

COMPENDIUM OF SAFE ABORTION IN ZIMBABWE



Opinion Editorials

Written by Zimbabwe Sexual and Reproductive Health Champions working on the Making Abortion Safe Program with the Royal College of Obstetricians and Gynaecologists (RCOG)

Table of Contents

Executive Summary	3
Overturning Roe vs Wade in the US: Lessons for reproductive justice activists in Zimbabwe	4
Restrictive Termination of Pregnancy Laws Won't Stop Unsafe Abortions	5
The Politics of the Uterus	6
Abortion and the moral dilemma; the contradictions of policy and practice	7
Comprehensive Post Abortion Care is an Essential Component of Universal Health Coverage (UHC) and Critical for the Attainment of Health Related Sustainable Development Goals (SDGs)	8
Abortion policy and the vicious cycle of poverty	9
As International Safe Abortion Day Draws Closer, Its Time To Reflect on progress towards a ccess to Safe abortion for women and Girls	10
Abortion conversation must recognise women's bodily autonomy and integrity	11
Adolescents: The face of unsafe abortion: Time to act	12
Values clarification workshops to improve abortion knowledge and attitudes: Post assessment	13
Going Beyond The Legal Framework On Abortion To Save Lives of Women and Girls	14
Unsafe Abortion – The Hidden Health Crisis	15
Unpacking Zimbabwe's post-abortion Care Responsibility and Gaps	16
Abortion is not illegal but restricted in Zimbabwe	17
Access to abortion is critical for women's socioeconomic growth	18
The burden of unsafe abortion among adolescent girls	19
The Tripple Tragedy in Women's Health: Unmet Need for FP, Unwanted Pregnancy and Unsafe Abortion	20
Discussing the intersection of abortion and gender equality	21
The Role of Medical Professional Societies in Informing Communities on Maternal Health, Post-Abortion Care, and Abortion Laws Reform in Zimbabwe	22
Reviewing the impact of the legal lacuna in Zimbabwe's abortion law	23
Demystifying safe abortion: Getting the FACTS right	24
Time to Put Teenage Pregnancy, Abortion back on the Political Agenda	25
Protecting adolescents from unplanned pregnancies through access to comprehensive SRHR services	26
Author Biographies	27
Mildred Mushunje (PHD)	27
Dr Munyaradzi Murwira	27
Mufaro Musiyazviriyo	27
Edinah Masiyiwa	27
Memory Kadau	27



Executive Summary

The Zimbabwe Sexual and Reproductive Health Rights (SRHR) Champions, in partnership with the Royal College of Obstetricians and Gynaecologists (RCOG), have been implementing the Making Abortion Safe Programme since 2021. The promotion of safe, quality abortion in Zimbabwe is critical to addressing high rates of unsafe abortions which makes it one of the leading causes of maternal mortality and morbidity.

Objectives of the Making Abortion Safe Programme in Zimbabwe are::

- To build the capacity and improve knowledge of service providers (police, prosecutors, magistrates, social welfare officers) to support rape/incest survivors in accessing timely, safe abortion
- To work with professional bodies (Confederation of Midwives, Zimbabwe Nurses Association - including their Provincial Chairs, Faculty of Health, ZSOG) and other relevant organisations to increase knowledge of the Termination of Pregnancy (ToP) Act amongst healthcare providers
- To create a safer environment for women and girls to gain awareness and access to information about the ToP Act

To meet the above objectives, the SRHR Champions published Opinion Editorials (Op-Eds) to open debate on safe abortion in Zimbabwe. The Op-Eds aimed to promote understanding of the legal framework on abortion and the health risks associated with unsafe abortions and to challenge misconceptions about safe abortion services. They also provided a platform for diverse voices to advocate for the importance of access to safe and legal abortion services. The Op-Eds in this compendium highlight the need for legal and policy reforms to ensure that safe abortion services are accessible to all women in Zimbabwe. Through their Op-Eds, the champions also sought to challenge the stigma and discrimination surrounding safe abortion as well as emphasise the health and safety benefits of providing comprehensive reproductive healthcare.

Key points and call to action:

- **Reproductive rights and bodily autonomy:** Safe abortion is essential healthcare and a human right. The reproductive rights and freedoms of all women must be recognised and respected so that women can make informed decisions about their own sexual and reproductive health, including abortion.
- **Health and safety:** Unsafe abortions are among the leading causes of maternal mortality and morbidity worldwide. Abortions can be safely provided by healthcare professionals and should be safe, legal, high quality and accessible. Providing access to safe abortion services can significantly reduce maternal mortality and morbidity rates.
- **Legal and policy reforms:** The opinions outline the current legal framework on abortion, provided through the Termination of Pregnancy Act (1977) and the post-abortion care guidelines. Apart from also calling for legal and policy reforms to ensure safe abortion services are accessible and available to all women, the Op-Eds also maintain that restrictive laws and regulations push women towards unsafe and clandestine procedures, putting their lives at risk. Op-Eds urge the government of Zimbabwe to decriminalise abortion to reduce stigma and the number of people dying or facing injury from pregnancy-related complications.
- **Stigma and discrimination:** Stigma and discrimination surrounding abortion towards those who seek abortions and abortion care providers creates a significant barrier to safe abortion access. Societal attitudes must be challenged and acceptance, and support for women seeking safe abortion services must be promoted and normalised. Reducing stigma is crucial for ensuring that women can access abortion care without fear of judgment or harm.
- **Comprehensive reproductive healthcare:** A comprehensive approach to reproductive healthcare is necessary. Safe abortions are an essential part of sexual and reproductive health; they should be an integrated component of sexual and reproductive healthcare and be available as part of routine health services. Denying women access to safe abortions limits their reproductive choices and can have long-term negative consequences for their health and well-being.

The op-eds in this compendium were written and published from 2022 to 2023.

Overturning Roe vs Wade in the US

...Lessons for reproductive justice activists in Zimbabwe



Picture Credit Wikipedia

By Memory Pamela Kadau

On June 22, 2022, the United States (US) Supreme Court overturned the Roe vs Wade decision by a split decision of six to three. The Roe vs. Wade decision was passed by the same Court on January 23, 1973, and ruled that abortion was a right protected by the Constitution of the United States of America (USA) under the Right to Privacy enshrined in the Fourteenth Amendment. The decision to overturn this landmark ruling has allowed States to restrict abortion access entirely.

A Brief History of Roe vs. Wade

To understand the impact the Supreme Court decision of 1973 had on the US legal regime governing abortion, one must appreciate the federal system in the US. The federal system of government allows states to pass legislation in their territories on issues not governed by the Constitution or the national level of government, including abortion. It was one such piece of legislation restricting access to abortion in the state of Texas, which resulted in the Applicant (using a nom de plume of Jane Roe) appealing to the US Supreme Court. On January 23, 1973, in a seven-to-two decision, the court ruled that the US Constitution protected abortion under the Fourteenth Amendment's right to privacy.

The decision meant that all US states had to abide by the court ruling in all matters about abortion. The decision annulled all existing abortion restrictions up to 12 weeks and with some caveats later, so no additional court proceedings are necessary from state to state level. This resulted in a wide array of laws across the US depending on the political power in each state. Conservative-leaning states like Texas had very restrictive laws regulating abortion, while liberal states like New York had regulations making it easier to access abortion. Roe vs. Wade's ruling attracted both acclaim and vicious criticism.

The political left essentially saw it as a significant move in ensuring that women were in complete control of their bodies, which have been subjected to patriarchal control since the Middle Ages, specifically on abortion and contraception. On the other hand, the political right saw it as an attack on conservative ideals that subjected women to stringent cultural/religious controls through patriarchy. For 43 years, the ruling was roundly criticized by conservative politicians, supporters, and media who relentlessly worked to ensure it was overturned. This included the gradual change in the composition of the

US Supreme Court bench, which has leaned to the right in recent years. In 1988 and 1989, Planned Parenthood of South-eastern Pennsylvania v Casey brought suit against the governor, protesting the constitutionality of the statutes enacted by Governor Robert Casey, which required that a woman seeking an abortion give informed consent from either parent (when under 18) or husband.

In 1992, the U.S. Supreme Court affirmed 'the basic principle' of Roe vs. Wade, that women have a right to obtain an abortion before fetal viability but rejected Roe's trimester-based framework. However, both Planned Parenthood v. Casey and Roe vs. Wade were overturned by the Supreme Court in 2022.

So, when the decision to overturn the ruling was passed on June 22, 2022, the conservative politicians and media saw it as a victory for their cause and celebrated. The US states now retain the right to regulate abortion.

This discussion examines lessons for abortion advocates, women rights activists, and feminists in Africa, drawing lessons from the Roe vs. Wade case. Many may ask how a court decision made thousands of kilometers across the Atlantic Ocean affects abortion advocates, women's rights activists, feminists, and/or Sexual and Reproductive Health Service Providers on the continent, specifically in Zimbabwe. The lessons below will demonstrate the answer to this question.

Power structures still seek to control women's bodily autonomy

Women pushing against societal power structures have driven many of the historical struggles for emancipation and freedom. These power structures are the main tools of the patriarchy, which continues to define gender and social relationships in most of the world today.

Women leaders of the Suffragette movement of the 20th century advanced the cause of women's right to vote. Today, millions of women across the world enjoy this right oftentimes as if it has always been this way. Until the early 20th century, the majority of women globally did not enjoy this right and in Zimbabwe, women only got the right to vote in 1980. While the Suffragette movement was based mainly in the Global North, its impact reverberated worldwide, demonstrating the power of globalisation in spreading the influence of progressive and regressive ideas. Many other movements have continued to push for women's emancipation in all aspects of life. One area that has remained a sticking point is bodily autonomy and integrity.

The ability to determine when to give birth is an important aspect of women's bodily autonomy, yet power structures in many societies, are determined to control this choice. This is an important lesson to draw from the overturning of the Roe vs. Wade decision by the US Supreme Court. It is further evidence for women and feminists around the world that the struggle is far from over.

Rights work

A few years ago, Sexual and Reproductive Health Rights (SRHR) practitioners witnessed the chilling effect of the Global Gag Rule across the world. Women were denied access to contraceptives and forced to seek unsafe abortions, triggering a rise in maternal mortality rates due to unsafe abortions in our backyards. In addition, the Global Gag Rule resulted in many Non-Governmental Organisations (NGOs) losing funding, meaning that they could no longer sustain their work. Women and girls had nowhere to go for safe confidential Sexual and Reproductive Health (SRH) services.

Consequently, the overturning of Roe vs. Wade will likely affect the access to sexual and reproductive health services and the enjoyment of these rights in the same way. It can also influence in-country policies, and undermine and demobilize the work of SRHR advocates. The reality is that early marriages, child sexual abuse, high maternal mortality, and morbidity are some of the challenges that our communities are still grappling with. The overturning of Roe vs. Wade could push these conversations and work back to the margins in favor of the criminalisation of abortion, supported by religious and cultural inferences, ignoring the root causes of unwanted and unintended pregnancies such as limited access to family planning services, information deficits, contraception failure, rape, incest, etc.

Gains can be reversed

The 1973 Roe vs. Wade ruling represented a step toward enshrining the bodily integrity of women and the right to determine when to give birth in law. Few would have imagined then that a sustained pushback by conservative groups would result in its overturning 43 years later. What this shows is the fragility of gains made in the struggle for women's total emancipation. Conservative forces that are determined to sustain the status quo can quickly reverse gains made in the struggle. For us in Africa, this means we must be vigilant and stand on guard against relapsing back to the order we have so audaciously pushed back against. It is a stark reminder that what we celebrate today can easily be undone at a moment's notice, especially in countries like Zimbabwe where the democratic deficit runs deep, and institutions are weak. If women's rights activists and feminists fail to continue building solidarity and defending the gains we have made, we may one day, wake up to our version of these regressive decisions. It is time to push forward the conversation on domestic funding, or risk seeing all of our progress reversed by policy shifts at a global level.

Organise, Action, and Organise

While at face value, the overturning of Roe vs. Wade may seem an American issue, a deeper analysis shows that it is a global struggle for women's rights. Women's bodies are still seen as battlegrounds for power structures that are pushing back against the tide of women's emancipation, and if women's rights activists and feminists fail to defend their gains, they will be swept away by reactionary forces. For us in Africa, and specifically in Zimbabwe where our vulnerabilities are exacerbated by intersectionality, the lessons from the US are clear: we must better organize to defend and advance the cause of women's total emancipation now more than ever. The key message is 'continue strengthening and building the movement' to safeguard the gains and continue working on the realization of reproductive justice. **ORGANISE! ACTION! ORGANISE!**

Undermining of Sexual and Reproductive Health

Restrictive Termination of Pregnancy Laws Won't Stop Unsafe Abortions

By Edinah Masiyiwa

As part of my work as Executive Director of Women's Action Group, I have been conducting Value Clarification and Attitude Transformation (VCAT) workshops on abortion. Through them, I have interacted with more than 500 young people, policy-makers, and service providers. It is amazing how every one of the participants has an abortion story to tell. This shows the extent to which women are having abortions primarily unsafe ones. The fact that women are having unsafe abortions was confirmed by a study by the Guttmacher Institute (2016) which revealed that over 65,000 women had induced abortions in Zimbabwe.

An observation I made through the VCAT workshops is that most people think abortion is illegal in Zimbabwe, but that's not true. It is restricted. According to the Termination of Pregnancy Act (1977), abortion is allowed where there has been unlawful sexual intercourse (rape or incest), where the health of the pregnant woman is in danger, and when the foetus is grossly malformed. Most workshop attendees were unaware of the law that should benefit them. Another observation is that even the health workers who are supposed to offer abortion services are not aware of the law that governs the termination of pregnancy in Zimbabwe. A study by Dr. Madziyire et al. showed that only 25 percent of health providers and 47 percent of experts knew all four reasons why abortion is legal in Zimbabwe.

One then wonders why there are no efforts by the government to educate communities on the provisions of this important law that benefits women and girls. So many women have not been able to access safe abortions even if they are allowed to do so under the current law. This is largely due to a lack of information as well as the administrative barriers that exist.

With the recent judgement overturning *Roe vs. Wade* in the United States of America, many voices have called for access to safe abortion for women. This is because restrictive laws on abortion will not stop women from terminating their pregnancies. There is evidence that restricting access to safe abortion harms women's health. According to the World Health Organisation (WHO), 23,000 women die from unsafe abortions each year, and tens of thousands more experience significant health complications globally. Zimbabwe is no exception to these complications brought about by unsafe abortion.

Despite the restrictions on access to safe abortion in Zimbabwe, the Ministry of Health and Child Care (MoHCC) has put in place a post-abortion care programme that offers care to women who have had abortions, safe or unsafe. There is an extensive network of health institutions providing post-abortion care, but many communities are unaware of this programme, as revealed in a study by Women's Action Group (2017). The provision of complete post-abortion care treatment is essential to reduce maternal morbidity and mortality due to unsafe abortion.

TITLE 15

TITLE 15

Chapter 15:10 PREVIOUS CHAPTER

TERMINATION OF PREGNANCY ACT
Acts 29/1977, 6/2000, 8/2001, 22/2001

ARRANGEMENT OF SECTIONS

PART I
PRELIMINARY

Section

1. Short title.
2. Interpretation.
3. Prohibition of termination of pregnancy otherwise than in accordance with this Act.
4. Circumstances in which pregnancy may be terminated.
5. Conditions under which pregnancy may be terminated.
6. Appeal against refusal of superintendent to give permission.
7. Emergencies.
8. Information to be forwarded to Secretary.
9. Report by Secretary.
10. No person to be required to participate or assist in termination of pregnancy.
11. Fee to be as prescribed.
12.
13. Regulations.

[repealed by Act 22 of 2001, with effect from the 20th May, 2002]

AN ACT to change the law relating to abortion by defining the circumstances in which a pregnancy may be terminated and to provide for matters incidental to or connected with the foregoing.
[Date of commencement: 1st January, 1978.]

1 Short title
This Act may be cited as the Termination of Pregnancy Act [Chapter 15:10].

2 Interpretation

(1) In this Act—
“designated institution” means a State hospital or such other institution as may, in terms of subsection (3), be declared to be a designated institution for the purposes of this Act;
“foetus” includes an embryo;
“medical practitioner” means a medical practitioner who is registered in terms of the Health Professions Act [Chapter 27:19] as a medical practitioner;
[amended by Act 6/2000 with effect from the 2nd April, 2001.]
“Minister” means the Minister of Health and Child Welfare or any other Minister to whom the President may, from time to time, assign the administration of the Act;
“pregnancy” means an intra-uterine pregnancy where the foetus is alive;
“Secretary” means the Secretary of the Ministry for which the Minister is responsible;
“superintendent”, in relation to a designated institution, means the medical superintendent of a State hospital or the person specified, in terms of subsection (3), to be the superintendent of any other designated institution;
“unlawful intercourse” means rape, other than rape within a marriage, incest or sexual intercourse in contravention of section 4 of the Sexual Offences Act [Chapter 9:21].

www.yumpu.com

According to the International Planned Parenthood Federation (IPPF), almost all abortion-related deaths occur in low-and middle-income countries, with the highest number occurring in Africa. This includes Zimbabwe, where abortion is one of the leading contributors to maternal deaths. Unsafe abortion has been called a “forgotten emergency” because no one wants to talk about it, even though women dying from complications.

