

## CONFERENCE REPORT

### Decriminalisation of Abortion, Medical Abortion and Advocacy for Change Three Discussion Workshops

\*\*\*\*\*



At: 3rd Abortion & Reproductive Justice Conference: The Unfinished Revolution  
Rhodes University, Makhanda, South Africa, 9-12 July 2018

Report by Marge Berer with Christina Boateng and Pauline Diaz, 25 October 2018



Some of the participants

This is an informal report of a set of three workshops, facilitated by Marge Berer, that took place over three days with almost 10 hours of in-depth discussion and sharing of information and experience among the participants. This report was written by Marge Berer, International Campaign Coordinator, and is based on notes taken by Christina Boateng, Pauline Diaz and several other participants.

#### Background

We opened the first session by explaining that the Campaign is a membership-based network, initiated in 2012, to serve as an umbrella for those working for the right to safe abortion internationally. We have just over 1,300 members in 119 countries, from local groups and individuals to international, regional and national women's groups and NGOs, and our numbers are growing steadily. Our remit is to create a shared platform for advocacy, debate and dialogue, foster solidarity; promote coalition building; share information and experience to inform policy and programmes, and hold relevant stakeholders to account for the right of girls and women to make decisions about their own bodies and lives.

These workshop sessions, identified as Part 3 in the ARJC programme, were promoted on the [conference website](#) as a closed discussion group with a focus on Africa. About 33 people participated

overall. Three participants from the South African Department of Social Development also attended; they found the sessions extremely helpful, indeed eye-opening they said, and we understand they have encouraged positive changes by government in South Africa's abortion services as a result.

Everyone who registered in advance was asked to write a paragraph about what they wanted us to cover in the sessions. Their texts were rich in a wide range of political issues relevant to their work and were used by us to develop the agenda that was used throughout the three days.

These sessions were the first in what we hope will be a series of meetings on similar themes, including an international forum of 100+ people in Lisbon, Portugal, on 5-8 September 2018; two regional workshops – one in Quito, Ecuador, in October 2018 and one in Chisinau, Moldova, in November 2018; and a number of national workshops in the first half of 2019, which we hope to fund. Some of these have already taken place at this writing.

As follow-up work, we will also be proposing to participants to use their expertise on these issues to report research; write discussion papers, blogs, commentaries and journal articles; make videos; prepare informational leaflets for women and health professionals; and create other resources based on their experience and understandings arising from these forums – with a view to the Campaign publishing these in 2019.

The three Campaign sessions took place on three half-days during the main conference: 9-10-11 July. Some people came and went over the course of the three days because of commitments to participating in other sessions. But, overall, the continuity of the group was maintained. The response at the end was that it was excellent learning and sharing experience and very valuable. Marge Berer, Satang Nabaneh and Vania Kibui gave a report on the discussion in the closing plenary of the conference on 12 July.

The list of participants can be found at the end of this report. They came from France, Gambia, Kenya, Madagascar, Malawi, South Africa, Uganda, UK, USA, Venezuela, Zambia, and Zimbabwe. One of the US participants presented information based on several years of research in Morocco.

## CONTENTS

This report consists of:

- a summary of the discussion from each of the three days,
- the original agenda of the meeting that the discussion was based on,
- suggested reading on the themes and recent publications suggested by some of the participants,
- the conclusions of the participants and their recommendations for future work, and
- the list of participants.

\*\*\*\*\*

## DAY 1

### 1. Over-arching aim – decriminalisation of abortion

#### Introducing ourselves and jumping right into the theme

We started with everyone introducing themselves and answering the first agenda question: What kind of law on abortion do you want to see? Participants replied that the law should be known and understood; that it should be unrestrictive (or at least openly restrictive); that abortion should be reimbursed by social security, like any other health service; and that ensuring women can get safe abortions should be both enforced and implemented. They said it should give rights to everyone without stigma. It should address other aspects of sexual and reproductive health care too, not focus only on abortion. It should be a secular law, not based in religion. And it should not be about medical practitioners providing abortion. In fact, it should remove the power from doctors to control abortion and be about empowering women, including allowing women to manage their own abortions (with medical abortion pills). It should not permit conscientious objection. And there should be a strategy to monitor services and ensure they are of good quality.

We discussed the differences between legalisation of abortion and decriminalisation. The word “decriminalisation” implies taking abortion out of the criminal law entirely, yet a number of countries are saying they are decriminalising abortion when they mean only partially, i.e. only up to 12 or 14 weeks or only up to 24 weeks, and in other cases only to allow specified, limited grounds. We talked about the feasibility of moving beyond broadening existing legal grounds and making all abortions permissible at the request of the woman. Then we discussed what we would consider the minimal grounds we could accept, and the difference between what is feasible vs. what is desirable and what is at this stage only aspirational. Many participants stressed the importance of implementing the law, whatever it says, and of people, especially women and health professionals, knowing what was in the law and what was and was not permitted under it. The lack of such knowledge was considered a problem across the Africa region, and applies elsewhere too, preventing implementation even of existing laws.

