Voice and Choice: A Safe and Productive future for young women in SADC

Today we are here to represent Women of the South Speak Out (WOSSO), the Voice and Choice Southern Africa Fund (VCSAF), and the Safe Abortion Alliance of Southern Africa (SAASA). WOSSO is a partnership across the global south that amplifies grassroots voices to inform the decisions and policies that affect our lives. We strive to create a more equitable future for all, driven by a commitment to inclusivity and shared strength. The VCSAF aims to achieve sexual and reproductive health and rights for all. SAASA is a growing and dynamic coalition of individuals and organisations from across SADC who are working together to advance women's reproductive rights, particularly the right to access safe and legal abortion.

We are:

- Vimbai Nyika - Programmes Officer at Women's Action Group (WAG) Zimbabwe, who is working on awareness raising on SRHR, mental health and gender equality.
- Ulemu Hannah Kanyongolo - a researcher, lecturer in law at the University of Malawi and the founder of the Young Feminists Network, an organisation which advocates for women's rights.
- Veronika Haimbili - A Health Advocate and Communications Specialist who is serving at the Ministry of Health and Social Services, Namibia, as a consultant.
- Refiloe Harris - who works at She-Hive, an organisation that promotes adolescent sexual and reproductive health in Lesotho.

In a landmark ruling in 2024, She-Hive Lesotho, a Voice and Choice Southern Africa Fund grantee, succeeded in obtaining a court order allowing the termination of a pregnancy which resulted from rape of a sixteen year old girl whom we shall call Lerato, as we cannot name her for legal reasons. Lesotho's Penal Code of 2012 allows abortion in compliance with the provisions of the Maputo Protocol, including in instances of rape. However, it is not easy to prove and families seldom pursue cases within the short timeframe which is granted for legal and safe abortions. The court issued the order towards the end of the first trimester, just in time for the legal termination to be conducted.

Lerato's aunt first referred her to She-Hive, due to her paternal grandfather with whom she lived, abusing her. Lerato's mother passed on when she was only 3 months old. Her father is working in South Africa. She-Hive's investigation confirmed the aunt's concerns. She-Hive arranged for Lerato to be removed from her home and placed in the Department of Gender's emergency shelter, to receive psychosocial support (PSS) pending prosecution of the grandfather.

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While at the centre, a security guard raped Lerato and she fell pregnant. She-Hive took the case to court. This resulted in the issuance of a court order in favour of the termination.

She HIVE further approached the court for a directive for her to be issued with birth registration and an identification document. This has also been granted. She HIVE is now supporting the girl to get a social grant from the Ministry of Social Development so that she has her own money for basic living expenses.

We have begun our presentation with this story because it demonstrates the multiple vulnerabilities faced by young women in SADC. While we were able in this instance, through sheer dogged determination to make tenuous laws work in favour of young women, this is rarely the case.

Challenges faced by young women

Youth constitute 60% of the population of SADC, and young women are slightly more than half of these youth, in other words they are the largest single demographic in our region. Yet young women constitute the majority of those who are unemployed, missing in decision-making, and whose rights are violated through GBV.

Adolescent pregnancy is an underlying cause of child marriage - when girls get pregnant it often results in them getting married and some families would rather arrange for a girl to get married before she is pregnant. The case that we have just presented could easily have ended with the girl married to the security guard.

SADC has unacceptably high rates of adolescent or teen pregnancy - the percentages of women who gave birth before age 18 range from 13,9% in Lesotho to a high of 40,2% in Mozambique[1]. There are many reasons why young girls become pregnant. These include sexual abuse (a recently released UNICEF report has found that 22% of girls in Sub Saharan Africa experience contact sexual violence before the age of 18[2]), economic insecurity leading to transactional sex, as well as youthful exploration of sexuality without enough information or access to contraceptives. The unmet need for contraception in sexually active, unmarried women aged 15 to 24 varies from a low of 16,8% in Namibia to a high of 46,3% in Zambia.[3]

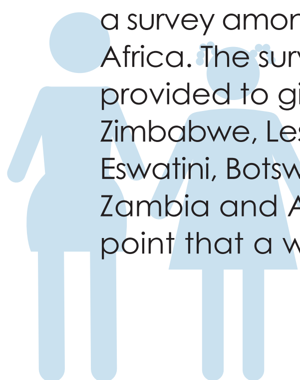
Pregnancy, in or out of marriage, often results in girls dropping out of school and social networks which limits their opportunities for economic advancement. Family, religious networks and the fathers of their babies reject young women who fall pregnant. They struggle with stigma and exclusion. Adolescent mothers, who often report unfriendly or abusive treatment from staff at local health services, access necessary maternal health care later than older women.