It is not surprising that there was not much debate about the *Roe vs. Wade* case in Zimbabwe. This is because women's health is not prioritised, especially in the lead-up to the 2023 elections. However, women's health has become a political issue and is finally getting the attention needed for women to access quality reproductive health services.

Awareness raising on abortion issues is essential, as safe abortion saves lives. With accurate information, women can make informed decisions about their bodies and health. Awareness raising can also help to address the stigma surrounding abortion. I saw this first-hand when I observed a shift in attendees' mindsets at the end of the 10 VCAT workshops. The VCATs have provided a safe space for open discussion about abortion.

The recently published WHO guidelines highlight the following as the three cornerstones of an enabling environment for abortion care: 1. Respect for human rights including a supportive framework of law and policy. 2. Availability and accessibility of information, and 3. A supportive, universally accessible, affordable, and well-functioning health system.[1] Again, we see the importance of information.

I hereby call on the government of Zimbabwe to ensure that all laws passed are disseminated effectively to the intended beneficiaries. I also call on civil society organisations, particularly those that promote women's rights, to disseminate information about the new laws. This will allow people to critically examine the laws and offer recommendations for effective implementation.

The government should also consider decriminalizing abortion, as recommended by the WHO. This should be done in conjunction with educating health workers on the Termination of Pregnancy Act. This will create an enabling environment for access to safe abortion, which will help to reduce maternal mortality ratio.

The Politics of the Uterus

By Mufaro Musiyazviriyo

The term “*abortion*” generally makes people uncomfortable.

In my work as a Sexual and Reproductive Health Rights (SRHR) Program Officer, oftentimes, I conduct awareness-raising trainings and focus group discussions on SRHR issues with young women and girls in tertiary institutions and communities, where incidents of unsafe abortions have been reported. I have made it a habit to begin my introductions by mentioning the term abortion publicly, in a loud tone. The observations I make of people’s expressions and immediate reactions to the word are quite interesting (I do need to invest in a less odd pastime). A quick survey of the faces and expressions in the room will denote displeasure and discomfort. Unease. Shock. Surprise. A sort of Agitation. Disagreement. A glance in my direction and immediately, eyes cast down to the earth, for how does one look in the eyes of one speaking such

found that over 300 young women out of the 500 trained in 2022 do not have information on abortion. A more specific evaluation of this fact has shown that the information is lacking from the very understanding of what abortion is (in terms of process, occurrence, and procedure) to the legal provisions that are stated in the Termination of Pregnancy Act of (1977). The majority of training participants perceive abortion as murder or killing. This belief stems from two reasons: the literal dictionary definition and religious fundamentalism.

What is Abortion/ Definitions of Abortion

The lack of information stems from the failure to understand what abortion is. I have observed in the training sessions that participants engage in a debate over dictionary definitions of abortion. Literature shows that existing definitions of abortion vary and there is often controversy surrounding what abortion means, as the definitions reflect not only scientific knowledge but social and political opinion. A dictionary explanation of abortion describes it as the expul-

based on different scenarios, thus making it difficult to allude to it as killing or murder. Therefore, in an analysis of definitions of the term abortion alone, I recommend using more extensive and scientific descriptions to paint a broader perspective of abortion that does not relegate it to the negative conclusion that it is an act of murder. Raising awareness in this way can effectively address the lack of accurate and comprehensive information on the subject and subsequently attract less discrimination towards the procedure or those who seek the service.

Awareness Raising about the Legality of Abortion

A research paper published by McKenzie and Magondiwa (2019) shows that at least one in every 10 people is aware of the legality of abortion in Zimbabwe. However, the majority believe that it is illegal and attracts jail time. This belief is likely because they have seen poster signs in the streets of Harare, both residential and industrial, that label abortion as murder or crime. These stern warnings have been



Picture Credit Yahoo Finance

profanity openly? Hence, this alludes to the popular connotation that people are generally uncomfortable conversing about abortion, despite the context of the subject matter.

My observations and findings have shown that these behavioural tendencies are influenced by values, attitudes, prior experiences, and beliefs. These have significantly contributed to and impacted the notable gap in awareness and knowledge of abortion-related issues by young people. Additionally, they have fuelled societal stigma and discrimination towards the phenomenon and those who have or wish to seek medical services. Research conducted by the National Library of Medicine in 2018 shows that Zimbabwe has one of the highest maternal mortalities in the world and the Guttmacher research in 2016 stated that over 65 000 women had induced abortions.

One of the teaching tools we use is the “Cross the Line Activity,” which is used to measure how many people in a room know about abortion and its legality in Zimbabwe, and how many are affected by moral, societal, and/or religious values and attitudes when it comes to abortion. Using this activity on the programs we have conducted with university students, we have

sion of a fetus from the uterus before it has reached the stage of viability (Britannica 2022).

The data I have gathered from focus group discussions show that this is the most popular definition of abortion. Furthermore, literal translation and interpretation of the definition, based on the (...before it has reached the stage of viability), support the popular belief that conducting an abortion is carrying out murder or killing, hence explaining the intended or unintended discrimination against the act and towards those who have carried it out.

According to a fact sheet by the World Health Organisation (WHO 2021), abortion refers to pregnancy termination before 20 weeks gestation. An extension of this definition specifies abortion as an essential health care service (WHO 2020), which encompasses care related to miscarriage (spontaneous abortion), induced abortion (the deliberate interruption of an ongoing pregnancy by medical or surgical means), incomplete abortion as well as fetal death (intrauterine fetal demise). The difference between the two definitions noted above is that the latter is more extensive in scope and offers a more scientific explanation and findings show that this makes it less popular.

Due to its more explanatory nature, the definition by WHO can be interpreted to speak on abortion

internalised by the people, without sound knowledge of the legal environment that supports these warnings.

Results from research-based discourse with Zimbabwean citizens on the legality of abortion in the country show that the majority believe that termination of pregnancy is illegal. When asked where they base this belief, they allude to the warning posters and oral modes of communication that have been passed down from generation to generation. To remedy this, one of the more feasible remedies would be to conduct structured training to raise awareness of the Termination of Pregnancy Act of Zimbabwe of 1977.

Vigorous publicising of this law will ensure that people know the lawfulness of abortion and the grounds for its legality. This will address issues of fear related to speaking about abortion, abortion-related stigma as well as instances where unsafe abortions of pregnancies conceived unlawfully are terminated using unsafe abortion methods. Furthermore, the lawfulness of seeking abortion services will result in knowledge generation of where the services are accessed, the timeliness of accessing the services, and how these can be accessed. The overall effects of this on the lives of young women will be to reduce the frequency of unsafe abortion practices and consequently reduce maternal mortality rates.

Abortion and the moral dilemma; the contradictions of policy and practice

By Memory Pamela Kadau

Moral dilemmas are situations in which an individual is faced with two conflicting ethical decisions, neither of which overrides the other. Middle-ground anti-abortionists often cite the moral dilemma as the reason why a definitive position on abortion cannot be reached. This article will look at the middle-ground challenge of the moral dilemma as it relates to abortion in the context of Zimbabwe.

Abortion in perspective

An abortion is the early termination of a pregnancy, which can happen spontaneously, for instance, a miscarriage, or can happen when the pregnancy is ended by medical or surgical means. The World Health Organisation (WHO) defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards or both. A safe abortion 'is a procedure that is completed with a method recommended by WHO, that is appropriate to the pregnancy duration, and when the person completing the abortion has the necessary skills (whether provider- or self-managed) and the environment meets established medical standards.'

WHO estimates that one in every four pregnancies ends in abortion, representing 25 percent of all pregnancies, globally. Medicins Sans Frontieres (2020) reports that there has been a major decrease in most leading causes of maternal deaths worldwide over the past two decades. However 'one glaring exception remains: 'unsafe abortion'. MSF reports that estimates put the number of unsafe abortions each year at over 25 million, with 97 percent of them being recorded in developing countries; leading to at least 22,800 deaths and millions of serious complications.

In Zimbabwe, the Parliamentary Portfolio Committee on Health and Child Care estimated that abortion stood at 80,000 cases per annum in 2019. These statistics also corroborate with findings of research conducted by Gutmacher on abortion in Zimbabwe in 2016, which found that an estimated 66,800 induced abortions occurred in Zimbabwe. This translates to 18 abortions for every 1000 women aged 15-49.

These global and national statistics show that if anything, safe abortion is a basic healthcare need for millions of girls, women, and others who become pregnant worldwide. Yet globally, only 50 countries

have changed their legal and policy frameworks to allow increased access to safe abortion and Post Abortion Care (PAC). This low number of countries changing their legal and policy frameworks means that for millions of women and girls, access to safe abortion is elusive. This forces them to engage in unsafe and illegal abortions which expose them to devastating health complications including death.

Abortion legal framework in Zimbabwe

In Zimbabwe, abortion is regulated by the 1977 Termination of Pregnancy (TOP) Act, which provides for abortion under very specific circumstances. The law provides for four conditions as follows:

- (i) To preserve the physical health of a woman – when a medical practitioner certifies that a pregnancy is a high risk and likely to compromise the health of a woman or even cause death, abortion is allowed.
- (ii) In case of rape – when a woman has been impregnated following an incident of rape, they are allowed by law to terminate the pregnancy.
- (iii) In case of incest – this is when sexual activities between two people too closely related, like a brother and sister, resulting in pregnancy, then such pregnancy can be terminated by law.
- (iv) In case of foetal impairment – where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that they will permanently be seriously handicapped.

These are the only four legally recognised situations for which abortion is provided. The limited scope of this legislation means that very few abortions out of the close to 100,000 that occur in Zimbabwe per year are within the law. The majority of abortions occur in unsafe ways, such as backyards or using traditional methods. Women and girls choose abortion for a variety of reasons such as mental health, contraceptive failure, pressure or lack of support from a partner, lack of preparedness, poverty, social pressures, economic challenges, and career choices among others.

Criminalising abortion will not stop abortion

Legal efforts to prevent women and girls from accessing safe medical abortion have done nothing to stop abortion. The effect of criminalisation has been to push women and girls to seek unsafe means to access abortion.

These unsafe abortions often result in lifelong medical challenges for women and girls or even death. News agencies and NGOs report extensively every year on 'backyard' abortion-related deaths and

the figures are shockingly very high. According to the Zimbabwe Demographic Health Survey (ZDHS 2015), maternal mortality rate reduced from 651 per 100,000 live births to 462 deaths per 100,000 live births (MICS 2019). Despite the reduction, the maternal mortality rate is still unacceptably high. Unsafe abortion is the fifth leading cause of maternal mortality in Zimbabwe. Legalising abortion would save lives. It would give women and girls access to safe and legal abortion services, which would reduce the number of unsafe abortions and maternal deaths. However, there isn't much conversation on this, and legislation remains limited, restricting women and girls from accessing safe legal abortion services.

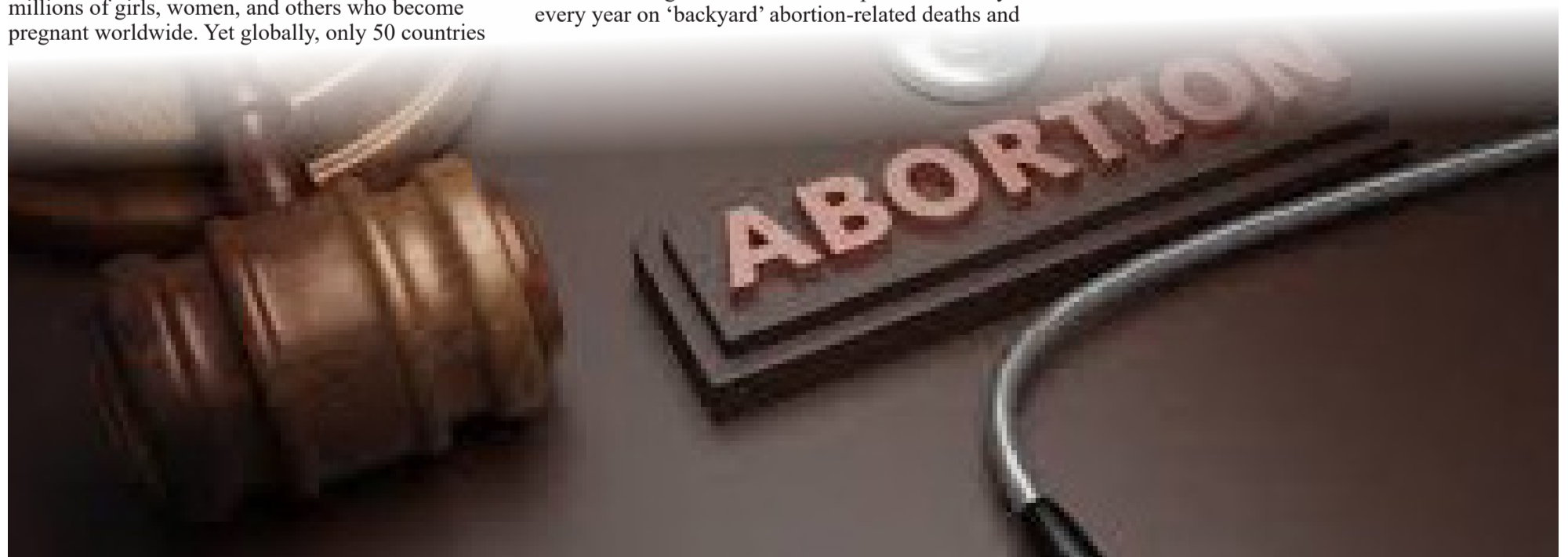
In addition, these figures could be the tip of the iceberg as most 'backyard' abortions go unreported. Women and girls who find themselves with unintended pregnancies will almost always seek to terminate even if the law does not recognise their rights. This is absurd as laws must work for the people and the number of abortions shows that it must be provided for by law. Moreover, abortion touches on the fundamental rights of privacy and dignity of women which the State ought to respect, protect, and uphold.

Knowledge and attitudes towards abortion among healthcare providers and experts

A 2019 study by Madziyire et al in the Pan African Medical Journal explored knowledge and attitudes towards abortion by healthcare providers and experts in Zimbabwe. The study interviewed a total of 227 participants, and its findings showed that 25 percent of providers and 47 percent of experts knew all the four reasons above why abortion is legal in Zimbabwe. This means that there is a big gap in knowledge and attitudes which poses contradictions between policy and practice regarding abortion as genuine legal cases can be denied. If those at the point of provision lack enough knowledge and show attitudes that are inconsistent with legal provisions, it only makes access to abortion services very difficult for women and girls needing them.

Furthermore, an investigative story by Anadolu Agency in September 2021 reported that even registered doctors and medical workers participate in abortions, earning between US\$150.00 to US\$200.00 per month. This shows that even within the health sector, the current legal framework premised on the middle ground approach, is not effectively addressing the issue of abortions and it is time policy comes through to fully address this major health issue..

From the foregoing, it is clear that contrary to middle-ground reasoning, abortion is not a moral dilemma but rather a basic health need for women and girls. Evidence from the numbers of 'backyard' abortions, the plight of women and girls suffer as a result of unsafe abortion, and the attitudes and knowledge of health care providers and experts, all point to one conclusion; that Zimbabwe must reform its abortion laws to allow for accessible safe abortion and Post Abortion Care (PAC) and save the lives of women and girls.



Comprehensive Post Abortion Care: An essential Component of Universal Health Coverage (UHC) and Critical for the Attainment of Health-Related Sustainable Development Goals (SDGs)

By Dr Munyaradzi Murwira

In my years of experience working in sexual reproductive health (SRH), the most topical debates include the topics of unintended pregnancies, teenage pregnancies, sexual gender-based violence (SGBV), and abortion among others. Termination of Pregnancy (abortion) is one of the most controversial and emotive issues across the social realm in a conservative society like Zimbabwe. The main thrust of social-cultural discussions in sexual reproductive health is around the prevention of unintended pregnancies thus avoiding the topic of abortion completely. However, the dilemma is when prevention fails, what happens next? The Zimbabwe Demographic Health Survey indicates that 14% of women aged 15-49 have ever experienced sexual violence, and thus are at risk of unintended pregnancy which may subsequently result in abortion.

Globally the World Health Organisation (WHO) estimates that each year, almost half of all pregnancies are unintended. Interestingly Six out of 10 unintended pregnancies end in induced abortions. Although Zimbabwe has one of the most successful family planning programs in Africa, with one of the highest contraceptive prevalence rates in sub-Saharan Africa, there is still a high rate of unintended pregnancies. According to the 2016 Guttmacher report on Zimbabwe, the estimated national unintended pregnancy rate is 70 per 1,000 women of reproductive age. Overall, 40 percent of pregnancies were unintended, and one-quarter of all unintended pregnancies ended in abortion. An estimated 66 847 abortions were performed in 2016, translating to 18 abortions per 1,000 women of reproductive age and most of these abortions are unsafe.