While there was a common assumption around the table that abortion could only be partially legalised in their countries, if at all at this point in time, almost everyone thought abortion ought to be fully decriminalised and treated like every other healthcare service. On the other hand, some argued persuasively that a positive law would be preferable to having no law at all because it would provide protection to both women and abortion service providers – a perspective that needs far more consideration.

### The Maputo Protocol

We discussed the role of the Maputo Protocol, which celebrated its 15th anniversary during the week of the conference, in influencing legal reform. The Maputo Protocol, first tabled in 2003, has since been ratified by a large majority of African countries. However, it is not based on seeking to achieve women’s autonomy. Article 14 is about SRHR. Article 14.2.a calls for guaranteeing reproductive health without stating any restrictions, which would include safe abortion. If we want to use the Maputo Protocol as our gold standard, we should focus on that clause. Article 14.2.c, however, specifies that States must: “*protect the reproductive rights of women by authorising medical [safe] abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus*”. Thus, calling for 14.2.c to be implemented, as most often happens, means agreeing to accept legal restrictions on abortion that are not broad enough to satisfy us – restrictions that allow abortion only when the woman is a victim, or needs protection, or her reasons are morally acceptable.

Overall, nevertheless, the group felt that the Maputo Protocol has had an important value: it has created a reference point and a common text and language for the Africa region and serves as a tool for civil society to promote safe abortion.

It was pointed out that very few people actually know what exactly is in the Maputo Protocol, and that perhaps it would be best to urge governments to implement it without specifying the details, but focus instead on what we think is best to promote.

However, it must be remembered that no country in Africa has implemented anything from Article 14 to date, let alone passed any laws guaranteeing the rights contained in it. For example, Tanzania ratified the Protocol without restrictions some time ago but many in the current government seem not to know this, or are opposed to having done so, and abortion remains highly restricted. In the Democratic Republic of Congo, in contrast, the government was convinced to take steps that mean they will be required legally to reform their abortion law in line with the Protocol. How soon they will do so will probably require continuing advocacy and campaigning, however.<sup>1</sup>

---

<sup>1</sup> The Campaign newsletter [reported on 31 July 2018](#) that the Democratic Republic of Congo had legally gazetted the Maputo Protocol in March 2018, responding to pressure from a national coalition of NGOs, which means they must now reform their current abortion law in line with the Protocol, according to their Constitution. And in Cote d’Ivoire, the text of a draft bill on reproductive health, including proposals for abortion law reform, was published by [Ivoire-Soir on 9 July](#) which would allow abortion if the woman’s life or health were at risk, or if pregnancy is the result of rape or incest, or if the fetus has a serious condition or diagnosed malformation. These grounds are in line with the Maputo Protocol, presumably not by accident, though in both countries law reform may or may not actually happen soon.

### Abortion as a single issue or an SRHR issue

Our next question was whether it was better to try to campaign for safe abortion as an SRHR issue or as a single issue. One person thought it should be a single issue campaign, but thought the abortion movement suffers from self-stigma over abortion and therefore feels obliged to couch abortion within broader SRHR issues. Most people in the group thought it was easier to try and have abortion accepted when it was shown to be related to contraceptive use, safe motherhood, etc. In addition, it was said, if we propose laws that are broader and are more inclusive of a range of SRHR issues, it makes it easier for lawyers to interpret specific bits in a more positive way.

### Legal grounds

As regards the content of specific laws on abortion. Throughout the world, there are only six main grounds on which abortion is legal:

1. If there is a risk to the woman's life
2. If there is a risk to the woman's health, and sometimes also mental health
3. In cases of rape, incest or what some countries call defilement
4. In cases of serious or severe fetal anomaly (or more recently only fatal fetal anomaly, though the line between them is not always at all clear)
5. For socio-economic reasons
6. At the woman's request

Yet in every country, these grounds are phrased in almost 200 different ways, and interpretation matters at least as much as the words themselves. In 2008, the World Health Organization created a graph showing that the number of maternal deaths from abortion complications for each of these six grounds dropped significantly when the most common reasons women have abortions, that is, grounds 5 and 6 above, are legal. On the other hand, it has been argued both in England in 1933 and Colombia in 2006 that if abortion is not both safe and legal, the woman's life and health are at risk; therefore, if abortion is legal on health grounds, the law can be interpreted to cover all abortions.

### Other barriers

We summarised other sorts of barriers, including needing 1-2-3 doctors' approval, a judge's approval, spousal consent, and/or parental or guardian consent for minors and those unable to give consent.