1 UNFPA Population Data Portal. Percentage of women aged 20-24 who gave birth before age 18. Accessed 17 October, 2024.
2 UNICEF. 2024. When Numbers Demand Action: Confronting the global scale of sexual violence against children. New York, UNICEF.
3 UNFPA Population Data Portal. Unmet need for Family Planning for spacing, sexually active unmarried women aged 15 to 24. https://pdp.unfpa.org/?_ga=2.149874806.1984151695.1729179124-555461704.1720437614&data_id=dataSource_8-2%3A1210%2CdataSource_8-5%3A9564&indicator=51&page=Explore-Indicators. Accessed 17 October, 2024.

To avoid the problems of adolescent motherhood, and to be able to continue with their education and progress to a career, many young women opt for abortions. Women all over the world of different backgrounds choose to have abortions for many reasons. Strict abortion legislation does not reduce the number of abortions. However, it drives girls and women to seek clandestine abortions, many of which are not safe, with devastating consequences.

Even in cases where legislation allows abortion in certain circumstances, for instance incest or rape, the burden of proof is often onerous. Many girls and their families do not attempt to prove this to access the safe abortion which should be available, especially as the time frame for an abortion is limited. Instead, they chose clandestine abortions. Further, where safe medical abortions are available legally, as in Mozambique and South Africa, many girls fear the attitudes and lack of confidentiality of health providers, coupled with deep societal stigma about adolescent pregnancy as well as abortions. They may, therefore, chose the anonymity and "social safety" of clandestine abortions.

Those that can afford to pay can access safe abortions, within their own countries, or by going to countries such as South Africa where safe abortions are available legally. The Sexual and Reproductive Justice Coalition, a Voice and Choice Southern Africa Fund grantee, conducted a survey among abortion providers in South Africa. The survey found that abortions are provided to girls and women from at least Zimbabwe, Lesotho, Mozambique, Malawi, Eswatini, Botswana, Nigeria, Namibia, DRC, Zambia and Angola. This underscores the point that a woman who has decided to have an abortion will find a way to have one. It also underscores the economic divide. Abortion should not be the prerogative of only those that can afford to pay.



The majority who cannot pay seek unsafe options which include drinking a range of plant or chemical based concoctions or inserting a stick, root or wire into the cervix. Being poor, rural and young are all associated with higher risk of unsafe abortion.

The World Health Organisation (WHO) estimates that there are approximately eight million abortions in Africa annually. Of these three quarters are not safe - with about a quarter unsafe (carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both) and half are least safe (that involve ingestion of caustic substances or use dangerous methods). Consequently, Africa has the highest rates of abortion related deaths of any region in the world. The global average death rate from unsafe abortion is 103 per 100 000 unsafe abortions, while the death rate in Africa is 220 deaths per 100 000 unsafe abortions. Thus, while Africa accounts for about one quarter of unsafe abortions globally, it accounts for about two thirds of abortion related deaths.[4]

Maternal Mortality ratios (MMR) in most of SADC are persistently high (as high as 547 and 566 per 100 000 live births in the DRC and Lesotho). Currently, only Seychelles in SADC has an MMR that is lower than the Sustainable Development Goal (SDG) target of 70 per 100 000 live births. The estimated contribution of unsafe abortion to MMR ranges from 4% in Botswana to high contributions of 13,8% in Mozambique and Tanzania and 14,1% in Zambia.[5]

[4] Population Reference Bureau. 2021. Abortion facts and figures 2021. Washington, DC. PRB. https://www.prb.org/wp-content/uploads/2021/03/2021-safe-engage-abortion-facts-and-figures-media-guide.pdf Accessed 18 August, 2024.
[5] WHO, Africa, Country Abortion Health Profiles as of 2019. https://staging.afro.who.int/pt/node/13767 Accessed 17 July, 2024.

Normative frameworks - regional

SADC needs to act urgently to be able to adhere to the **SADC Protocol on Gender and Development** as well as meet the following targets of the **SADC Sexual and Reproductive Health and Rights (SRHR) strategy:**

1. Maternal mortality ratio reduced to fewer than 70 deaths per 100,000 live births (SDG 3.1.);
5. Rates of unplanned pregnancies and unsafe abortion reduced;
6. Rates of teenage pregnancies reduced;
7. Universal access to integrated, comprehensive SRH services, particularly for young people, women, and key and other vulnerable populations, including in humanitarian settings, ensured (SDGs 3.7 and 5.6);
9. An enabling environment created for adolescents and young people to make healthy sexual and reproductive choices that enhance their lives and well-being (SDGs 4.7 and 5.6);
10. Barriers - including policy, cultural, social and economic - that serve as an impediment to the realization of SRHR in the region removed (SDGs 5.1 and 5c).