The Magnitude of Abortion in Zimbabwe

The country has one of the highest maternal mortality ratios in the world (525 per 100,000 live births) as per the 2017 Inter Census Demographic Survey. A 2016 study by Madziyire et al indicated that abortion accounted for 9 percent of maternal deaths in Zimbabwe. WHO estimates that almost 45 percent of all abortions are unsafe with a high risk of complications. The most recent source of data in Zimbabwe on the contribution of abortion to maternal mortality is from 2007; at that time, abortion complications were one of the top five causes of maternal mortality. It is extremely difficult to accurately capture maternal deaths associated with unsafe abortion, especially in contexts where abortion is highly restrictive and stigmatized. A 2013 report compiled by NGOs in Zimbabwe revealed that more than 20,000 women die each year because of unsafe abortions. National Health and ZIMSTAT reports show that abortion is one of the top ten in-patient causes of illness in Zimbabwean hospitals.

A Lancet report by Grimes in 2006 indicated that although unsafe abortion is a significant contributor to morbidity and mortality among women of reproductive age, the evidence base on the consequences of unsafe abortion is limited. The annual cost to health systems of providing post-abortion care (PAC) is higher than the preventive costs of safe abortion. The costs of treating unsafe abortions and their complications consume significant resources for women, their families, and the nation. It costs more to treat someone who has had an unsafe abortion than to provide a safe abortion. The cost of hospital admission, antibiotics, uterus cleaning, blood transfusion, and recurrent costs for seeking treatment are astronomical. The socio-economic impact of abortion on girls and women is immense. The woman who would be a source of support for her children and family, suddenly faces an endangered future. Productivity is reduced

due to illness and recurrent hospital visits. Several other lives could be saved if fewer medical resources were applied to provide safe abortion rather than to redress the complications of unsafe abortion that are costly.

Termination of Pregnancy in Zimbabwe

The Termination of Pregnancy (ToP) Act of Zimbabwe was enacted in 1977 by the Parliament of Rhodesia and was retained after Zimbabwe's independence in 1980. The ToP Act has not been reviewed since then. The ToP Act spells out three circumstances in which pregnancy can be terminated; (1) Unlawful intercourse – rape or incest, (2) To save the woman's life, and (3) In the case of serious foetal anomaly up to 22 weeks of gestation.

Access to abortion services in Zimbabwe is

“The country has one of the highest maternal mortality ratios in the world (525 per 100,000 live births) as per the 2017 Inter Census Demographic Survey.”

difficult with women currently facing a myriad of challenges. Legal and administrative barriers coupled with stigma among both women and health service providers as well as fear of legal and social repercussions as well as risking imprisonment, are leading deterrent factors for safe abortion. The duration of the process for legal termination of the pregnancy, and the costs associated with legal abortion are so deterrent that some women cannot afford it; others give up while still in the process of obtaining the legal authorisation to terminate the pregnancy. The process for granting termination of pregnancy takes long, leaving the women with the impossibility to abort due to late gestational age. Due to the restrictive abortion laws and high cost in the private sector, most of the unsafe abortions are done clandestinely by herbalists, and community members, and at times by medical practitioners with high risk of complications. Studies indicate that rather than reduce abortion incidence, restrictive abortion laws result in women pursuing clandestine and unsafe abortions.

In a study conducted in 2019 by Concept Foundation, only 19 percent of healthcare providers knew the main conditions under which abortion is legal in Zimbabwe. This massive gap in knowledge shows the importance of ensuring that healthcare providers and the public are made aware of the provisions under which they can currently perform as well as access legal abortion.

WHO defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Making health for all a reality, and moving towards the progressive realisation of human rights, requires that all individuals have access to quality health care, including comprehensive abortion care services. Lack of access to safe, timely, affordable, and respectful

abortion care poses a risk to not only the physical but also the mental and social, well-being of women and girls.

Post Abortion Care Services & Access to Safe Abortion

Universal Health Coverage (UHC) means that all people have access to the health services they need, when and where they need them, without financial hardship. To make health for all a reality, we need individuals and communities who have access to high-quality health services so that they take care of their health and the health of their families; skilled health workers providing quality, people-centered care; and policy-makers committed to investing in universal health coverage. Universal health coverage is based on strong, people-centred Primary Health Care (PHC). Health systems that achieve UHC and the health-related Sustainable Development Goals rely heavily on a solid foundation of PHC. The WHO supports the integration of sexual reproductive health (SRH) services within national Primary Health Care (PHC) strategies to advance progress towards Universal Health Coverage (UHC). To achieve Universal Health Coverage (UHC), the country needs to include PAC as an integral component of Primary Health Care (PHC).

A study conducted on post-abortion care in Zimbabwe showed that 85 percent of cases are treated in the Public Health system with a total of 25,245 PAC patients being recorded in 2016. The study also showed that only 20 percent of Public Health facilities had the basic capability to provide PAC. A Guttmacher report on clandestine abortions in Zimbabwe showed that women seeking PAC reported experiencing substantial delays between being seen at a health facility and receiving complete treatment, often due to lack of money, waiting delays, staffing shortages or staff attitudes, or medicine shortages or inability to get complete treatment at a single facility. The report also indicated that 50 percent of Public Health facilities faced stock-out challenges of drugs and equipment for PAC, thereby severely impacting the efficient delivery of PAC. The private sector do provide PAC services, but can be very expensive with cost fetching as high as US\$400.

Ensuring that women and girls have access to abortion care that is evidence-based, which includes being safe, respectful, and non-discriminatory, is fundamental to meeting the Sustainable Development Goals (SDGs) relating to good health and well-being (SDG3) and gender equality (SDG5). Integrating SRH within PHC for UHC requires both political commitment as well as coherent strategies. The Ministry of Health & Child Care (MoHCC) has made efforts to reduce maternal mortality by improving PAC services; this includes having Post Abortion Care guidelines, supplying drugs, and providing training for service providers.

There is an urgent need to promulgate a Statutory Instrument (SI) to streamline ToP processes (removing Legal and Administrative barriers). Capacity building of service providers on ToP is key to improving access to PAC. The current PAC guidelines should be reviewed to incorporate current WHO best practices. Advocacy for increased awareness of the provision of the ToP Act and the possible review of the Act is required.





Pic by Michael Gwarisa

Abortion policy and the vicious cycle of poverty

By Memory Pamela Kadau

The previous article submitted that abortion doesn't bring about a moral dilemma as middle-ground propagation would argue. Safe abortion services should be made accessible to women, and this demands policy and legal reforms. This article explores how the existing policy framework on abortion perpetuates the vicious cycle of poverty in women and fuels child sexual abuse termed 'child marriages.'

Abortion and poverty

Poverty wears the face of a woman, and the untold story is that hundreds of thousands of women are trapped in poverty because of the existing legal framework for abortion. The Termination of Pregnancy (TOP) Act of 1977, restricts accessibility of abortion services to only a few cases which force many women to give birth even when they lack the financial capacity to cater for the children. The high cost of living and informality of the economy make it difficult for women to obtain gainful employment. According to the Zimbabwe Chamber of Information Economy Associations, 88 percent of economically active women are employed in the informal sector, with the vast majority working in agricultural production. The informal sector has low wages and poor working conditions, and many women working in it live from hand to mouth.

In addition, the majority of women living in poverty lack adequate information on contraceptive methods, which means that they often end up having unwanted and unintended pregnancies. This means that women who are already in poverty tend to have children they cannot adequately support financially, which exacerbates their poverty situation. Children born in poverty lack opportunities to access quality education, especially for girls. This limits their life chances and makes it difficult for them to achieve upward social mobility,

leaving them and their offspring trapped in poverty.

Furthermore, the government's social welfare department is underfunded and cannot therefore support those in extreme poverty. Most women who give birth due to unintended pregnancies often end up as single mothers, lacking support from their partners, and without social welfare support, they live in extreme poverty with their children. Research by UN Women (2018) shows that girls who grow up in poverty are at the highest risk of getting early and unintended pregnancies, which deepens their poverty situation due to the costs of childcare. Most of the women in such situations ordinarily prefer to access safe abortion so they can terminate pregnancies whose resulting child they are unable to adequately care for.

It thus becomes apparent that policies and laws must allow safe abortion services to be accessed by women when they need them, including post-abortion care. More importantly, the State cannot limit the accessibility of abortion services while it cannot provide welfare to women who give birth due to unintended pregnancy.

Correlation between limited access to safe abortion and 'child marriages'

There is a correlation between limited access to abortion services and child marriages. Girls who indulge in sex with older men cannot often negotiate safe sex and this results in unintended pregnancies. Zimbabwe's cultural practices proscribes pregnancies out of wedlock and families routinely send girls who have fallen pregnant to their partners even if they are not interested in marriage. This means that girls who find themselves pregnant are forced to get married and oftentimes, this results in child marriages. These children in forced marriages are generally traumatised because of the abuse perpetrated by their spouses.

If abortion services are legally accessible to these girls and women, then they can avoid such unsavory situations. The existing legal framework on abortion robs women of their dignity, which is guaranteed under various provisions of the constitution and international conventions to which Zimbabwe is a party.

In summation, it is perceivable that existing legal frameworks in Zimbabwe are restrictive on women's reproductive health rights as noted in how existing policy framework on abortion keeps women in the poverty trap, which promotes child sexual abuse termed 'child marriages'. The situation is exacerbated by the high unemployment rates that have resulted in the majority, especially women, making their living in the informal sector that is prone to low production and in-work poverty. Limited access to adequate information on birth control further places women at a greater risk of unintended pregnancies which has a detrimental effect of a bleak future. Also, the failure of the government social welfare program to provide relief in the form of grants further perpetuates poverty for the women who find themselves in unplanned pregnancy situations.

International Safe Abortion Day a time to reflect on progress toward access to safe abortion for women and girls

By Edinah Masiyiwa

September 28, 2022, was International Safe Abortion Day, and the day ran under two themes: “Diverse Actions, Different Places, One Demand: Access to Safe and Legal Abortion Now” and “Abortion in Uncertain Times.”

These themes speak to me as an advocate for sexual and reproductive health and rights, and they give me the energy to continue working on safe abortion access. They communicate that firstly, we will achieve access to safe abortion through working in our different spaces from research, to advocacy, to awareness raising at community and policy level, to service providers. As a country, we have even set up a coordinating structure for non-governmental organisations working on abortion to meet and discuss their work on abortion to ensure women and girls in need of abortion access the service.

In addition, what inspires me within these themes is the fact that we have one demand, which is to have access to safe and legal abortion. This is what I dream for the women and girls of Zimbabwe.

However, Zimbabwe continues to face challenges as we try to advance the abortion agenda, an agenda that could save many women’s lives. The Termination of Pregnancy Act of 1977 still hampers access to legal safe abortion for women and girls in Zimbabwe. The World Health Organisation estimates that in developing regions, there

are 220 deaths per 100,000 unsafe abortions. Zimbabwe recorded more than 66,000 induced abortions, most of which were unsafe, in 2016. Despite the restrictions on the Termination of Pregnancy Act, unsafe abortions are still thriving.

Evidence has shown that even among those who are eligible to access safe legal abortions, some are not doing so because of a lack of information on the law. Even some of the health workers who are supposed to provide abortion services are not aware of the law. This evidence shows that there is still more that needs to be done in terms of awareness raising.

The legal framework also has gaps that were identified through research done by my organisation, Women’s Action Group (WAG) in 2021. The gaps include a lack of guidelines on what each service provider is supposed to do when they come in contact with someone who has been raped, for example. There are no time frames on how long each service provider should take as they attend to survivors of rape and incest. Another gap identified is that there is no obligation on the Investigation Officer to advise a survivor of rape or incest that she can apply to a magistrate for a certificate authorising termination of pregnancy.

The second theme of “Abortion in Uncertain Times” also speaks to the present situation where at times women fail to gain access due to reasons related to issues like COVID-19. The COVID-19 pandemic shook health systems to the core, adding further to the complexity of this topic of abortion. Imposed national lockdowns and movement restrictions affected access to timely abortion for millions of women across the globe.

Natural disasters such as cyclones also predis-

pose women to sexual abuse and this also affects their access to safe abortion. For instance, when Cyclone Idai hit Zimbabwe in 2019, there were cases of men who raped women and girls. There however has been no clear follow-up on these cases as the perpetrators could not be identified. There is evidence that some might have fallen pregnant and were not able to access termination services.

The Roe vs. Wade judgement in the United States has also brought uncertainty on abortion. The gains that have been made in our country around abortion advocacy could be derailed by this judgement. Zimbabwe also held elections in 2023 and unfortunately, some members of parliament who had become champions before the elections were also not convinced to continue conversations on abortions for fear of losing votes during elections.

It is therefore important for those working on promoting access to safe abortion in Zimbabwe to come together as we commemorate International Safe Abortion Day to develop a clear agenda that will ensure women and girls’ access to safe abortion.

Firstly, we need to raise awareness about the Termination of Pregnancy Act and ensure all survivors of sexual violence report to the police. Secondly, we need to ensure there are standard operating procedures for service providers who are in the continuum of care for sexual violence survivors. Thirdly, the Termination of Pregnancy Act of 1977 has lived its life and needs to be changed. There is a need for a law that responds to the current environment in Zimbabwe.



Abortion conversation must recognise women's bodily autonomy and integrity

By Memory Pamela Kadau

My previous Op-ed touched on the legal regime regulating abortion in Zimbabwe having previously established that abortion doesn't pose a moral dilemma. If anything, abortion services are part of the basic health needs for tens of thousands of women each year in Zimbabwe. That the law proscribes safe abortion by choice, limiting it to exceptional cases of medical emergencies, rape, and incest, is an act of injustice that undermines this right. This article will look at the dimension of how existing abortion regulation undermines the fundamental right of pregnant women to bodily integrity enjoyed by all other humans.

Section 51 of the Constitution of Zimbabwe states that "every person has inherent dignity in their private and public life, and the right to have that dignity respected." The constitution further provides for the right to access basic healthcare services, including reproductive healthcare services in section 76. These two sections must be seen in the broader context of protecting the bodily integrity of all citizens and they are further reinforced by international conventions and instruments to which Zimbabwe is a party. Yet pregnant women in this country and the rest of the world, have been denied the right to bodily autonomy and integrity through coercion or violence, even with the existence of such constitutional provisions.

At this stage, dear reader, I must provide working definition/s of bodily autonomy and integrity so that we have a shared understanding of what I am referring to. Bodily autonomy is the right for women to determine their fate without undue policing of their bodies, which is a prerequisite to living a life with dignity (IESOGI, 2021). Bodily integrity refers to the recognition that our bodies are our own, they matter, and we have the right to determine what or who gets access to them.

This bodily integrity extends to sexual and reproductive health issues for which pregnancy is part of, thus pregnant women retain their right to bodily

integrity hence they must have a choice of keeping or terminating it. It is a common cause that pregnancy transforms a woman's body into one that supports another but the body remains hers. This stark reality is often overlooked in anti-abortion political arguments, particularly when that discourse is male-dominated, as is the current situation in Zimbabwe.

However, to understand why this is so, I need to explore a little deeper about pregnancy. For most of human history, pregnancy was not acknowledged or confirmed until the stage of quickening i.e. the moment when a pregnant woman begins to feel the movements of the pre-nate. The term pre-nate is the scientific word that refers to the developing entity as long as it resides inside a woman's body.

This process of a foetus moving occurs well into the second trimester and well after the earlier stages of embryonic development. Until the 19th century, society didn't have the technology to detect pregnancy in the early weeks and while there are indigenous ways of knowing if a woman is pregnant, these only provided knowledge much later in the development of the embryo. It is in this context that any laws, cultural practices, attitudes, and understanding of pregnancy refer to the pregnancy after 15-20 weeks because that is when everyone becomes aware of it. This is why the discourse on abortion excludes scientific evidence which shows that safe abortions can be performed up until week 12 of the pre-nate's development. It is understanding based on our past, yet to move forward, society must embrace the change that science has brought about.

I certainly affirm the dignity of the unborn and acknowledge the bodily integrity of both individuals involved in pregnancy. However, it would be disingenuous to continue talking about abortion as though a woman's body is only related to foetal life. Much of contemporary discussions on abortion suggest as though a woman's uterus is no longer her own when it is nurturing a foetus. This is problematic and raises serious questions: Do pregnant women retain their bodily integrity rights just like all other humans? Do they remain equal to other citizens and therefore able to make their own choices? Do we understand the mental stamina required for a woman to carry a

pregnancy to term?

Now because we have the relevant scientific evidence on pregnancy, women must retain their choice and be allowed by law and policy to safely determine if they want to keep a pregnancy or not. Illegalising abortion impacts negatively the legal status of women. It is fundamentally flawed and hypocritical to recognise foetuses as full persons while women, with the burden to carry and care for the foetuses, lose their rights as full constitutional persons.

If fertilised eggs, embryos, and foetuses are treated as separate persons, the consequences to pregnant women can be grievous. These include losing their rights to life, health, bodily integrity, and medical decision-making, as well as their right to privacy in medical information. A pregnant woman who goes for her first appointment at prenatal care has no privacy or confidentiality in her medical information because she is carrying a separate person, who may be protected by the State. She would have no right to privacy at all upon becoming pregnant. These are far-reaching consequences that should never be imposed on a person without choice as this would amount to a gross violation of bodily integrity and a host of other rights.

Choice is even more critical in developing countries like Zimbabwe where poverty is very high. Research has demonstrated that denying women access to abortion triggers outcomes that have far-reaching consequences throughout their lives, impacting everything from the education years they complete, to how much they earn and levels of poverty. It has also been observed that women who have been denied abortion become mothers who suffer from anxiety, depression, and low self-esteem and this negatively impacts their child's development.