### Legal landscape in African countries

Next we asked participants to describe the current legal landscape in their countries. The following information was provided:

<b>Malawi</b>	<ul style="list-style-type: none"><li>- Abortion legal only if risk to woman's life. Providing and having an abortion are both illegal.</li><li>- The law has remained restrictive since colonial times, but it is never really enforced, that is, no one is prosecuted for doing or having abortions. Hence, Malawi allows illegal and therefore unsafe provision.</li><li>- There have been several unsuccessful attempts to reform the current legislation but both have failed.</li><li>- Most recently, there was a decision to include everyone at the table to discuss law reform, i.e. religious and traditional leaders, as well as NGOs, to discuss law reform, including the Catholic Church, who all acquiesced in changing the law. But the Vatican got very angry when they heard this, and the Malawian Catholic church leaders stopped the law reform from going ahead after all.</li></ul>
<b>South Africa</b>	<ul style="list-style-type: none"><li>- Law allows abortion on request to 12 weeks, 12-20 for socio-economic and medical reasons, 20+ weeks if risk to life. As many as half of all abortions take place in "informal settings".</li><li>- A University of Cape Town study found 26% of abortions happen in the second trimester, raising concerns about barriers in accessing abortion in the first trimester. Or are women</li></ul>

	<p>waiting until the second trimester to seek abortions for some unknown reason? (This comes up as an issue in other countries too, later in the discussion.)</p> <ul style="list-style-type: none"> <li>- Illegal is not necessarily unsafe – some providers outside of the legal system are still following the correct abortion pill regimen, and the pills are coming from the public health system.</li> <li>- What is reported vs. not reported: medical abortion pill sales are not necessarily recorded in the public health data unless in companies' reports and their figures are not shared.</li> </ul>
<b>Morocco</b>	<ul style="list-style-type: none"> <li>- Abortion permitted only if there is a risk to life and with consent of the spouse.</li> <li>- Providers in the public health system are more concerned about their legal liability and position than about providing care.</li> <li>- Policing of private facilities – police will raid a gynaecologist's clinic on a tip that abortion is being provided there, and there are arrests and charges.</li> </ul>
<b>Zimbabwe</b>	<ul style="list-style-type: none"> <li>- Women not aware abortion is legal for any reasons. Safe abortion is a class issue. Access is problematic but no one understands the law surrounding access.</li> <li>- Abortion following rape is legal but women need to show proof of rape.</li> <li>- There are issues around consent in relation to a minor, who needs written consent from a magistrate.</li> <li>- For both reasons, due to procedural delays, access to legal abortions doesn't exist.</li> <li>- Mildred's case – see <a href="http://www.southernafricalitigationcentre.org/2014/04/08/judgment-in-mapingure-v-the-state-a-step-forward-for-womens-rights-or-a-token-gesture/">http://www.southernafricalitigationcentre.org/2014/04/08/judgment-in-mapingure-v-the-state-a-step-forward-for-womens-rights-or-a-token-gesture/</a></li> </ul>
<b>Madagascar</b>	<ul style="list-style-type: none"> <li>- Abortion is totally illegal.</li> <li>- Private facilities provide abortions but to a limited number of women.</li> <li>- Fine of US\$6000 or jail.</li> <li>- Cases (2) known of women held in jail without trial in 2017.</li> <li>- There is a lot of self-use of MA pills and other methods.</li> </ul>
<b>Botswana</b>	<ul style="list-style-type: none"> <li>- Abortion allowed for risk to life/health, fetal anomaly, rape/incest, but there are only unsafe abortions in reality.</li> <li>- No peer research on the role of providers.</li> <li>- Providers are very afraid of providing abortions and post-abortion care.</li> </ul>
<b>Zambia</b>	<ul style="list-style-type: none"> <li>- Gynaecologists control access to abortion because 3 doctors' approval is required by law (and there are few doctors) and gynaecologists do not want other health professionals to be able to manage abortions.</li> <li>- Post-abortion care services were decentralized but the infrastructure is weak.</li> <li>- One of the few countries in the region that has approved mifepristone, it is unclear why. Stock out problem means it isn't available.</li> <li>- Pharmacists as providers of misoprostol are a great support.</li> </ul>
<b>Kenya</b>	<ul style="list-style-type: none"> <li>- Abortion in the penal code but with exceptions, including in the constitution. But prosecutions happen.</li> <li>- Excellent standards &amp; guidelines published 2012 but withdrawn almost immediately. Advocates are in court trying to have them reinstated and also fighting to have providers released and women damaged by unsafe abortion who had a right to a safe abortion compensated.</li> </ul>
<b>Venezuela</b>	<ul style="list-style-type: none"> <li>- Restrictive setting and no data.</li> </ul>

#### Key supporters of law reform in African countries

The first session ended with a listing of who is actively supporting abortion law reform at national level in their countries. One person reported that even though the US Global Gag Rule was a shock, it had done two things: it had brought civil society together to campaign and it had also given a warning to national governments that they had to consider their own role in addressing the issues because US development funding was no longer available. People variously reported that women's groups were the most actively engaged. One person commented, however, that in many places, there is no

agreement among feminist groups as to what they are asking for. This needs debate and consensus-building; unified campaigns, which can bring a lot of people on board, are crucial.

