – cannot access health care. In one instance, a woman who had been raped could not visit her local clinic, which had closed. Her treatment by a traditional leader resulted in her death.¹⁰⁵

Consequently, the implementation of the policy means that more unsafe abortions are practised in Malawi – it is estimated that there are 78,000 unsafe abortions performed annually.¹⁰⁶ Local NGOs such as Banja La Mtsogolo and Family Planning Association of Malawi were forced to cease their involvement in HIV health programmes run in Malawi.¹⁰⁷ In this respect, the policy has widespread, negative impacts on health across Malawi, mainly targeting already vulnerable and marginalized groups of people, including adolescents.

CONCLUSION

Although the existence of an international right to sexual and reproductive health has been extensively debated as far as African States are concerned, it exists in the Africa regional rights framework in the form of the unequivocal language of the Maputo Protocol. Explicit also is the right to safe abortion, at least in the listed circumstances. African states thus should ensure that there are legislative, policy and other measures in place at a national level to provide access to safe abortion to ensure the highest attainable standard of health for women.

Policies like the Global Gag Rule impose onerous and unfair barriers to achieving these obligations. The GGR has not only caused significant damage to health care outcomes in the region and the health of civil society but it poses a threat to the principle of State sovereignty when States are hindered from fulfilling their national and international obligations.

106. "Abortion law reform bill in Malawi supported by religious leaders – again", International Campaign for Women's Right to Safe Abortion, 27 February 2019, <https://www.safeabortionwomensright.org/malawi-abortion-law-reform-bill-in-malawi-supported-by-religious-leaders-again/>.

107. Penal Code, s 150.

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THE GLOBAL GAG RULE AND ACCESS TO ABORTION:

Impact on law reform in Zimbabwe,
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