In conclusion, I emphasise the fact that the right to bodily autonomy and integrity is fundamental, even for pregnant women. The State and society cannot use violence and coercion to force pregnant women to keep foetuses against their will when safe scientific termination methods are available. To do so is injustice writ large!



MY BODY IS MY OWN

CLAIMING THE RIGHT TO AUTONOMY AND SELF-DETERMINATION

Picture Credit UNFPA ESARO

Adolescents: The face of unsafe abortion: Time to act



Picture Credit Michael Gwarisa

By Mildred T. Mushunje (PhD)

Background

Abortion is a public health and human rights issue that remains highly stigmatised regardless of efforts to liberalise it. Zimbabwe is one of the countries with high cases of unintended pregnancies among adolescent girls, which contributes to unsafe abortions (ZDHS, 2015), and these account for about 5 percent of maternal deaths (Ministry of Health, 2015). Contrary to populist belief, abortion is permitted under the colonial Termination of Pregnancy (ToP) Act of 1977, which allows for abortion under the specific circumstances of rape, or incest and to save the woman's life or preserve her physical health, or foetal impairment. Adolescents are defined by the World Health Organisation (WHO) as those between the ages of 10-19 years and young people as those aged between 10-24 years old. Adolescents account for almost one-quarter of the female population in Zimbabwe, and little is known about their experiences with abortion (Guttmacher, 2021). 22 percent of adolescent females aged between 15-19 years have begun childbearing and 70,000 illegal abortions are performed in Zimbabwe annually, many of them involving adolescents under 16 years old (Guttmacher, 2021).

According to Guttmacher (2016), adolescent girls and women in Zimbabwe had an estimated 45,000 unintended pregnancies in 2016, accounting for 17 percent of all unintended pregnancies in the country. The proportion was also higher among adolescents living in urban areas (53 percent) than among those in rural areas (35 percent). A higher proportion of unintended pregnancies ended in abortion among unmarried adolescents (13 percent) compared with married adolescents (6 percent), and among adolescents living in urban areas (25 percent) rather than rural areas (1 percent). Adolescents in rural areas have lower abortion rates which could be explained by limited information on available SRH services and the provisions of the ToP and forced marriages.

Challenges faced by Adolescents in accessing services

Adolescents are a diverse group and often face a multitude of challenges in obtaining sexual and reproductive health services, one of which is abortion services. Challenges include but are not limited to teenage pregnancies[1], child marriages[2], maternal mortality[3], unsafe abortions[4], Gender based violence[5], and high HIV prevalence[6]. These challenges reflect that sexual reproductive health constitutes an important aspect of public health. Attitudes and social norms have negatively impacted the advocacy agenda for SRHR services and safe legal abortions. Adolescents' ability to meet their reproductive health needs is often determined by factors such as marital status and urban or rural residence (Guttmacher, 2021). Barriers that keep adolescents from meeting their sexual and reproductive health care needs put these young girls at risk for unintended pregnancy and increase the chances that they will need to seek an abortion, which in most instances is unsafe. The limited/restricted access to SRH services for adolescent girls and young women is one of the leading causes of clandestine abortions.

Consent confusion:

Age of consent to services, though meant to protect children against sexual abuse and child marriages should not be used to deny adolescents SRHR services for those who require them. According to demographic health data for Zimbabwe, nearly 40 percent of girls and 24 percent of boys are sexually active before they reach the age of 18. A series of inconsistencies in the country's legislative and policy framework related to sexual and reproductive health has contributed to significant confusion over whether people below the age of 18 need parental consent to access sexual health services. The limitation of access to sexual and reproductive health services to persons above 16 years of age is often linked to the age of sexual consent, which in Zimbabwe was set at 16 by the Criminal Law (Codification and Reform). The recent Zimbabwe Constitutional Court ruling suggests that the legal age of sexual consent should be increased from 16 to 18 years old. The notion is that a person under the age of 16 cannot legally have sexual intercourse and, therefore, can only access SRHS with a police report or adult company. If a child under the age of 16 years cannot legally con-

sent to sexual intercourse at law, it is then presumed that a child under the age of 16 years does not need contraceptives or other SRHS, which is a belief that prejudices adolescents and has resulted in unintended pregnancies amongst adolescents. In Zimbabwe, the push to remove age restrictions on access to sexual and reproductive health has been conflated with the lowering of the age of consent. This confusion is compounded by various circles that advocate raising the age of sexual consent from 16 to 18, in line with the constitutional provision that only people aged 18 and above are allowed to marry. The conflation of sexual consent and the age of marriage, informed by cultural and religious attitudes, has negatively impacted adolescents' access to SRHR services further pushing them to clandestine abortions.

A Call to Act

It is imperative that stakeholders prioritise the protection of adolescents from unsafe abortions by:

- Removal of age restrictions in accessing reproductive health services by adolescents, to enable them to access prevention tools, which protect them from unintended pregnancies and unsafe abortions.
- The age of consenting to sexual activity and the minimum age of marriage should not be linked to the age at which adolescents can access sexual and reproductive health information, education, and services.
- Urgent review of the outdated ToP and consideration of the expansion of circumstances for a termination of pregnancy.
- Awareness raising and sensitisation on the right of adolescents to access sexual and reproductive health information and services.
- Provision of age-appropriate Comprehensive sexuality education which goes beyond abstinence-only approaches.
- Make SRHR services accessible and affordable to adolescents.

Values clarification workshops to improve abortion knowledge and attitudes: Post-assessment

By Mufaro Musiyazviriyo

The Termination of Pregnancy Act of 1977, states that it is illegal to terminate a pregnancy unless it has been sanctioned by Government authorities which includes, the court and state hospitals agreeing that the pregnancy in question was as a result of unlawful intercourse (rape/incest). The Act also allows for termination of pregnancy if the pregnancy endangers the life of the woman, or the child to be born will suffer from a physical or mental defect of such a nature that they will permanently be seriously handicapped.

Despite the law allowing for termination under certain circumstances, there have been incidents where abortion was supposed to be allowed by the Government authorities but the bureaucratic procedures led to some women giving birth, some suffering impairments, and in worst cases, succumbing to unsafe abortion complications.

Nokutenda Hwaramba (15), Memory Machaya (14), and many other young girls whose stories are unknown because they never got public attention died due to pregnancy-related complications despite the law recognising that children below the age of 18 cannot consent to sex, rendering their pregnancies products of unlawful intercourse.

The majority of women who opt for unsafe abortions, which sometimes turn fatal, know that their fate, demise, and future are yoked on a piece of legislation that was promulgated in 1977. Some of these women are unaware of this legislation and to their knowledge, abortion is not permitted in Zimbabwe as was shown by the signs that were hung on trees on the streets of Harare stating that, “**ABORTION IS A CRIME**” or “**ABORTION IS MURDER.**”

The Ministry of Health and Child Care introduced the post-abortion care guidelines which allow women and girls to receive post-abort care at any state health institution without being questioned. These guidelines were set after noticing that the cause of the high number of maternal deaths was because of unsafe and illegal abortions occurring in the country.

Civil society groups and other organisations have been tireless in pleading with policymakers to look into the Termination of Pregnancy Act of 1977 and make it more responsive to the needs of women. These efforts by human rights advocates are commendable and have helped to break the taboo around abortion in Zimbabwe and start a public conversation about this important issue. These conversations have opened up so many opinions from the public, with most of them acknowledging that abortions are happening in their respective communities, but some are not willing to have abortion legalised, fearing that it would erode social norms.

These conversations show that restructuring the abortion laws alone is problematic as it ignores important aspects and conditions in which women can seek termination of pregnancy. A typical example is that of South Africa which has a progressive legislation governing access to abortion services, but this has not translated to positive results on the ground. South Africa still has many cases of unsafe abortions (Jewkes, Brown, Dickson-Tetteh, Levin & Rees 2002). The silence around abortion as well as experiences of ostracisation among women who have terminated suggest that stigma is still very high and that it still plays a role in abortion practices and experiences, as well as reproductive decision-making.

The Royal College of Obstetricians and Gynaecologists under the Making Abortion Safe (MAS) enrolled champions to address unsafe abortions in Zimbabwe, Rwanda, Nigeria, Sierra Leone, and Sudan. The selected champions took part in the value clarification attitudes transformation (VCAT) training using the Ipas toolkit at the beginning of the project. The value clarification theory was inspired by the



Pic: Credit Michael Guarisa

field of humanistic psychology led by thinkers such as Abraham Maslow and Carl Rogers, who believed that people are responsible for discovering their values through honest, open-minded self-examination. According to UNESCO 2006, it is a technique that encourages people to relate their thoughts and feelings to enrich their awareness of their values.

Zimbabwe champions took up the VCAT approach to start conversations on making abortion

safe in Zimbabwe. The discussions largely dwelled around, the myths and misconceptions

around abortion, legal literacy on abortion, how socialization has an impact on one's

values, and exploring religious and cultural arguments on abortion. The VCATs were conducted

in universities across Zimbabwe targeting young learners and communities targeting parents

and custodians of culture.

The most popular description of abortion from the participants during the VCATs was the terming of the procedure as “killing of an unborn baby” hence the need for a discussion on language and correct terminology. A popular debate arose consistently in the VCATs conducted on the difference between the terms unborn baby and foetus, with the majority of the participants, particularly young women arguing that once one instantly got pregnant, life would begin to form in a woman's womb.

This debate was backed up by biblical knowledge with some participants quoting and reading out bible verses that described life. They argued that abortion is killing, and therefore wrong. In an interesting discussion with the young people, one quoted the bible saying that “children are gifts from God”. Another young man responded, “Can a gift come from a sin?” he argued that fornication is a sin, and many of the people who seek termination of pregnancy do so because the pregnancy is the result of pre-marital sex. An analysis of that discussion showed that the values many of the young people had on abortion were rooted in religious beliefs and moral upbringing.

Some of the reservations on abortion included the belief that involving women's rights in terms of choice and bodily autonomy is a direct abuse and misuse of the right. One of the young women questioned why abortion was only being centred on women's rights and not men's rights as women were only mainly ‘responsible for carrying the pregnancy to term but the pregnancy had an “owner” who has more

rights over what happens to that life’. The term that was given to describe that in the local Zimbabwean language was ‘samusha’ which ‘owner of the home or head of the household’ in vernacular, and this is represented by the male figure in that home. Many young women agreed with this to a larger extent. This shows how deeply young girls are entrenched in patriarchal values from birth, which hinders them from making decisions.

Cross the Line activity is one of the activities conducted during the Value Clarification in Action Training (VCAT) program, which directly interrogates the different values and beliefs of individuals towards abortion. About whether it was killing, at least 95 per cent crossed the line, confirming that their reasoning was based majorly on biblical standing. An analysis of this activity showed that many young people were sexually active and understood the task and responsibility of parenting a child, but they feared societal judgment associated with abortion more than anything else. Another observation was that many young people would neither cross the line nor stay where they were but instead remain in the middle, showing how conflicted they are between their understanding of rights, the need for termination, and their values and beliefs.

In another activity during the VCATs, one young person admitted to breaking a friendship with one of the students who had been known to have had an abortion. She stated that she did not mind playing with her friend, but when the story became public knowledge, she distanced herself for fear of being put in the same category. She went further to say that other young women would rather die than live with the shame of being known to have committed such a taboo act, as they cannot stand the name-calling and finger-pointing.

The legal framework that governs abortion in Zimbabwe is a huge barrier to women accessing health-care services, infringing their constitutional rights as stated in section 76 (1). However, it is important to note that abortion is regarded as a taboo, and anyone who is known to have had an abortion faces so much stigma, shame, and isolation within the community. This forces many women to have clandestine and unsafe abortions. VCATs are important and need to be conducted consistently as conversations continue to happen with policy-makers for more liberal legislation. Otherwise, we will have another law that does not serve its purpose. VCATs can also be used with policymakers, and healthcare providers as we prepare for a shift in the law governing abortion.

Going beyond the Legal Framework on Abortion to Save Lives of Women and Girls

By Edinah Masiyiwa

The death of Nokutenda Hwaramba, a 15-year-old girl who died at a shrine while giving birth, is a stark reminder of the dangers that pregnant girls face in Zimbabwe. Like many other pregnant girls giving birth in shrines, Nokutenda's life was cut short for preventable causes, and this angers me so much. One reason girls like Nokutenda do not deliver safely in a health center is "church doctrine," which leaves them under the care of untrained religious people.

It is concerning that such a doctrine is still allowed in Zimbabwe, a country that has signed the Maputo Protocol, which highlights the need for institution delivery. As a country, we popularised the slogan, "No woman should die while giving birth." Yet, Zimbabwe is not following the necessary steps to ensure the safety of pregnant women and girls.

According to the Constitution of Zimbabwe Section 76 (1), "Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services."

However, the Public Health Act of 2018 is not

particularly explicit, but its Section 35 has been interpreted to mean that children – defined as persons under the age of 18 – require parental or adult consent to access medical health services. This means Nokutenda's parents her to the hospital for delivery, but they chose to take her to a church shrine.

I was deeply disturbed by the arguments put forward by some members of the apostolic sect about why delivery should happen at shrines instead of hospitals during a survey carried out by UNICEF. Their responses included; "People are just like animals. Animals can give birth without any assistance. So, this issue of specialist medical personnel is not necessary. Birth is a natural process,"

"Once a pregnant woman goes to the clinic, it shows that one does not have faith in God".

It is astonishing that such beliefs still exist in the 21st century. Despite these harmful beliefs, some parents still bring their pregnant daughters to these leaders instead of taking them to hospitals, resulting in their daughters suffering and even dying.

Additionally, Nokutenda should have had access to termination of pregnancy, as she was a minor who had been raped. This is one of the reasons allowed under the Termination of Pregnancy Act (TOP)

(1977). The Constitutional Court recently put the age of consent to sex at 18 years. Unsurprisingly, her parents might not be aware of the provisions of this law, as it is shrouded in secrecy, and talking about abortion is seen as taboo. However, termination of the pregnancy could have saved Nokutenda's life, as it would have been done safely under the supervision of medical practitioners.

Despite the legal framework that outlaws having sex before 18 years, the Multiple Indicator Survey (2019) revealed that 4.6 percent of girls had sex before 15. When I look at the legal framework, it is clear that there is a will to protect young girls, but the practice is a different story.

Young girls are not protected at all and this needs to change.

Firstly, we need to ensure the implementation of the laws and policies that can protect young girls. Indeed, I have had the opportunity of visiting waiting mother's shelters in Zimbabwe, and most of the pregnant "women" are adolescents. This is also supported by reports in 2021 which indicated that teen pregnancies are on the rise with the government reporting more than 4,000 pregnancies in January and February of that year.

As citizens, we must raise our voices to ensure awareness of laws, such as the ToP, among girls and their families. We need to ensure adolescents have access to sexual and reproductive health services. We might want to deny the fact that adolescents are sexually active, but they are. Let us all work together towards reducing teenage pregnancies.

Secondly, churches should not be left to do what they want in opposition to the laws. Right now, it looks like nothing much is being done about this issue by our government. Instead, our political leaders have addressed the members of Apostolic Faith churches with other messages and notably said nothing about this. If our President would give a directive that no woman should deliver in the shrines, I am sure this would go a long way in reducing pregnancy-related deaths.

Thirdly, there is a need for a targeted intervention such as a mass media campaign that will save people from dying from pregnancy-related complications, particularly where access to safe delivery is denied because of religious beliefs.

Our norms as a society need to be questioned if we are willing to let girls die in shrines.

**SAFE ABORTION
SAVES LIVES**

Unsafe Abortion

The Hidden Health Crisis



Women demonstrate unsafe abortion through drama: PIC CREDIT KATSWE SISTERHOOD

By Dr Munyaradzi Murwira

In the early years of my medical career, it was always exciting to start a new role in the various medical specialties at a Central Hospital. As such, I was looking forward to the experience of working in the Obstetrics and Gynaecology department. However, my first Gynaecology department night shift was a baptism of fire. I was greeted by a scene of chaos in the emergency ward, with multiple sick women lying on stretcher beds and the floor awaiting my help. It was a horrific experience to see both young and mature women crying, writhing in agony, and covered with blood-stained garments.

This article explores the horrors of unsafe abortion and the realities faced by women and health workers in Zimbabwe, particularly about post-abortion care services. This opinion piece will also demonstrate the challenges faced by many health personnel dealing with women suffering from complications of unsafe abortion. I will also discuss the dilemma of coming from a Christian background and the conflict of societal values versus the professional calling of providing services to everyone presenting for health care regardless of their social status, race, ethnicity, or health condition.

I was astounded by the magnitude of suffering being experienced by women from all walks of life, including married and unmarried women from across the reproductive age. Back then, we were very fortunate to have experienced medical personnel to provide guidance and mentorship. Senior staff in the department were able to calm me down indicating that this was the norm and there was nothing unusual about the

situation. These women usually present late at night or in the early hours of the morning seeking post-abortion care services at public hospitals, often in desperation.

I did not realise then, that abortion was such a serious public health issue with women resorting to extreme measures to get rid of unwanted pregnancies. The types of items and substances that are used to achieve this goal by the women range from chemicals to physical objects (of various forms, shapes, and sizes). Believe me, it was a very traumatic experience to deal with very sick women with complications ranging from severe infections to perforated internal organs (uterus, bladder, and intestines). The Zimbabwe Termination of Pregnancy Act of 1977 is very restrictive and only allows abortion with a few exceptions.