In some places health professionals were engaged along with NGOs. In others, some people in the government were engaged as well as law and human rights experts.

We discussed the need to take a public stand and call for change to happen from the ground up. For that, we need support from a wide range of people. The participants said the following should be invited to be involved as key supporters in any campaign to change the law: political parties, senior politicians, members of parliament, government ministers, health department officials, judges, professional associations including of lawyers, obstetrician-gynaecologists, midwives, nurses, family planning providers, trade unions, religious leaders and human rights experts. This is a good list for everyone of where to seek support when launching a public campaign for abortion law reform.

Initially, however, no one talked about how important the actual abortion experience of girls and women is, especially those most at risk of unsafe abortions, who can talk about their experiences and stand up for other women. So we discussed this, and we also discussed the importance of a critical mass of support from all quarters, in order to be able to push the issue up the political agenda to effect change.

\*\*\*\*\*

## **DAY 2**

### **Addressing the opposition, medical abortion and issues related to abortion services**

#### Who/where is the opposition?

Everyone agreed the opposition needs to be addressed. Who are they, however, and how should they be addressed? The opposition uses feminist language in order to target women. They have a strong international lobby, which is very organised and well-funded.

One person warned that we needed to be careful when we talk about the opposition as a whole group because often even within the same organisation there are differences of opinion on the issues. Moreover, the spectrum of views between “pro” and “anti” may be wide and diverse, so it is important to listen to everyone, even if they are not as progressive as pro-choice people. And, it may be that the person at the top of an organisation is pro-choice but members of their staff/team may not be.

Restrictive law and policy are often blamed and this can act as a smoke screen, as health service providers are often the ones who actually limit access to abortion. Ensuring accountability is important when providers are failing to implement existing laws. It is apparent that there are many who oppose abortion at the point of implementation, whether it is at the level of departments of health, clinic managers, or doctors/nurses themselves.

Promoting the harm reduction approach is a quite good way to engage religious leaders. It may also be very useful for more people to know what religion actually says about abortion – for example, there are different Islamic schools of thought, each of which has their own interpretation on circumstances in which abortion should be allowed, and up to how many weeks abortions are deemed acceptable. And this is in fact true of all the major religions.

In Malawi, advocates have been supporting progressive people inside the groups which they want to work with. In Zimbabwe, sometimes the resistance to change does not come officially from an organisation but rather through online pressure and from “outside the borders”. Misinformation about the safety of abortion can be problematic – e.g. some sex workers think that getting an abortion later in pregnancy (i.e. second trimester) is safer, and then the conversation with them has to include the consequences of what may be seen as infanticide. Later abortions may also be thought to be safer than early ones because it will be more like a natural birth, supposedly with less bleeding. These beliefs have emerged in Kenya, Uganda and Zimbabwe. This is misinformation, but it is also explained by the fact that local practitioners, usually in rural areas, are only used to supporting women



who have stillbirths and/or miscarriages. They therefore feel more comfortable handling abortions at a later stage. It's more like childbirth that way, as they see it, which is all they know.

In recent times, infanticide is again emerging as a problem though it is not new, and the opposition is able to spin this issue in anti-choice campaigns. Infanticide is associated with the lack of access to abortion, safe or unsafe. None of these issues came up in research in South Africa, however, where abortions after 20 weeks are thought to be more common than elsewhere. It was also pointed out that many women in South Africa are using Depo Provera for contraception and if they fall behind in getting an injection, they often won't know they are pregnant for a long time as the injectable stops their periods; hence, they often seek later abortions.

Zambia is relatively liberal but is still very traditionally Christian. There is an important narrative in which abortion takes power away from the state and from the spouse/partner. Few arguments in support of safe abortion speak to this belief. Moreover, another reason for the state being against abortion is, for example, as in Zambia, that AIDS reduced the population a lot and abortion does the same. So one of the reasons for being against abortion is needing to rebuild the population. However, whether this motivates individual women to have more children is another thing. Historically, neither negative nor positive policies necessarily affect fertility rates significantly at a population level.