Normative frameworks - Africa

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (or the Maputo Protocol) in Article 14 on Health and Reproductive Rights gives women the right to choose to control their fertility through access to contraception. The Maputo Protocol was also the first treaty in the world to recognise abortion, under certain conditions[6], as women's human right which they should enjoy without restriction or fear of being prosecuted.

The legal status of abortion in SADC can be summarised as Member States whose legislation provides for:

- More than the requirements of the Maputo Protocol are South Africa and Mozambique (where abortion is available on demand) as well as Zambia and Seychelles (where abortion is available on socio-economic grounds);
- Compliance with the Maputo Protocol are Angola, Botswana, DRC, Eswatini, Lesotho, Mauritius, and Namibia;
- Partial compliance with the Maputo Protocol are Comoros, Malawi, Tanzania and Zimbabwe;
- Non-compliance with the Protocol is Madagascar.[7]

Global trends

Globally, there is a growing movement towards complete decriminalisation of abortion founded in notions of gender equality and human dignity, and challenging legal restrictions to women's bodily autonomy.[8]

The WHO 2022 Abortion Care Guideline calls for "the full decriminalisation of abortion."[9]

6 In cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.
7 Centre for Reproductive Rights, The World's Abortion Laws. https://reproductiverights.org/maps/worlds-abortion-laws/ accessed 29 August, 2024
8 Malagodi M, Gender Equality and the Complete Decriminalisation of Abortion , Int'l J. Const. L. Blog, Nov. 10, 2021, at:http://www.iconnectblog.com/2021/11/gender-equality-and-the-complete-decriminalisation-of-abortion/ accessed June 30, 2022.
9 WHO, 2022. Abortion care guideline. Geneva, World Health Organization. https://apps.who.int/iris/handle/10665/349316. accessed 21 June, 2022

The guideline say that decriminalisation means:

Removing abortion from all penal/ criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.[10]

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

The African Union Special Rapporteur on the Rights of Women, Honourable Commissioner Maria Teresa Manuela, has called on States to decriminalise abortion[11] and empower women and girls to make their own choices about their reproductive health."[12]

We stand ready to work with you in building a SADC in which the young women of this region play their rightful role as full active citizens, able to make their own choices, able to amplify their voices.

Appendices - additional information

Traditional unsafe abortion methods used in Sub-Saharan Africa include:[13]

- Substances ingested/inserted.
  - Plants/plant-based infusions: Aloe vera / burnt bean ashes / cassava leaves / garlic / gourd / honey / lime tree root / mango tree seeds / plectranthus (spurflower) / papaya-leaf poultice / boiled henna root / sisal leaves.
  - Store-bought non-pharmaceutical items, usually consumed in large quantities: Ammonia-based cleaning products (Handy Andy, Jeyes Fluid) / baking soda / beer / blood tonics / brandy / chalk / Coca-Cola / Maggi cube (concentrated bouillon) / fish poison / Nescafé/ steel wool mixed with Oros-Crush (soft-drink syrup) / toothpaste.
  - Combinations of store-bought and plant-based substances: Bark steeped in alcohol / lemon juice on a vaginal suppository / plants soaked in alcohol / strong black tea plus chloroquine (antimalarial).
- Pharmaceuticals.
  - Over-the-counter, usually in large quantities: Aspirin / Cafemol (caffeine plus paracetamol) / folic acid / laxatives (castor oil and Epsom salt) / paracetamol / potassium permanganate (wound cleaner) / snake antidote.
  - Antibiotics / Antimalarials / Deworming agents / Vasodilators Uterotonics Hormonal contraception.
- Objects inserted into cervix: Cassava sticks / metal rods or wires / scissors / tree roots.

[10] Ibid.
[11] Emphasis Gender Links.
[12] African Commission on Human and Peoples' Rights, 28 September, 2021. "Statement of the Special Rapporteur on the Rights of Women on the Occasion of the Global Day of Action for Access to Safe and Legal Abortion", 28th September, 2021 https://www.achpr.org/pressrelease/detail?id=602 Accessed 6 July, 2022.
[13] Bankole, A. et al From Unsafe to Safe Abortion in Sub Saharan Africa: Slow but Steady Progress, New York: Guttmacher Institute 2020.

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