Where abortion is permissible, the process has many administrative and legal barriers leading women to seek clandestine and unsafe abortions. Post abortion care services are mainly provided in the public sector and there is limited information about what happens in the private sector. A recent study by Concept Foundation showed that the private sector cost for abortion care in Zimbabwe ranges from US\$180 up to US\$450, and this is out of reach for many girls and women seeking post-abortion care services.

The social stigma and judgmental attitudes associated with the subject of abortion affect both the women and health providers in our context. Individual socio-cultural beliefs and attitudes of some medical colleagues regarding the provision of post-abortion care limit access to essential health services by women. In addition, there is fear of criminal prosecution for both the women and health providers.

The dilemma as a health provider is whether you report the women presenting to the hospital seeking medical assistance to the police or you provide the

service and turn a blind eye. As a health care provider, how do you verify that the abortion has been induced illegally or is a natural spontaneous abortion? This is almost impossible, especially when there is no obvious evidence available.

According to the Guttmacher – Lancet Commission, nearly 56 percent of unintended pregnancies end up in induced abortions, and abortions in developing countries are more likely to be illegal and unsafe due to restrictive abortion laws. The commission report also indicates that 50 percent of abortions are unsafe in developing countries with 14 percent of abortions being performed by untrained persons using dangerous and invasive methods.

Abortion contributes to almost 10 percent of maternal mortality, with Africa having the highest number of deaths due to abortion complications (141 abortion-related deaths per 100,000 abortions). Globally 6.9 million women seek treatment for abortion complications. In Zimbabwe, the Ministry of Health & Child Care reports show that over 30,000 women are admitted to hospital annually due to abortion complications. Abortion complications are among the top 10 causes of hospital admissions in Zimbabwe. The proportion of women who present to hospitals with complications is far less than the women who suffer the consequences at the community level, including those who die in their homes.

Investing in quality comprehensive post-abortion care services at all levels, including the private sector, is essential to reduce complications of unsafe abortion. This will ultimately contribute to the reduction of maternal mortality in Zimbabwe. More research is required to better understand the full magnitude and impact of abortion in the Zimbabwean context.

Unpacking Zimbabwe's post-abortion Care Responsibility and Gaps



Picture Credit iStock

By Memory Pamela Kadau

Across the world, abortion-related complications constitute part of the major reasons women seek emergency obstetrical care. According to the Post Abortion Care Consortium, Post-abortion care (PAC) consists of emergency treatment for complications related to spontaneous or induced abortions. It also includes family planning and birth spacing counselling and the provision of family planning methods for further unwanted or unplanned pregnancies that may result in repeat induced abortions. Comprehensive PAC also includes services such as medical assessment for sexually transmitted infections, including HIV/AIDS.

Like other 180 countries in the world, Zimbabwe is bound by the 1994 International Conference on Population and Development (ICPD). All the countries agreed to provide health care services to women who need them, regardless of their official position on the legalities of abortion. Paragraph 8.25 of the 1994 ICPD convention states that “In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education, and family planning services should be offered promptly, which will help to avoid repeat abortions.” It therefore means that Zimbabwe has a responsibility to provide quality PAC to all women regardless of the circumstances of their pregnancy termination. It should be commended that Zimbabwe public health services offer PAC services to women and girls.

It is important to note that abortion-related complications can result in severe morbidity, especially when safe abortion is unavailable or restricted. This is the case in Zimbabwe, where the Termination of Pregnancy (ToP) Act limits access to safe abortion. It has seen the country experiencing tens of thousands of unsafe or ‘backyard’ abortions each year. Worldwide, especially in developing countries, abortion-related complications are a significant and preventable cause of maternal mortality. Research shows that these account for 8–9 percent of maternal deaths globally, with 42 to 63 women dying out of every 100,000 abortions.

Furthermore, a review of 70 studies from 28 countries estimated that at least 9 percent of women admitted to hospitals for abortion-related reasons had a near-miss event, i.e., they had complications such as severe hemorrhage that would have most likely resulted in death had they not made it to hospital.

However, in Zimbabwe, public health facilities are ill-equipped to provide comprehensive PAC services, especially in rural areas, informal urban settlements, mining, and farming communities. In most of these areas, cases of repeat abortions are common, and these can be reduced by integrating contraceptive services into abortion and post-abortion care services.

According to one study by Riley, Madziyire, and Chipato; an estimated 65,000 abortions occurred in Zimbabwe in 2016, and 40 percent resulted in complications that required treatment. The study evaluated two components of quality of care: structural quality, using PAC signal functions, a monitoring framework of key life-saving interventions that treat abortion complications; and process quality, which examines the standards of care provided to PAC patients.

abortion-related complications can result in severe morbidity, especially when safe abortion is unavailable or restricted

The research found critical gaps in the availability of PAC services; only 21 percent of facilities had basic PAC capability and 10 percent of referral facilities had comprehensive capability. For process quality, only one-

fourth (25 percent) of PAC patients were treated with the appropriate medical procedure. The health system had only 41 percent of the basic PAC facilities recommended for the needs of Zimbabwe's population and 55 percent of the recommended comprehensive PAC facilities.

These findings illustrate the large gaps in the availability and distribution of facilities with basic and comprehensive PAC capability in the country. These structural gaps are a contributing barrier to the provision of quality PAC services to all women needing them. The gaps are even more visible in rural, informal peri-urban, mining, and farming communities where health facilities are either not available or poorly equipped. It is therefore clear that the country needs to increase focus and investment in expanding the provision of and improving the quality of life-saving PAC services.

This is more important and urgent because PAC has been shown to lower mortality and morbidity related to unsafe abortion, and to reduce future unwanted pregnancies by providing contraceptive services. Additionally, Zimbabwe is bound by the 1994 ICPD to address abortion-related morbidity and mortality through the provision of quality health care. Part of the commitment must extend to reforming abortion laws to make safe abortion available to all women who need it.

In conclusion, evidence shows that despite the global commitment in 1994 by countries like Zimbabwe to provide quality post-abortion care, in practice there is still a long way to go. Increasing the provision of such care is essential to reduce the level of abortion-related morbidity and mortality, which is a major concern for women. Greater emphasis should be placed on preventing unwanted pregnancies and unsafe abortions and improving access to PAC in healthcare facilities (by fully funding PAC), especially in marginalised communities. Lack of access to safe abortion and PAC services is a missed opportunity to improve women's health and well-being. Making these services available would go a long way in enhancing women's bodily integrity in Zimbabwe.

By Memory Pamela Kadau

Zimbabwe's Termination of Pregnancy Act (TOP) provides a legal framework for when and how women and girls can access safe abortion services. The Act only provides three grounds for lawfully terminating pregnancy in the country. It further provides that pregnancies can only be terminated by a registered medical practitioner with the authorisation of a court order. However, these grounds are very narrow, resulting in many women and girls seeking unsafe abortions yearly. Unsafe abortions expose women and girls to health complications and death. The article will also compare with jurisdictions like South Africa to show that Zimbabwe needs to amend its law to grant wider access to abortion for women and girls. These conversations are becoming more urgent, given a recent upsurge in the rape of girls as young as nine years, some of whom are getting pregnant and giving birth. The 'Tsholotsho nine-year-old girl case' is a tragic example of this

The law and abortion in Zimbabwe

As highlighted above, abortion is regulated by the TOP Act of 1977, which may have been relevant at the time of inception but is now outdated and out of touch with the needs of women and girls. Currently, the law only provides three grounds for legal termination of pregnancy.

Firstly, abortion is guaranteed by law if the pregnancy endangers the life of the woman and could result in permanent impairment to her physical health. In such cases, the pregnancy can be lawfully terminated under the certification of two registered medical practitioners who must certify that the termination is necessary and safe.

Secondly, abortion may be authorised when there is a risk that the child to be born will suffer from a physical or mental defect, which is a serious risk to them. The physical or mental defect must be of such a nature that the child to be born will be permanently and seriously handicapped to ordinarily lead a meaningful life without excessive pain. This means that where the mental defect is likely to be temporary or deemed minor, the abortion will not be authorised. In addition, the medical superintendent should not authorise abortion unless satisfied that two medical practitioners have examined the pregnant woman and certified the termination.

Thirdly, pregnancy may be lawfully terminated when there is a reasonable possibility that the pregnancy was conceived as a result of unlawful intercourse. According to the TOP Act, unlawful intercourse is "rape, other than rape within a marriage, and sexual intercourse within a prohibited degree of relationship, that is to say, incest. A court of law can determine that the pregnancy was conceived as a result of unlawful intercourse and grant an order to have it terminated. This section excludes women in marriage yet spousal rape is rampant and often results in pregnancy, which a woman may not be prepared to carry. Statutory rape is also not permissible grounds for an abortion under the TOP Act of 1977.

The law further provides that no person is allowed to assist in the termination of pregnancy without legal authorisation and no medical practitioner, nurse, or any person employed in a hospital is allowed to assist with unauthorised termination of pregnancy. In addition, the TOP Act states that no person should offer extra fees in connection with the termination of a pregnancy other than the prescribed fees paid to the institution.

All these provisions show how narrow Zimbabwe's law on access to abortion is, which leaves behind many women and girls needing the services.

Comparative analysis of TOP Act with South Africa

In South Africa, the principal law which governs termination of abortion is the Choice of Termination of Pregnancy Act which was passed in 1996, to

Abortion is not illegal but is restricted in Zimbabwe



Picture Credit ABA Journal

reduce abortion-related deaths in the country. The Act gives women the right to access abortion within the first 12 weeks of pregnancy regardless of their age or marital status. It stands as one of the most progressive liberal examples of abortion laws globally. Compared to the Zimbabwean TOP Act, which limits access to abortion only to three grounds, South Africa is way ahead in terms of empowering women and girls to have a choice on when to have children. Since 1996, South Africa has recorded a significant decrease in morbidity for women who have accessed safe abortion, especially younger women. A review of South African national data shows that abortion mortality dropped by more than 90 percent between 1994 and 2001. The country also witnessed a rapid increase in women seeking termination services compared to the previous law. It has also become easier for women to access post-abortion care services in South Africa, which increases their health and well-being. Zimbabwe's policymakers need to learn from South Africa, seeing how increased access to safe abortion has guaranteed better sexual and reproductive health outcomes for women and girls.

Effects of the existing legal framework

The rigid legal framework has resulted in the proliferation of unsafe abortions across the county. According to a study by PLOS ONE organisation in 2018, and Guttmacher in 2016, about 66,800 abortions had been performed in the country. In 2019, the Parliamentary Portfolio Committee on Health and Childcare estimated that abortion stood as high as 80,000 cases per annum. Given the reported rise in sexual activities among adolescent girls and women in general during the COVID-19-induced lockdown period between March 2020 and February 2022, one

can project that the current annual figure could be as high as 100,000 cases.

Over 90 percent of these abortions are done in unsafe backyard facilities, which do not offer post-abortion care (PAC), and often result in health complications and even death for women and girls. News agencies and non-governmental organisations (NGOs) have extensively reported on these 'backyard' unsafe abortions and these reports show that deaths resulting from the procedure are very high. The Zimbabwe Demographic Health Survey of 2015 shows that the country's maternal mortality rate is 614 deaths per 100,000 live births, and 30 percent of these are due to illegal abortions. However, these figures may only be the tip of the iceberg, as most backyard abortions go unreported. Women and girls who have unwanted and unintended pregnancies and do not meet the narrow provisions of the TOP Act to access abortion resort to these desperate measures, which violate their dignity.

It is clear from the foregoing that the narrow provisions of the TOP Act violate women and girls' sexual and reproductive health rights. The Constitution of Zimbabwe in section 76, as well as international and regional conventions and declarations to which Zimbabwe is a state party, demand that the country respect, promote, and protect the sexual and reproductive health rights of women. The current TOP Act falls short of this requirement and must be amended to allow more women and girls to access abortion, a basic health need.

Access to abortion is critical for women's socio-economic growth

By Memory Pamela Kadau

The economy is often described as consisting of firms, government, and households. The economic activities of households are determined by income, savings, and what they can spend on such basics as health, food, education, clothing, and social activities, amongst other recurrent needs of households. The number of dependents in each household is of critical importance for the economic balance of the household. Children constitute the majority of dependents in households, and meeting their needs takes up a significant amount of the household budget. In Zimbabwe, the government doesn't provide childcare support for single mothers or any struggling parents/guardians who take care of children, and they have to meet all the costs on their own. This stark reality makes controlling family size a matter of women's bodily integrity and a critical socio-economic factor determining the well-being of women and their households.

In this respect, abortion rights are deeply intertwined with economic security, independence, and mobility for millions of women and other abortion patients who are struggling in poverty or living on the edge. For some women, adding one more dependent is the final straw on the proverbial camel's back, pushing them right into the vortex of the vicious cycle of poverty. This makes abortion an irrefutable economic issue. Determining the size of a family is one of the most profound economic decisions that a person will make in their lifetime. It defines their bodily integrity as much as it determines the socioeconomic status they will attain. It is much more profound for men than women.

In addition, the state of the economy depends on the state of the people living in it. The state of people living in it depends on how many mouths need feeding in every household, and how thinly stretched are the time, patience, and finances of the heads of those households. These circumstances are more unforgiving for women. Hence, the State cannot impose laws that take away the rights of its most vulnerable people, mostly women, to make a final determination on the growth of families they will naturally take care of with little assistance from the State. To illustrate this, I will look at a few examples concerning the financial constraints and what lack of access to abortion services means for women and their subsequent offspring.

Firstly, abortion access influences a family's ability to afford higher education and rising food, fuel, and healthcare prices. It is intertwined with income and wealth inequality with higher earning households being able to feed, cloth, educate, and care for an extra being. It impacts daycare waiting lists in underfunded public schools meager incomes and family health, both physical and mental. Thus, access to abortion and abortion services can have a powerful impact on women's economic outcomes, including what kind of jobs they can and cannot take, educational attainment, chances of being in poverty and financial distress, mental health, and so much more.

Therefore, the legalisation of abortion will help hundreds of thousands of Zimbabwean women to secure the right to access a critical health service. Research in countries that have legalised access to abortion, like South Africa, Sweden, and Finland, shows that the availability of the service has positively affected women's labor force participation and educational attainment, significantly bolstering the ability of women and families, along with state and local economies, to thrive. The direct opposite is true for most countries that deny women the right to an abortion, it has had nationwide consequences, and the effects on women and families' economic security are particularly devastating. This gruesome reality is reflected in children taking up family responsibility. An example is the recent case of a



Picture Credit The Business Journals

Tsholotsho minor who was sexually abused, leading to pregnancy and birth at the tender age of nine years.

It is therefore imperative to protect girls and women from the disempowering jaws of poverty. Robust action is needed to strengthen the nation's social safety net and advance policies to help working families, women, and other people who can become pregnant, facing unintended parenthood in our most vulnerable communities. However, the ultimate solution is reviewing the Termination of Pregnancy (TOP) Act, and making access to abortion services easy for women and girls. Denying access to abortion has devastating consequences for women's socioeconomic welfare, with downstream effects on their children, communities, and local and national economies. In countries like Sweden, access to reproductive health care, including abortion, led to increased labor force participation and enabled many women to finish school. This development not only increased women's earning potential but also allowed them to plan and balance their families and careers. This is imperative if Zimbabwe is to deal with the scourge of child marriages and women's poverty, which torments single mothers pushing them into crime and sex work.

As an example, I have previously written about the impact of the reversal of the Roe vs Doe case in the USA by its Supreme Court. Research in that country shows that following the Supreme Court's decision in 1973, women experienced a significant increase in labor force participation. The largest gains occurred in the decade and a half following the Roe vs Doe case, during which women's labor force participation grew at the fastest rate on record, including faster than during the 15 years before the Supreme Court's decision. Equally important, the Roe framework helped to sustain these higher rates of labor force participation for the generations of women who followed, especially from vulnerable communities.

This could apply to Zimbabwe's women in mining, farming, and informal settlements whose access to health care services is part of a range of intersectional factors exacerbating their vulnerability. In addition, because of the Roe Case, research shows that women's educational attainment also grew during that phase. One study found that access to abortion for women facing early, undesired pregnancies increased the probability of them entering college by 41 percent and completing college by 71 percent. These positive effects were particularly pronounced for Black women (a vulnerable group) experiencing early pregnancies: access to abortion increased their probability of entering college by up to 200 percent.

Furthermore, because of abortion legalisation, wom-

en's earnings were boosted. According to one study, women whose abortion care allowed them to delay an unplanned start to parenthood by one year saw an 11 percent increase in hourly wages later in their careers. Provided that many women are their families' sole or primary breadwinners and that access to abortion has positively impacted women's economic security overall, it is unsurprising that abortion legalisation also lowered the chances of a child living in poverty.

When a mother gives birth after thorough planning, the children enjoy the best care available and have better life opportunities, and mothers have fewer chances of sliding into poverty or depression. One 1997 study by a women's foundation in the USA found that the so-called marginal child who was not born due to abortion access—and who would have been born absent abortion legalisation—would have been 40 percent more likely than the average American child at the time to live in poverty.