In Nigeria, one group developed a programme on how to talk to the press. They also did a media campaign using the biblical quotation: "Do not judge me." They decided it was important to customise their message for each person/point of view. In Morocco, people feel it is hard for them to interpret the issues differently from what the government or a religious leader has decided. Local feminists were opposed to a group coming in from outside and intervening in an ongoing local debate; they felt it would take them backwards. They needed to move at their own pace.

It was stressed that the role of religion vs. politics was especially sensitive. For example, a local religious leader could authorise abortion, but the state could still prosecute. Or vice versa, the government could be ready to change the law but conservative religious leaders do their best to block it. One person suggested including pro-choice religious groups like Catholics for Choice in the national discussion to show that many religious people are pro-choice. At the same time, some women have negative views on abortion. The example was given of single mothers, who are sometimes against abortion because if a pro-choice stance is accepted, they will be more stigmatised for having had a child outside of marriage when they could have had an abortion.

#### Abortion data and the consequences of legal restrictions

Data on the prevalence of abortion and abortion-related deaths are estimates only, based on complicated calculations. Numbers are important if recorded accurately, but legal exigencies mean that data are distorted to protect both women and health professionals. What you actually do with the data you collect is important. One person commented that data were becoming their own sideshow. However, in a world with no data, what could you tell policymakers to convince them the services you need are crucial?

Miscarriages are over-reported in hospital data where abortion is legally restricted, for a number of reasons. In many cases, they are in fact induced abortions among women who presented seeking post-abortion care for complications. Similarly, it is easier to record a late abortion as a stillbirth so as to avoid anyone asking questions. In addition, it is not recorded that women had used medical abortion pills. It was suggested that collecting information from women outside of the hospital setting might yield different and possibly more useful information. This has certainly been done in many countries using qualitative research methods (see, for example, the sisterhood method in relation to identifying maternal deaths in the community) but studies among women at the community level tend to include only small numbers as they are often under-funded.

Many women are unsuccessful in legally restricted settings in obtaining an abortion, and go on to have the baby. It was pointed out that an increase in abortions might be one indication that provision of abortion services is improving and reaching more women who need them, but anti-abortion people will say abortions are increasing and treat that as a negative thing. That makes some people ask: "What about addressing this issue without numbers?" Having to collect and provide data is scaring

providers because they fear it may be used against them. As long as women are accessing the services, they are comfortable, but they are not comfortable with reporting the numbers.

One person asked: “Is it possible to calculate the number of women having abortions with MA pills on the basis of sales of misoprostol?” The answer is: unfortunately not – because sales come from so many different places. Figures are not recorded or reported centrally anywhere, and no one knows how many misoprostol tablets each woman buys and then uses, or whether she shares them, or even whether it is actually misoprostol tablets that she had bought.

One research-based approach that has been used effectively in many countries in order to reduce unsafe abortion deaths and morbidity is for the Health Ministry to appoint a special commission to carry out “confidential enquiries into maternal deaths”. In these enquiries, which may be carried out every 2-3 years, every death related to pregnancy, whether wanted or unwanted, is studied, involving the health professionals who treated the woman. The purpose is to examine and understand why it happened – without blaming or punishing anyone involved – in order to find ways to prevent deaths in the future. This is an effective teaching and learning method for health professionals to understand why things went wrong. It is also a way to hold governments accountable for doing more to prevent deaths and serious morbidity, including but not only from unsafe abortion. The UK carried out these enquiries every three years for decades, until the number of deaths was so small it was barely worth continuing. The reports are an excellent learning tool as well.

#### Strategies to address the opposition

We need to network and collaborate with each other at country level in order to share information and plan strategic activities together. Working with the media is really important, to give them accurate information to publish about abortion. The Campaign media officer regularly contacts journalists when text is inaccurate and also talks to them about not using anti-abortion images that may be posted with their articles. We have published guidelines (in English and Spanish) for working with the media and the Bhekisisa Mail & Guardian Centre for Health Journalism in South Africa have also published guidelines on reporting for journalists, focused on the South African context, both of which can be adapted for use elsewhere.<sup>2</sup>

#### Untrue information about abortion

The group listed some of the untrue information about abortion that they have seen shared in the Africa region and we talked about what is true. Many anti-abortion groups claim that breast cancer causes abortion. While it is true that women who have never been pregnant have a higher risk of breast cancer (among other important reasons), having or not having had an abortion is not related to this. Or that abortion causes infertility. It is true that unsafe abortion can cause infertility if the woman suffers from an infection that is not treated in a timely way or suffers other serious damage to her reproductive organs that requires a hysterectomy. But safe abortion does not cause infertility; it is in fact one of the safest forms of clinical procedure available. Women who have abortions who become infertile have had unsafe abortions, often with invasive methods which do permanent damage or suffer negative outcomes because treatment was not available or provided soon enough to prevent lasting damage.