In our local context, research by several human rights organisations like Amnesty International, SAFAIDS, and Women Action Group (WAG) among others, make it clear that when women do not have access to abortion care, they are more likely to suffer financially. Another research, led by an interdisciplinary team, the Turnaway Study, tracked two groups of women: one composed of those who had received abortion care and the other composed of women who had been denied care. The study determined that women who were forced to carry a pregnancy to term experienced a wide range of negative financial consequences, including lower credit scores, increased debt, and more negative public financial records such as bankruptcies and evictions. In addition to the impact on women themselves, the study showed that these restrictions are associated with worse child developmental outcomes and a greater likelihood of child poverty.

While in Zimbabwe there is little research on the quantum of socio-economic exclusion of women through strict abortion laws, it cannot be denied that the majority of women seen at traffic intersections begging are a living testimony of what lack of options to accessing abortions can mean for vulnerable women. I, therefore, urge organisations like the Zimbabwe Gender Commission (ZGC) to invest in empirical evidence to inform policy-making on matters of sexual and reproductive health rights including abortion. The current legal framework on abortion is costing the Zimbabwe economy millions of dollars and sinking hundreds of thousands of households into poverty each year. A simple amendment to the law could strengthen women's socioeconomic status in Zimbabwe.

The burden of unsafe abortion among adolescent girls

By Dr Munyaradzi Murwira

Introduction

Adolescents are a diverse group with varying sexual and reproductive health needs, and abilities to meet those needs. These variations stem from their unique life circumstances, including background, level of education, marital status and place of residence. Adolescents often face a multitude of challenges in accessing Sexual and Reproductive Health (SRH) services. These include social stigma, judgmental attitudes of the community, health care providers, financial constraints and lack of information. Key SRH issues affecting youths include among others, STIs/HIV & AIDS, teenage pregnancies, unintended pregnancies, drug and substance abuse, and Sexual Gender-Based Violence (SGBV).

The Zimbabwe teenage pregnancy study 2016-17 revealed that 9 percent of the adolescents aged 10-19 years had ever been pregnant, while 17 percent of the adolescents aged 15-19 years had experienced pregnancy (17.6 percent based on Multiple Indicator Cluster Survey – 2019). Adolescents with no comprehensive knowledge of pregnancy were at higher risk of pregnancy.

Marginalised and vulnerable adolescents were more likely to become pregnant compared to adolescents from stable and well-to-do families. Adolescents aged 15-19 years in rural areas were more likely to be at risk of pregnancy compared to their urban counterparts. Zimbabwe has formulated policies and laws related to adolescent sexual and reproductive health. The Age of Consent in Zimbabwe, which is 16 years, protects the girl child from sexual abuse. However, most cases of rape and abuse go unreported.

Consequences of Adolescent Pregnancy

Girls who fall pregnant between the ages 15 to 19 either drop out of school, risk being chased away from home or may be abandoned by their family as well as by the man responsible for the pregnancy. Medical effects of teenage pregnancy include a high risk of complications of pregnancy and delivery, with associated death of the mother and the baby. More than a tenth of the adolescents reported that their first pregnancy did not end in a live birth (stillbirth or miscarriage/abortion).

According to the 2016 Guttmacher study, adolescent girls in Zimbabwe accounted for an estimated 45,000 unintended pregnancies in 2016, leading to 17 percent of all unintended pregnancies in the country. The proportion of pregnancies that were unintended was twice as high among unmarried adolescents (63 percent) as among married adolescents (32 percent). The proportion was also higher among adolescents living in urban areas (53 percent) than among those in rural areas (35 percent).

Access to Post Abortion Care



Pic: Credit Michael Gwarisa

Girls in Zvimba march against child marriages and teen pregnancies

Barriers that prevent adolescents from accessing their sexual and reproductive health care needs put them at risk for unintended pregnancy and increase the chances that they will seek an unsafe abortion. While adolescents account for almost one-quarter of the female population in Zimbabwe, little is known about their experiences with abortion.

The Guttmacher study estimated that 4,100 induced abortions occurred among adolescent women in Zimbabwe in 2016. Although women of all age-groups had similar levels of unintended pregnancy, adolescent women had the lowest proportion of unintended pregnancies that ended in abortion (9 percent compared with 16–38 percent among other age groups). These findings suggest that adolescent women in Zimbabwe carry a higher proportion of unintended pregnancies to term than older age groups. A higher proportion of unintended pregnancies ended in abortion among unmarried adolescents (13 percent) compared with married adolescents (6 percent), and among adolescents living in urban areas (25 percent) rather than rural areas (1 percent). Post-abortion care can be lifesaving treatment for women with abortion complications.

However, there are disparities in access to sexual and reproductive health care across age groups, with adolescents being 21 percent more likely than patients aged 20–49 to experience delays in getting post abortion care. Young people with unintended pregnancies face widespread stigma & discrimination (family, community & providers), and have limited access to services (cost of services, provider attitudes), in addition, they have a high risk of accessing clandestine cheaper options for abortion, with resultant high risk of complications and death.

Conclusions & Recommendations

Adolescent pregnancy is a national health and social problem, requiring effective evidence-based interventions targeting the identified vulnerable groups of adolescents. High levels of pregnancy among adolescents call for tailored policies and programs to address the diverse needs of adolescents to prevent unintended pregnancy and resultant abortions. The recommendations include among others:

Addressing socio-cultural and religious norms and community values that undermine the rights of women and girls and perpetuate adolescent pregnancy in communities. Enforcing laws and legislation that are in place in order to protect the girl child against early marriages and teenage pregnancy.

Strengthening female adolescent empowerment through life skills initiatives, female sensitive programmes, and improving educational, socio-economic and recreational opportunities for young people.

Ensuring the provision of comprehensive sexual reproductive health education for all young people; increasing accessibility to services, targeting the differing needs of adolescents; and capacitation of health care providers to offer respectful and non-discriminatory sexual reproductive health services to young people.

Providing adolescents with information on the legal criteria for abortion and the provision of safe abortion services to the full extent of the law. Mapping of adolescent pregnancy hotspots at the sub-national level accompanied by focused interventions to address underlying factors.

The Tripple Tragedy in Women's Health: Unmet Need for FP, Unwanted Pregnancy and Unsafe Abortion



Couple gets Family Planning demonstration session(Pic Credit UNFPA ESARO)

Dr Munyaradzi Murwira

Introduction

Women and girls in developing countries face multiple obstacles in accessing affordable, high-quality and comprehensive sexual reproductive health and rights (SRH&R) services. This article explores three key issues that affect women's and girls' sexual reproductive health outcomes, morbidity and mortality. The "Tripple Tragedy" in women's health, particularly in the developing world include the Unmet Need for Family Planning, Unwanted Pregnancy and Unsafe Abortion.

The Primary Health Care (PHC) concept, coupled with the Universal Health Coverage (UHC) approach, presents an opportunity to ensure universal access to SRH&R services for women and girls. UHC entails that all individuals and communities have access to the full spectrum of essential and quality health services including an explicit commitment to provide sexual and reproductive health services to all. International efforts to address the "Tripple Tragedy"

are supported by the WHO/UNFPA call to action for attaining UHC through integrated SRH&R and HIV/AIDS interventions. The UHC agenda provides an important opportunity for equitable health coverage, which meets the needs of the rights of all, particularly the marginalised and vulnerable populations.

Efforts to address the "Tripple Tragedy" in Zimbabwe are articulated by the SRH&R goals within the National Health Strategy 2021-2025. These goals are to; increase the modern contraceptive prevalence rate from 67 percent in 2015 to 80 percent by 2025; reduce the Adolescent Birth Rate from 108 per 1,000 women in 2019 to 93 per 1,000 by 2025; reduce Maternal Mortality Ratio from 462 in 2019 to 240 per 100 000 live births by 2025; and Achieve Universal Access to Reproductive Health by 2025.

Unmet Need for Family Planning

Unmet need for family planning (FP) is the proportion of women who would want to use contraception but are not able to do so due to various reasons. Improving access to SRH&R including FP will

greatly reduce the unmet need for FP. Focus of FP programmes should be young people and marginalised communities. The current national FP strategy 2022-2026 aims to reduce unintended pregnancies among women of reproductive age (reduce unmet need of FP from 10 percent to 7 percent by 2026). In Zimbabwe, 10 percent of currently married women have an unmet need for family planning. Unmet need is higher in rural areas (11 percent) than in urban areas (9 percent). Unmet need is higher in women with low socio-economic status and is significantly higher in sexually active unmarried young women (40 percent in unmarried sexually active 15-19 years and 17 percent in unmarried sexually active 20-24 years respectively). There is also a disparity in unmet need based on geographic location, with unmet need being highest in southern provinces (Matabeleland South 16 percent, Masvingo 15 percent and Matabeleland North 13 percent).

Unwanted and Unintended Pregnancies

In Zimbabwe, up to 40 percent of pregnancies are unintended or unplanned; and 1 in 4 of those unintended pregnancies end in abortion. A hospital-based study in Harare by Mbizvo et al. showed that 41 percent of pregnancies were unplanned and that younger women below 19 years and older women over 35 years were more likely to have unplanned pregnancy. Some factors associated with unplanned pregnancies included unemployment, being single, divorced/separated/widowed, and women with low income. Having unwanted pregnancies is linked to social and psychological effects, and sexual gender-based violence among women and girls. Improving access to FP and reducing the unmet need will go a long way in averting unwanted and unintended pregnancies in Zimbabwe.

Unsafe Abortion

In Zimbabwe, almost 25 percent of unintended pregnancies end in abortion. It is estimated that more than 65,000 induced abortions occur in Zimbabwe annually. Due to restrictive abortion policies and limited knowledge, most of these abortions are clandestine and potentially unsafe, and mostly performed outside the formal health system. As a result, too many women are still dying from unsafe abortions, with the survivors facing stigma and discrimination.

Through the Population Reference Bureau project on – "Breaking the Silence: Expanding Access to Safe Abortion in Zimbabwe," there have been efforts to use media to describe the problem of unsafe abortion, its health and financial costs, challenges posed by the law, and steps that decision-makers can take to remedy the situation in Zimbabwe.

Conclusions

Integration of Sexual Reproductive Health and Rights (SRH&R), Maternal and Child Health (MCH) and HIV/AIDS programmes offer a platform to enhance universal access to sexual reproductive health services for women and girls in Zimbabwe. To address the unmet need in marginalised and vulnerable communities, focused FP programming is essential. The risk factors for unwanted pregnancy closely mirror those for maternal mortality, rendering unwanted pregnancy a significant indicator of factors known to increase the risk of maternal death.

Health policies should address factors contributing to unwanted pregnancy, its prevention and mitigation in order to prevent reproductive morbidity and mortality due to unsafe abortions. The Ministry of Health and Child Care (MoHCC) should consistently review relevant policy guidelines in line with current best practices for enhanced access to comprehensive SRH&R services including safe abortion care.

Discussing the intersection of abortion and gender equality

By Memory Kadau

Recently, the Prime Minister of the United Kingdom (UK), Rishi Sunak, declared that ‘women are women, and men are men.’ His comments added further controversy to the ongoing debate on gender equality and the rights of transgender individuals. However, his remarks also present an opportunity to interrogate issues related to gender equality, particularly in the context of abortion. Throughout history, women have been denied the right to control their bodies, including the decision to have or not have a child.

Abortion or the termination of a pregnancy, has long been a contentious and polarising issue worldwide. Beyond the medical and ethical dimensions, abortion intersects with broader socio-political contexts, particularly those concerning gender equality. The ability to decide about one’s reproductive health, including whether to continue or terminate a pregnancy, is intertwined with the fundamental principles of autonomy, bodily integrity, and gender justice.

This article will critically examine the multifaceted relationship between abortion and gender equality. It will begin by providing historical context and the evolution of abortion laws and regulations. It will then discuss the impact of restrictive abortion policies on women’s rights and gender disparities. Furthermore, this Op-Ed will explore the global disparities in abortion access and their disproportionate impact on marginalised communities. Finally, it will emphasise recognising abortion as essential to gender equality and reproductive justice.

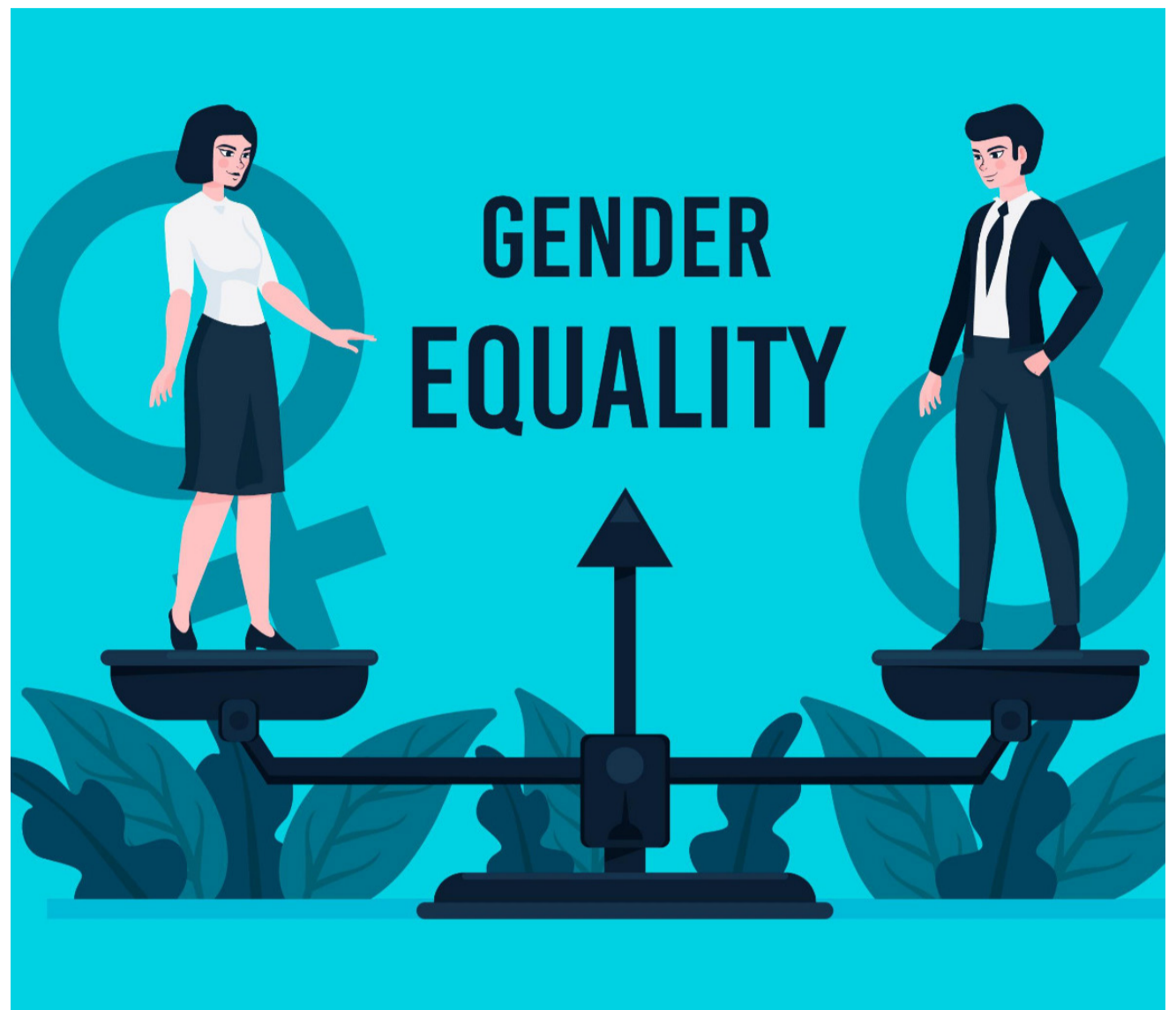
Historical Context and Legal Frameworks

The regulation of abortion has a long history marked by changing societal norms, medical advancements, and evolving legal frameworks. Abortion was often practised and accepted, with regulations emerging in the 19th century as medical professionals sought to establish control over reproductive procedures (Reagan, 1997).

In many countries, including Zimbabwe, abortion laws have been influenced by societal attitudes toward gender roles and sexuality. In conservative societies, restrictive abortion laws often reflect traditional patriarchal values, limiting women’s autonomy over their bodies (Hoggart et al., 2020). However, the past century has seen significant shifts in legal attitudes toward abortion.

Legalisation of Abortion: In several countries, abortion has been legalised to varying degrees, often due to the recognition of women’s rights and the acknowledgement of the dangers posed by unsafe, clandestine abortions (Drower, 2019). For example, the United States landmark case of *Roe v. Wade* in 1973 established a woman’s right to choose abortion as an essential component of reproductive autonomy. Sadly, this was reversed by the Supreme Court in 2022. However, most State legislatures in that country are legalising access to abortion.

Restrictive Abortion Laws: Some countries continue to uphold restrictive abortion laws influenced by conservative religious and societal values. These laws limit access to safe abortion services and,



Picture Credit www.knowesg.com

in many cases, disproportionately affect women and marginalised communities (Duvall et. al 2017). Zimbabwe’s Termination of Pregnancy Act is an example of a restrictive law as it provides abortion in very few cases. Other countries have entirely banned abortion and imposed stiff sentences on women who terminate pregnancy.

Impact of Restrictive Abortion Policies on Gender Equality

Restrictive abortion policies often have profound implications for gender equality. They can exacerbate existing disparities and reinforce traditional gender roles and power dynamics. Here are some examples in which restrictive abortion policies adversely impact gender equality:

Bodily Autonomy: Access to safe and legal abortion is fundamental to bodily autonomy, enabling individuals to decide about their bodies. Women’s autonomy is compromised when such access is restricted, reinforcing gender inequality and traditional oppression.

Healthcare Disparities: Women’s health is negatively affected when denied access to safe abortion services. Restrictive policies can increase maternal mortality and morbidity rates, disproportionately impacting marginalised communities like rural areas, farming communities and informal settlements.

Economic Inequality: Forced pregnancies, particularly for low-income women, can have economic consequences. Women may be forced to forgo education and career opportunities, perpetuating economic disparities between genders, and trapping them in a cycle of poverty.

Gender-Based Violence: Restrictive abortion laws can exacerbate gender-based violence, as women may be coerced into continuing unwanted pregnancies or face violence for seeking abortions. This results in many women staying in abusive relationships and having no recourse because they depend on their abuser for livelihood and income.

Stigmatisation: The stigmatisation of abortion can contribute to the perpetuation of gender stereotypes and the marginalisation of women who seek abortions. This stigma reinforces societal norms that devalue women’s reproductive autonomy and entrench gender equality.

Reproductive Justice: Research shows that reproductive justice, which extends beyond reproductive rights to social, economic, and political factors, is essential for gender equality. Restrictive abortion policies can undermine reproductive justice by limiting access to comprehensive reproductive healthcare based on one’s gender.

In conclusion, the debate on gender determination and access to abortion is essential as it sheds light on how policymakers and power holders treat gender equality. The current state of abortion worldwide, characterised by significant disparities, highlights the uneven playing field in women’s ability to exercise their reproductive rights.

These disparities are often exacerbated by socio-economic factors, cultural attitudes, and legal frameworks that disproportionately impact marginalised communities and women of lower socio-economic status.

The Role of Medical Professional Societies in Informing Communities on Maternal Health, Post-Abortion Care, and Abortion Laws Reform in Zimbabwe

By Memory Pamela Kadau

Maternal health, post-abortion care (PAC), and abortion laws reform are critical issues that require comprehensive and accurate information dissemination to communities. In Zimbabwe, medical professional societies play a crucial role in informing and educating the public about these topics. In 2022, the World Health Organisation (WHO) introduced new guidelines on abortion to help countries deliver lifesaving care.

This article explores the significant role of medical professional associations in Zimbabwe in promoting maternal health, providing post-abortion care, and advocating for abortion laws reform. Further, it proposes ways medical professional societies can call for the ratification and implementation of national policies in Zimbabwe.

Maternal health education and outreach

Maternal health education is essential for ensuring safe pregnancies, reducing maternal mortality rates, and improving overall healthcare outcomes for women. Medical professional societies in Zimbabwe actively contribute to maternal health education through various initiatives. These societies organise workshops, conferences, and public awareness campaigns to disseminate evidence-based information on prenatal care, safe delivery practices, and postpartum care. For example, the Zimbabwe Medical Association (ZIMA) regularly conducts training programmes for healthcare professionals to enhance their knowledge and skills in managing maternal health issues.

The Zimbabwe Society of Obstetricians and Gynaecologists (ZSOG) holds several activities, including annual scientific conferences, to promote women's health in line with international best practices and to create dedicated practitioners in Obstetrics and Gynaecology. Medical professional societies also collaborate with government agencies, non-governmental organisations (NGOs), and international partners to develop educational materials, such as brochures, posters, and audio-visual resources.

The societies have also produced educational materials on maternal health, including guidelines for healthcare providers and informational booklets for expectant mothers. These materials are distributed in healthcare facilities, community centres, and schools to reach a wider audience.

Post-Abortion Care Services

In Zimbabwe, PAC services are crucial for addressing the health consequences of unsafe abortions and reducing maternal morbidity and mortality. Medical professional societies play a pivotal role in ensuring the availability and accessibility of PAC services. They work closely with healthcare providers, policymakers, and NGOs to develop national guidelines for PAC and advocate for their implementation.

For instance, the Zimbabwe Nurses Association (ZINA) has actively contributed to developing PAC guidelines and nurse training programmes. Medical professional societies also conduct workshops and training sessions to enhance healthcare providers' skills in providing comprehensive PAC services. These initiatives are aimed at ensuring that healthcare professionals are equipped with the necessary knowledge and skills to offer post-abortion counselling, treatment of complications, and contraception counselling. ZSOG regularly organises PAC training programmes to improve the quality of care provided by obstetricians and gynaecologists.

Legal and Policy Reforms

However, the restrictive abortion laws in Zimbabwe pose significant challenges to women's reproductive rights and access to safe abortion services. Medical professional societies are at the forefront of advocating for abortion law reform to ensure safe and legal access to abortion services. They engage in evidence-based advocacy, policy development, and public awareness campaigns to promote a more progressive approach to abortion. Medical professional societies also collaborate with women's rights organisations, human rights advocates, and legal experts to highlight the negative impact of restrictive abortion laws on women's health and well-being. They provide expert opinions and recommendations to policymakers and actively participate in drafting new legislation. Medical professional societies also engage in public awareness campaigns to debunk myths and misconceptions surrounding abortion. They use various channels such as social media, radio, and community forums, to disseminate accurate information about abortion, its legal status, and the available services. These campaigns aim to reduce stigma, promote informed decision-making, and encourage public support for abortion law reform.

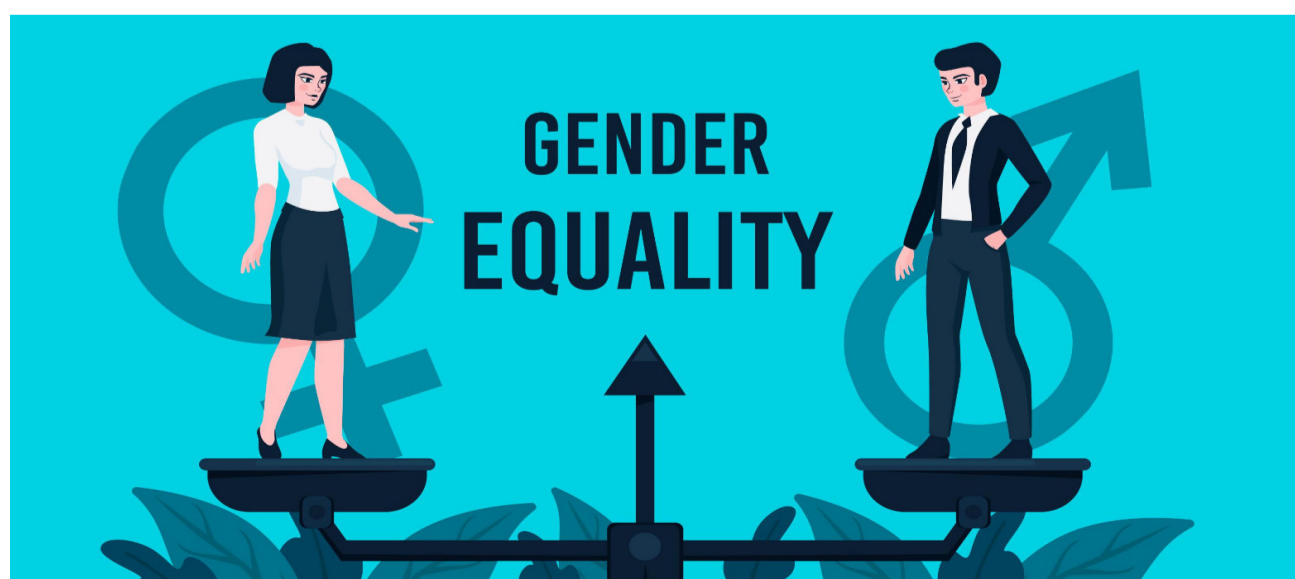
In 2022, WHO introduced new guidelines on abortion to help countries deliver lifesaving care. The role of medical professionals in promoting the recent WHO abortion guidelines is crucial in ensuring the provision of safe and comprehensive reproductive healthcare. Medical professionals can actively

advocate for these new abortion guidelines by spreading information about their availability, purpose, and significance.

They can educate their colleagues, patients, and the general public about the importance of safe and legal abortion services in improving overall sexual and reproductive health outcomes for women. Medical professionals can pursue training to stay updated on the latest guidelines, evidence-based practices, and techniques related to abortion care. This will enable them to offer accurate and comprehensive information to patients and provide high-quality abortion services. Medical professionals need to adhere to the WHO abortion guidelines within their clinical practice.

This includes providing comprehensive counselling, ensuring the availability of safe and legal abortion methods, following appropriate protocols for medical, medication, and surgical abortion procedures, and providing post-abortion care. Medical professionals are essential in challenging and reducing the stigma surrounding abortion. Providing non-judgmental and supportive care can create a safe and empathetic environment for patients seeking abortion services. They can also engage in public discussions to dispel myths and misconceptions about abortion and promote access to accurate information.

Lastly, medical professionals can collaborate with organisations, policymakers, and like-minded professionals to advocate for implementing and expanding the new WHO abortion guidelines. This can involve participating in policy discussions, contributing to research and evidence-based studies, and engaging in public awareness campaigns. In summary, medical professionals are crucial in promoting the new WHO abortion guidelines by raising awareness, staying updated, incorporating approaches into practice, destigmatising abortion, and advocating for comprehensive reproductive healthcare. Their involvement and commitment are essential in ensuring the accessibility and quality of safe abortion services worldwide.



Zimbabwe bears the burden of one of the highest maternal mortality ratios in the world. According to the Multiple Indicator Cluster Survey (MICS) of 2019, Zimbabwe has a maternal mortality ratio of 462 deaths per 100,000 live births and a neonatal mortality rate of 32 deaths per 1000 live births. While this represents an improvement from the 614/100 000 live births for maternal deaths recorded in 2014, the slow rate of progress indicates that Zimbabwe is unlikely to meet the Sustainable Development Goal (SDG) target for reducing maternal mortality. The article explores the impact of existing gaps in abortion law, which has resulted in limited reforms and the high maternal deaths over the past two decades. It concludes by providing recommendations for policymakers to reach SDG three on Good Health and Well-being, including reducing the global maternal mortality ratio to less than 70 per 100,000 live births.

Limited legal scope for abortion

The Termination of Pregnancy (ToP) Act is the principal legislation governing abortion in Zimbabwe. However, the provisions of this law are narrowly defined, only allowing abortion in limited circumstances, including if the pregnant woman's life is in danger or in cases of rape, incest, or fetal impairment. In practice, obtaining a legal abortion is challenging, leading to a prevalence in clandestine and unsafe abortions.

The government of Zimbabwe, through the Ministry of Health and Child Care (MoHCC), has taken several steps and measures to increase access to, and improve Post Abortion Care (PAC) to reduce maternal mortality. However, the harsh reality is that the health system is overwhelmed to provide resources for PAC adequately. Budgetary constraints have persisted, health workers have been at loggerheads with the government over salaries and working conditions, while infrastructure has rapidly deteriorated in most health centres nationwide. As a result, the health system is incapacitated to provide adequate and quality PAC.

National abortion statistical analysis

Zimstat reports that in 2016, an estimated 65,300 induced abortions occurred in the country, translating to a rate of 17 abortions for every 1,000 women aged 15–49. A regional comparison shows that Zimbabwe has one of the lowest abortion rates in Sub-Saharan Africa; the regional rate is double that of the country. Within the country, abortion rates differ across regions and economic classes. Harare and Mashonaland provinces have the highest rate at 21 per 1,000 women aged 15–49; the lowest are in Manicaland and Masvingo provinces at 12 per 1,000 women of the same age. Most abortions occur outside official medical facilities because the law still provides for narrow grounds. Yet, statistics show that abortion is a primary sexual and reproductive health need for thousands of women.

Access to Post Abortion Care (PAC)

PAC is an essential component for women who have undergone abortions. A UN Women research estimates that the vast majority (85 percent) of PAC in Zimbabwe is provided in public health facilities. About 50 percent of the cases are attended at district hospitals and about one-third at larger, central hospitals. The majority of the women who seek treatment at public health facilities often have mild or moderate complications. However, a significant number (19 percent) have severe complications.

Many women experiencing complications from unsafe abortion or miscarriages often face delays in obtaining PAC. Evidence shows that most

Reviewing the impact of the legal lacuna in Zimbabwe's abortion law



Picture credit NewsDay

women, on average, approximately spend two days experiencing difficulties and receiving completed treatment at public health facilities. Significant reasons for treatment delays include insufficient money for relevant payments, transportation, and distance to a health facility.

PAC is not offered at most primary health centres, such as village or farm clinics, which are most accessible to rural women. Additionally, women must seek medical treatment and PAC at multiple facilities to complete treatment.

Furthermore, many public health facilities request payment from patients for PAC. This is a significant cause for delays in accessing this critical service, particularly for poor and vulnerable women. Ordinarily, PAC is part of emergency treatment and should be provided at no cost. Public health facilities also lack adequate medication for effectively treating PAC patients.

Years of underfunding and lack of prioritisation of PAC have seen most public health facilities lacking the critical drug for PAC's misoprostol. In addition, half of the facilities designated under national guidelines to provide manual vacuum aspiration, do not have the equipment to do so. Where equipment is available, use is low owing to the perceptions and attitudes of medical care workers. The first step to address these challenges is reforming the abortion law as this would increase women's access to safe abor-

tion services. There is also a need to allocate more resources and skills to PAC as well as enhance the capacity of medical care workers to provide quality treatment and services to women needing them.

Recommendations

- Having noted the impact of the existing legal framework, this article makes the following recommendations to policymakers:
- Amend the law to expand the circumstances under which abortion is legally permitted.
- Improve awareness of healthcare professionals and the public about legal provisions to reduce the number of clandestine and unsafe procedures.
- Ensure the availability of safe, legal abortion services and post abortion care to reduce ill health and death from unsafe abortion.
- Increase the availability and use of WHO-recommended post abortion care methods by ensuring facilities have adequate training, supplies and equipment.
- Increase funding to ensure public health facilities have the resources to provide PAC free of charge and fully implement the National Guidelines for Comprehensive Post abortion Care in Zimbabwe.

Demystifying safe abortion: Getting the FACTS right

By Memory Pamela Kadau

Abortion is a sensitive and divisive issue. It separates opinions, mostly due to a lack of understanding about the facts surrounding this subject. This article looks at some of the popular MYTHS surrounding abortion and presents the FACTS to enrich the debate on the topic. In doing so, the article will pose a question and then highlight a popular myth which will then counter with factual information from science and practice.

- **What is abortion?**

Myth: There is a tendency by anti-abortionists that the procedure is equivalent to murder or infanticide.

FACT: The World Health Organization (WHO) defines abortion as a pregnancy termination prior to 20 weeks gestation. Spontaneous abortion is another term for miscarriage which refers to a pregnancy loss that occurs before the 20th week of gestation or the expulsion of an embryo or fetus weighing 500g or less. In the Zimbabwean context, abortion is defined as spontaneous or induced termination of pregnancy before 22 weeks of gestation or delivery of a foetus less than 500 grams foetal weight. Pregnancies after this gestation age are called pre-term deliveries.