#### Engaging women at the community level

There is a need to increase the visibility of women’s experience of seeking and having an abortion. Personal stories of women who have had an abortion can be a powerful tool for advocacy purposes, and important to challenge the opposition and lobby policymakers. Abortion is present in our everyday lives, and our silence belies this.

A number of examples were given:

- In Nigeria, in a research project, when women were asked about anything related to abortion outright, they did not disclose. However, by asking around the subject in various ways, women eventually opened up and talked about their abortions.

---

<sup>2</sup> See <http://www.safeabortionwomensright.org/press-room/> for both these sets of media guidelines and other guidance and ideas for working with the media.



- In Zimbabwe, volunteer advocates have been really good at making women feel comfortable about talking about the subject.
- In Kenya, using “near misses” stories arising from unsafe abortions as examples for advocating against the opposition to abortion has been effective.
- Research in Brazil has shown that doctors who know someone in their personal lives who has had an abortion are more supportive of abortion, and the closer they are to the person, the more supportive of abortion they tend to be. Often times, however, doctors may not know they know anyone who has had an abortion.
- KMET in Kenya invited Miss Kisumu to become an SRHR champion and publicised this widely, which had a very positive impact.
- Several years ago, for International Safe Abortion Day, Ipas did a video in several Latin American countries, in which they interviewed people on the street, asking three questions: “Do you think abortion is wrong?” Most people replied yes almost automatically. “Do you know someone who has had an abortion?” Many people hesitated but answered yes. “Do you think they should go to prison?” Most of the respondents were silenced by this question, and did not answer. But it was clear they had never thought about it that way before. After each interview, the video ended: “Think about it”. Short but powerful. Some of the group responded: “Wow, let’s do that in Africa!!”

The opposition to abortion tries to present abortion as a symptom of wider societal problems (e.g. drinking, sex outside marriage, prostitution) and link it only to specific groups (e.g. sex workers, young women, adolescents). This gives them leverage as they use a narrative of deviant behaviours related to sex as resulting in abortion. In contrast, we need to show that it is often women with small children and women who have had all the children they want, most of whom are married, and women whose contraception has failed, who also have abortions – indeed, the majority of abortions. We need to point also to sexual abuse, rape, sexual coercion in marriage, and rape in war zones and crisis settings that often lead to unwanted pregnancies. Yet only girls and women are blamed and punished.

Moreover, it was pointed out that while abortion is, first and foremost, a women’s issue, unsafe abortion and the refusal of abortion affect many others too – i.e. women’s families, partners and children – especially if they die from complications of unsafe abortion.

Lastly, there was a call to invest in youth, a much trumpeted topic, but one where more heat than action has been generated.

#### Current situation – abortion services and post-abortion care (PAC) services

Only Tunisia, Ethiopia and South Africa have abortion laws that allow abortion services to be widespread. Although South Africa has the most permissive abortion law on the African continent, of the 3,000 facilities that could provide abortions, only 264 have actual services and the counselling culture was described as appalling. Facilities must be designated to provide abortions, which is a barrier, but the real issue is unwillingness among health professionals to do abortions. Yet South Africa was one of the first global south countries to change its law and also among the first to allow training for nurses and midwives to provide first trimester abortion care in the late 1990s, a fact which few people seem to remember, but it seems after the initial training an ongoing programme never materialised in the way it was envisioned.<sup>3</sup>

For much of the rest of the region, complications and deaths from unsafe abortion remain high even though post-abortion care – whose availability and quality of care differ widely across countries – has become the norm. As more women are using misoprostol, doctors are more willing to treat women who have induced an abortion with pills because the outcome is so much less damaging and traumatising than with dangerous invasive methods. In most cases of women seeking post-abortion care after using pills, the abortion is incomplete (or is in fact still happening but the woman got scared) and further doses of misoprostol or vacuum aspiration will complete the abortion, with treatment to prevent infection.

A lot of doctors are taking a stand and calling for safe abortion because they have been sensitised by seeing the damage caused by unsafe abortions in their wards, and the sometimes shocking

---

<sup>3</sup> See Dickson-Tetteh K, Billings DL. [International Perspectives on Sexual and Reproductive Health](#) 2002;28(3):144-50.

consequences. One participant said she wondered, though, would they have been convinced to support the pro-choice argument on the grounds of women's choice or is it only for public health reasons? Perhaps we should accept that public health reasons are enough, at least as a starting point, since this is the major concern of all health professionals. Supporting choice is not on the medical school curriculum, though it should be.

There was an excellent research project in Gabon which published two papers: a "before" paper in 2009<sup>4</sup> and an "after" paper in 2012.<sup>5</sup> The initial research found that women being treated for complications of pregnancy and delivery received treatment much more quickly than women with complications of unsafe abortion (less than 2 hours in the former cases versus almost 24 hours in the latter). The women who had died from complications of unsafe abortion might well have survived had treatment been initiated sooner. Training and addressing negative attitudes about abortion among the health workers changed this picture dramatically and deaths from unsafe abortion fell substantially.