- **Is giving birth safer than a safe abortion?**

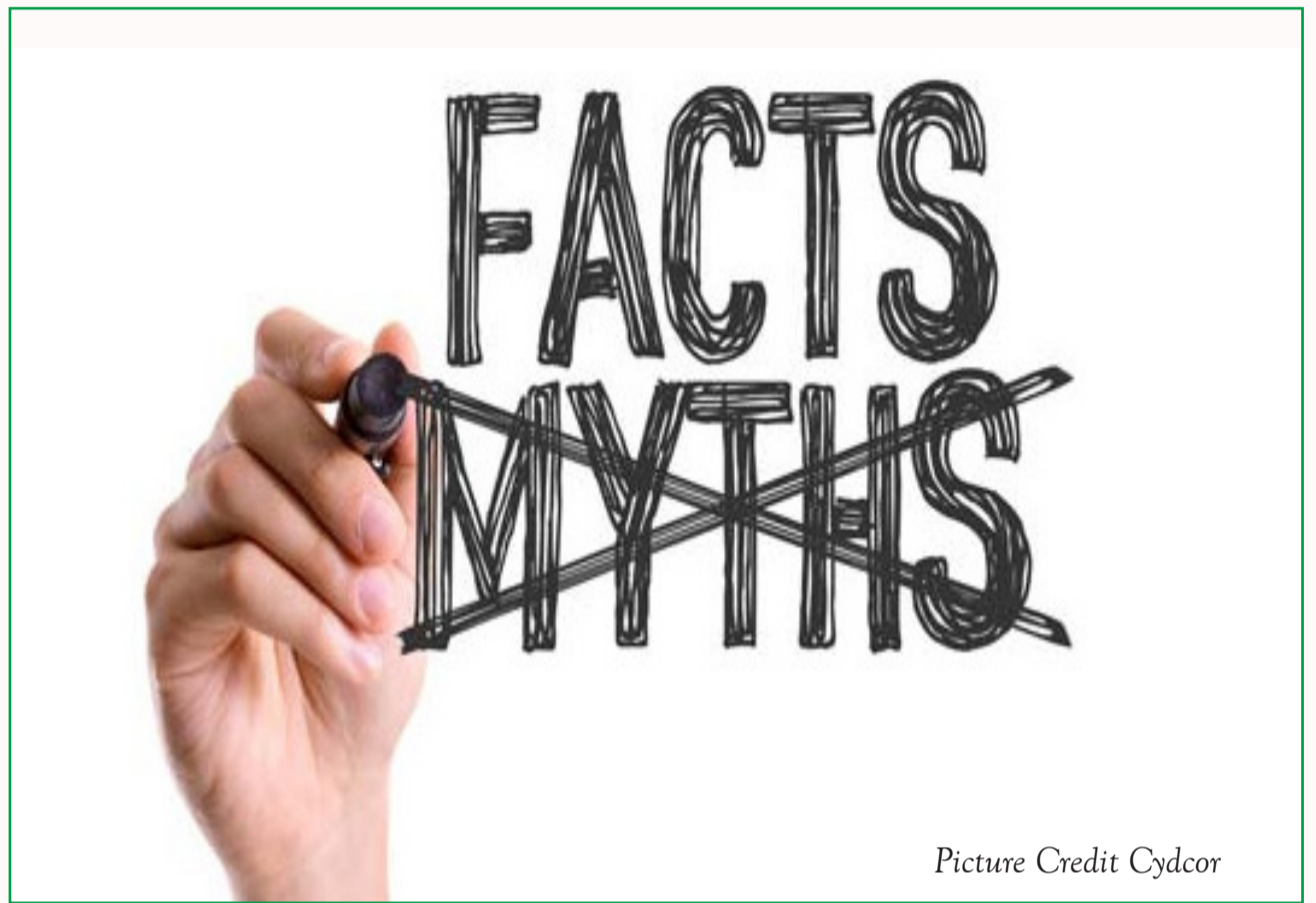
Myth: Those opposed to abortion advance the argument that it is safer to give birth than to undergo a safe abortion.

FACT: Medical research shows that the chance of someone suffering injury or death is greater when carrying a pregnancy to term and giving birth than when having a safe abortion. Safe abortion in developed countries is one of the safest procedures in contemporary medical practice.

- **What proportions of abortions are safe across the world?**

Myth: Anti-abortion conspiracy theories state that most abortions are done safely and in secret by coordinated groups which are murdering fetuses for medical experiments. These arguments are often shared on social media platforms with large audiences.

FACT: About 50 percent of abortions in the world are unsafe, which risks the lives of women and girls who undergo these procedures. This is due to legal and practical restrictions to abortion which leaves millions of women unable to access safe and hygienic health services. Nearly all of these unsafe abortions (97 percent) take place in low- and middle-income countries.



Picture Credit Cydcor

- **Which proportion of women have a higher rate of abortion?**

Myth: Those opposed to abortion advance the view that it is mainly single women who seek abortion across the world.

FACT: Global health research by the World Health Organization shows that married women have a higher rate of abortion (35 per 1000 women) compared to unmarried women (26 per 1000 women).

- **How do legal restrictions affect the rate of abortion?**

Myth: Anti-abortionists claim that laws banning or restricting access to abortion reduce the number of abortions.

FACT: The reality is that abortion rates are similar in countries where abortion is highly restricted and where it is broadly legal. The abortion rate is 37 per 1,000 women in countries that prohibit abortion altogether or allow it only to save a woman's life, and 34 per 1,000 in countries that allow abortion without restriction as to reason, a difference that is not significant.

- **What is the legal status of abortion in most African countries?**

Myth: Those against abortion in Africa argue that it is a Western concept and the majority of Africans reject it. They even state that most countries have laws banning or severely restricting the procedure.

FACT: A review of the abortion laws across Africa show that in almost all countries, the law permits abortion to save the woman's life, and in most of the countries abortion is permitted to preserve the physical and/or mental health of the woman. Of Africa's 54 nations, only five do not currently allow abortion in at least one circumstance: Madagascar, Senegal, Sierra Leone, Mauritania, and Egypt. However, four of five of these have signed and/or ratified the Maputo protocol, which supports abortion provision in several circumstances only Egypt has not.

- **How is abortion perceived in indigenous cultures and religions?**

Myth: Anti-abortionists advance the argument that abortion is not supported by indigenous cultures and major religions, making it immoral and a sin.

FACT: The majority of religions and indigenous cultures developed their core beliefs and values before technology and science could adequately explain the development of a human embryo from fertilisation, through all stages of fetal development, to birth. Therefore, changing society's views and perceptions today does not in any way undermine the core beliefs of religions and indigenous cultures as it is simply informed by present scientific understanding. Abortion is not immoral or a sin.

In conclusion, it is important for civil society, academia, media, and all stakeholders involved in Sexual and Reproductive Health (SRH) work, to always share facts to challenge popular myths. This is important for governments, whose actions can ultimately ensure or deny access to safe abortion. It is wrong for governments to rely on myths and not facts to deny women their fundamental right such as access to reproductive health care, including abortion.

Time to Put Teenage Pregnancy, Abortion back on the Political Agenda



Pic by Michael Gwarisa: Young mothers at ANC visit at Mbare Polyclinic

By Edinah Masiyiwa

As has become a norm, we commemorate both the International Safe Abortion Day on the 28th of September and World Contraception Day on the 26th of September. It is against this background that we need to focus on the problem of early unintended pregnancies among girls between the ages of 10 to 14 years. Recently, news of early pregnancies featured in different Zimbabwean media outlets, thanks to a new survey conducted on the topic which revealed that the adolescent (10 to 19 years) pregnancy rate is at 23 percent. A United Nations Populations Fund report in 2016 noted the increase of adolescent pregnancies from 99 live births per 1000 girls to 115 live births per 1000 girls. The same report highlighted that early sexual debut and sexual abuse of females increased the girls' risk of unintended pregnancies, and 54 percent of girls aged 10 – 14 years who had ever had sex experienced rape or forced sex on their first sexual encounter.

In the global arena, the neglected crisis of unintended pregnancy was the subject of UNFPA's flagship 2022 State of World Population report. The report examined how such pregnancies represent a global failure to uphold basic human rights. The report states that more than three in five unintended pregnancies end in abortion. An estimated 45 percent of all abortions are unsafe, carried out in countries where the procedure is illegal, restricted, or unaffordable in safe settings. Unsafe abortion hospitalises around 7 million women a year globally and is a

leading cause of maternal death.

Zimbabwe has gone through an election process, and the President was inaugurated on the 4th of September 2023. In the lead-up to the elections, many organisations and even the parliament disengaged from the development agenda, as their focus was on securing seats in the next parliament. The Parliament of Zimbabwe was dissolved on the 22nd of August in line with the provisions of the Constitution.

It is disturbing how politics can derail the entire development agenda. Organisations working on reproductive justice had gained momentum on the abortion issue, as noted by the Health Times when they reported that Parliament was warming up to the issue. The previous members of Parliament had attended capacity-building sessions on access to safe abortion including the termination of pregnancy. We were fortunate to have parliamentary champions on Sexual and Reproductive Health and Rights (SRHR) who had been trained on SRHR, including abortion. These members of Parliament were ready to raise a motion on the review of the current Termination of Pregnancy Act.

The two days we are commemorating provide an opportunity for us to re-launch the advocacy campaign for access to safe abortion and contraceptives, particularly for adolescent girls. The connection between the two days provides a great opportunity for advocacy.

In a statement, the late former UNFPA Executive Director said in 1994, "Healthy families are created by choice, not by chance."

Almost thirty years later, the same is still true: Zimbabwe needs healthy families, and it's time we talk about choice to have a child or not, as we fight for reproductive justice. The time to push for contraception and access to safe abortion is now, considering that we have a new parliament.

With unsafe abortions still a major contributor to maternal mortality in Zimbabwe, the new parliament must put the issue of teenage pregnancy as well as the Termination of Pregnancy Act on the agenda. The policy framework should allow sexually active adolescents to access contraceptives to prevent unwanted pregnancies. Adolescent girls with unwanted pregnancies should be allowed to terminate if they choose to do so. Unwanted pregnancies affect the health of individuals as well as families. The Parliament has a mandate to make or enact laws that protect and uphold the rights of women and girls. The termination of Pregnancy Act (1977) is one law that needs to be reviewed, as it no longer serves women and girls of this day. Forty-six years later, women's bodies are still being regulated by this law, and the concept of bodily autonomy is being violated.

I also call on health service providers to give adolescents free contraceptives should they present at their facilities in need of such services. Health workers should not stigmatise these girls, as this might be a barrier to accessing care. Our society should also be aware of the changes that are in place, as evidenced by the early sexual debut in young girls.

Parents and guardians should also protect young girls from sexual abuse as this has been identified as one of the causes for unwanted pregnancies.

Protecting adolescents from unplanned pregnancies through access to comprehensive SRHR services

By Dr Mildred T. Mushunje

Adolescents' sexual and reproductive health matters, and their lives matter! Adolescents and young people make up the majority of the population in the Sub-Saharan region, including Zimbabwe. An adolescent is any persons aged between 10 and 19 years. Very young adolescents are defined as those aged between 10 and 14 years, and older adolescents as those aged between 15 and 19 years[1]. Investing in their good health and well-being increases their chances of having better and more productive adult lives (SRHR Africa Trust, SAT, 2021[2]). However, they remain at a very high risk of unintended pregnancies. Zimbabwe is one of the countries with high cases of unintended pregnancies especially amongst adolescent girls and young women (AGYW). Poor access to comprehensive Sexual reproductive health and rights (SRHR) services is a key factor in unplanned pregnancies amongst adolescents, and this often leads to unsafe abortions which is one of the contributory factors to adolescent mortality (ZDHS, 2015) and unsafe abortion contributes about 5 percent to maternal deaths (Ministry of Health, 2015). Abortion in Zimbabwe is a public health and human rights issue which remains highly stigmatised regardless of advocacy efforts to liberalise it.

Zimbabwe has one of the highest cases of unintended pregnancies among adolescent girls in the world. Girls who become pregnant are often forced into marriage, as it is generally taboo for girls to have children and not be married. A 2018 Amnesty International study[3] showed that the impact of "out of pocket" costs on contraception disproportionately disadvantaging adolescents who are already marginalised. With limited access to contraception, when a young woman becomes pregnant, and the option of a safe abortion is unavailable due to the restrictive circumstances of rape, incest and ill health (Termination of Pregnancy Act, 1977), she may end up being forced to marry to "save face" and not bring shame to the family. A 2022 landmark Constitutional ruling, which was widely celebrated, outlawed marriage before the age of 18 whereas in the past, girls could be married at 16 years and boys could marry at 18 years. However, child marriages continue to happen.

A UNICEF[4] report published in September 2023 shows staggering and worrying statistics for adolescent pregnancies. An estimated 1,706,946 Ante Natal Care (ANC) bookings were made in 1,560 healthcare facilities captured in the DHIS- 2 platform from 2019-2022 among women and girls aged 10 years and above. Of these, 21 percent were among adolescents aged 10-19 years. A total of 1532 maternal deaths were recorded and of these, 25 percent



Picture By Michael Gwarisa

were among adolescent and young women under 24 years. Of the estimated 50,957 pregnant women newly testing HIV positive, 0.1 percent were among adolescents aged 10-14 years, 15 percent among the 15-19 years. Adolescent pregnancy prevalence was 23.7 percent (337/1418) for adolescents aged between 10 -19 years. Among the 337 pregnant adolescences, 4.0 percent (20) had disabilities.

The UNICEF study found that 30 percent of the adolescent girls were sexually active and that sexual debut is 16 years. Sexual activity is unmatched with access to SRHR services as evidenced by the high number of unplanned pregnancies. The UNICEF report also highlights that one of the reasons for adolescent pregnancy was a restricted and sanctioned access to contraception. Socio-cultural beliefs and social expectation of how adolescents should handle themselves limited their access and uptake of contraception. Religion and cultural persuasions still expect adolescents to abstain from sexual activities until they are married when in reality, adolescents are sexually active as reported by UNICEF (2023) and SAT (2021).

Challenges faced by adolescents in accessing SRHR services include limited access to comprehensive SRHR services, high cost of contraceptives, stigma faced at health care facilities, child marriages in which adolescents cannot negotiate for use of contraceptives or safe sex. Attitudes and social norms have negatively impacted on the advocacy agenda for SRHR services and safe legal abortion for adolescents. Limited access to SRH services is one of the leading causes of clandestine abortions.

Conclusion

Unplanned pregnancies among adolescents remains an issue of concern. To guarantee their future health and wellbeing adolescents need to be protected and supported to access comprehensive SRHR services at an affordable cost. Information dissemination among adolescents is key so they understand the provisions of various laws on SRHR including the Termination of Pregnancy Act.

A call to action

Adolescents must be protected against unplanned pregnancies. Key action points includes:

- Supporting adolescents to access a package of comprehensive SRHR services which consists of information, education, counselling, and referral to services.
- Enacting an SRHR law with specific attention paid to the needs of adolescents.
- Reviewing the archaic Termination of Pregnancy Act to cater for the changing reality and needs of adolescents.
- Making SRHR services affordable for adolescents.
- Conducting research to understand the changing needs of adolescents' SRHR needs and in turn develop age-appropriate interventions.

Author Biographies



Mildred Mushunje (PHD)

Dr. Mildred Mushunje is a passionate and self-driven advocate for gender and social justice. She has a keen interest in women's and children's rights and is an award winner from the International Federation of Social Workers in recognition of her work on Gender-Based Violence. She is the Director of SRHR Africa Trust (SAT) and current Chair of the Civil Society Regional Reference Group of the Spotlight Initiative, a global EU-funded program on ending GBV. Her research interests include women's empowerment, social protection, and child rights and she has published widely on these. She holds a bachelor's Degree in Social Work (Zimbabwe), a master's Degree in Gender and Development Studies (University of Manchester), and a Doctoral Degree in Social Work from the University of KwaZulu Natal (S.A).



Dr Munyaradzi Murwira

Dr. Munyaradzi Murwira (MBChB, MPH) is a Public Health Specialist with 20 years of experience in Sexual Reproductive Health and Rights, Maternal and Child Health, and Population and development at the national, regional, and international levels. He served as the Executive Director of the Zimbabwe National Family Planning Council (ZNFPC) between 2010 and 2021. Between 2008 and 2010, he worked as a Senior Family Planning Advisor for Family Health International (FHI) in the Zimbabwe HIV/AIDS Partnership Project. Before joining Family Health International, he served as Technical Director for ZNFPC for the period 2003 - 2008. Currently, he is an Independent Consultant and Lecturer in Sexual Reproductive Health/ Maternal Child Health at the University of Zimbabwe. He has experience in the Public and Private Health sectors, including Policy Development; Strategic Leadership; Epidemiology and disease Control; Health Services Management; Programme Design, Implementation, and management; and Monitoring and evaluation.



Mufaro Musiyazviriyo

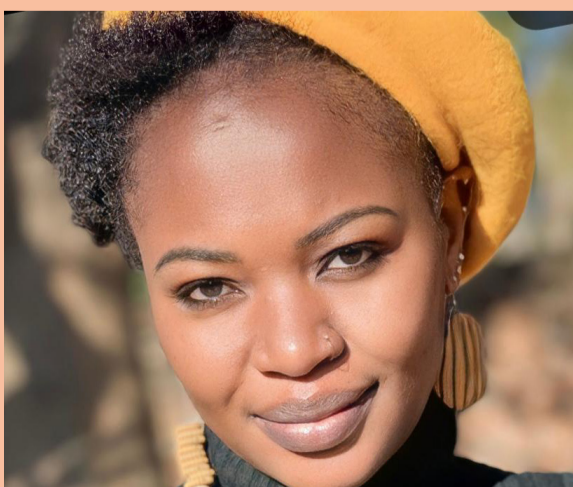
Mufaro is an upcoming young safe abortion activist with a passion for women's rights. Her experience ranges from SRHR to working with sex workers and other marginalised women in communities. She is a RCOG SRHR champion and coordinator for the Zimbabwe programme.



Edinah Masiyiwa

Edinah Masiyiwa is the Executive Director of Women's Action Group (WAG), an NGO promoting sexual and reproductive health and rights in Zimbabwe. Edinah is a gender and reproductive health consultant, with 25 years' experience. Her passion for women's rights is informed by her experience as a nurse midwife. Edinah holds a master's degree in development studies and an advanced certificate in sexual and reproductive health and rights.

Edinah is a member of the Country Coordinating Mechanism for the Global Fund in Zimbabwe. She is a Senior Aspen New Voices Fellow. Edinah is an SRHR Champion under the RCOG. Edinah has written extensively on SRHR issues.



Memory Kadau

Memory Kadau is a Pan-African feminist with 15 years of experience in organisational development, grant-making, program management, monitoring, evaluation, and learning (MEL), development communication, human rights, governance and democracy, leadership and Sexual and Reproductive Health Rights (SRHR), specifically sexual violence. Memory is an affiliate and SRHR Champion with the Centre for Women's Global Health, Royal College of Obstetricians and Gynecologists (RCOG), London 2021-2023.



Reproductive Rights
Menstrual Rights
Sexual Rights

**HER
BODY,
HER
CHOICE.**