Most countries say they have PAC services, but there are gaps in supplies and medicines, there is a lack of training, and often there is stigma amongst some of the health workers. More research is needed with health workers in PAC clinics on the quality and extent of PAC and whether women are getting good treatment in a timely way and their lives and health being saved.

Self-use of misoprostol pills is said to be working very well, but mainly because post-abortion care is available as a safety net. But post abortion care was appointed in the 1994 ICPD Programme of Action as an alternative to providing safe abortions to begin with, for countries that did not see themselves making abortion legal or safe in the foreseeable future. In that sense, post-abortion care has continued to give countries an excuse to keep abortion criminalised for 25 years now.

In Morocco, women who have had traumatic experiences with unsafe abortion methods were unlikely to seek post-abortion care. In Uganda, a harm reduction model based on that of Uruguay has been introduced; post abortion care can be accessed in public hospitals, and is said to be saving lives. In Kenya, the level of training and supplies for post abortion care is very poor in many public hospitals, and there is a lot of stigma amongst providers. However, data on access to post-abortion care and its effectiveness are very limited. In Gabon, the stigma involved with dealing with abortion complications still creates systemic discrimination.

One participant asked: What does harm reduction mean in the context of Africa? In South Africa, for example, for younger people, the idea of manual vacuum aspiration is frightening. Many prefer to use medical abortion pills. Yet, in Gauteng province, the health authority is not prioritising covering the cost of the pills, thereby leaving many with little access to MA in public services. Conditions like these are the reason why unsafe abortions are still rife in South Africa.

We came back to harm reduction later. This time what was said was that harm reduction in the African context means first and foremost getting basic information to women; secondly, increasing the provision of pills, though this is very restricted and restrictive, so the cost is high; and thirdly, preventing another unwanted pregnancy.

An in-depth study in Zimbabwe, published in the *BMJ Open* in February 2018, presented in another workshop in this conference, is among the few that have recorded in detail the severity and management of post-abortion complications. The study found that among 1,002 women seeking PAC in 127 facilities, 59% of women had complications classified as mild, 19% as moderate, 19% as severe, 3% as near misses and 0.2% died. A median of 47 hours elapsed between experiencing complications and receiving treatment; many delays were due to a lack of finances. Women who were in rural areas, younger, not in union, less educated, at later gestational ages or who had more children were significantly more likely to have higher severity complications. Most women were treated by doctors (91%). The main management procedure used was dilatation and curettage/dilatation and evacuation (75%), while 12% had manual vacuum aspiration (MVA) or electrical vacuum aspiration and 11% were managed with misoprostol.<sup>6</sup>

---

<sup>4</sup> Mayi-Tsonga S, et al. [Reproductive Health Matters](#) 2009;17(34):65-70.

<sup>5</sup> Mayi-Tsonga S, et al. [Reproductive Health Matters](#) 2012;20(40):16-21.

<sup>6</sup> Madziyire MG, et al. [BMJ Open](#) 10 February 2018.

Note: The authors of the study recommended moving post-abortion care to primary health care centres because the use of misoprostol for PAC was 96% effective.

As far as the workshop participants were concerned, overall post-abortion care has created as many problems as it has solved.

#### Training to provide abortion services

Limited or no training in doing abortions is a worldwide problem, both in countries where abortion is broadly legal and even more so where it is legally restricted. In the UK, for example, medical students get about two hours on the subject. In Kenya, it is 45 minutes. One participant said: We need to find out how many doctors (and we added midwives and nurses) and how many medical, midwifery and nursing students actually want to be trained and go into abortion provision as a calling – and think about how to encourage more to do so.

There was general agreement that training for abortion provision is non-existent in many parts of Africa; and where it is available it is often inadequate. In Madagascar, there is no training at all. In Kenya, many learn on the job; therefore, they may learn both the good and the bad, depending on which doctor they are shadowing and receiving “training” from. Zambian medical schools offer optional abortion modules, but there is very low uptake. Moreover, hygiene levels in many hospitals remain poor and the equipment used may not be changed between abortions. Gynaecologists still control the process. What happens outside the formal health system is another story entirely.

It was remarked that myths about abortion are believed and perpetuated by medical students as well as the public, and the lack of training means there is no opportunity for this to be addressed.

#### Abortion methods: outdated and unregulated

Dilatation & curettage (D&C) is still being done in many places by gynaecologists, especially in countries where abortion is legally restricted, both for abortion and post-abortion care. But D&C requires a hospital stay and general anaesthesia, making it far more expensive, and it carries more risks as well, though many of its practitioners deny this. The World Health Organization has not recommended the use of D&C for several decades now. Yet there has never been a concerted campaign to stop its use anywhere. One solution is to remove abortion services from hospitals and put them in the hands of trained midwives/nurses at primary care level, which would mean D&C is no longer likely to be used.

#### Medical abortion (MA) pills

Medical abortion (MA) pills are subversive of the status quo, and have become a harm reduction alternative in legally restricted settings. More in-depth research and information about what's changing in Africa because of medical abortion pills is needed, including barriers to accessing the pills and self-use.

Misoprostol and online informational websites on how to use it safely provide important opportunities when available together. But most women in Africa still don't know this information exists and don't know how to use the pills. The package insert with misoprostol pills is not about how to use them for abortion, and women need this information.

There are abortion information hotlines in Nigeria, Kenya, Malawi, Uganda and Morocco. Others are in the process of being set up and training provided for those who will work on them.

The GIWYN hotline in Nigeria was started because of misconceptions and stigma surrounding medical abortion pills. The hotline provides information about pregnancy, adoption and abortion on a toll-free number in 3 languages. They do not provide advice. The hotline operators are trained through role plays and scenarios to avoid inadvertently giving “advice”. GIWYN receives up to 1,800 phone calls per month. GIWYN is part of a coalition of 28 diverse NGOs, who support each other's work and share information.

Marie Stopes Uganda has a hotline that gets 2,000 calls a month asking for information on abortion. How to translate this information/advice into a service, however? One way is through a voucher

system, to get women to come to one of their clinics for follow-up, abortion-related or not. They are also working with pharmacists to train them to provide information on MA pills. But there is a high turnover of pharmacists, so this can be problematic. Ironically, emergency contraception is widely available and used, yet MA pills are illegal, even though the time in between when each should be used is only a few weeks.

Throughout Africa there are problems with women not knowing enough about MA dosage and regimen. There is also the problem that the combi-pack with mifepristone and misoprostol that is available does not contain enough misoprostol if the standard regimen needs to be supplemented with more misoprostol. This raises questions of whether to suggest using it or not, when it is unclear whether women will know to go back to get more misoprostol if they need it.

In Morocco, there is no protection for freedom of speech that would allow information on abortion to be provided, because abortion is in the penal code. It was noted that the current hotline number seems to be a private mobile number, which is risky, but means it does not require formal registration.

Adolescents are becoming increasingly internet savvy across the region, and are becoming aware of MA although they do not necessarily know how to use the pills most effectively.

Participants in the session felt that there was an important credibility issue when it comes to acquiring information on abortion in legally restricted settings in Africa.<sup>7</sup> And that there are a lot of issues with safety when women are not sure whether the pills they have obtained from a pharmacy or drug seller are the right ones, and bona fide or not, let alone how to use them.

When we talked about who could be trained quite easily to become MA pill providers – nurses, midwives and pharmacists as well as primary care doctors, it felt a bit like admiring an ideal, not something that could be implemented any time soon. Everyone could see that the role of pharmacists and other non-facility-based providers of medical abortion pills was a key to how change should happen. With simple training, they can provide a national service and make all the difference.

#### Cost of MA pills is high in Africa

It is important to find out who controls the costs and how to be able to reduce them. It is costly to import MA pills into a country, and for the providers as well

Telemedicine is proving very popular and highly successful in Australia and the USA. They are doing the same thing as the feminist internet providers (Women Help Women, Women on Web) on a more localised basis. This is especially valuable for rural women. But telemedicine is apparently illegal in South Africa and elsewhere, the strict laws would never allow it.

\*\*\*\*\*

### **DAY 3**

#### **Advocacy strategies**

##### What to do until the law changes...

We talked about the importance of progressive and purposive interpretation and application of the current restrictive abortion laws before law reform – because law reform is not around the corner across Africa just yet. One proactive activity is strategic litigation, as a way to initiate legal and human rights action in a high court to influence interpretation of the law and constitutionality of specific actions. There have been several cases in Kenya. The one that is ongoing at this writing involves the [Standards and Guidelines on Reducing Maternal Mortality and Morbidity from Unsafe Abortion](#), published by the government in September 2012 and withdrawn soon after, and a ban on training abortion providers was also instituted. Moreover, the case of a minor who was refused a legal abortion and later died from complications is also part of the case. The suit asks for reinstatement of

---

<sup>7</sup> See for example, re Madagascar: Pourette D, et al. [Contraception](#) Medical Abortion Special Edition, 2018;97(2), p116–121.

the guidelines, reversal of the ban on training providers, removal of the ban on Medabon (combi-pack), and compensation for the death of the girl and others.<sup>8</sup>

Two other key activities we discussed were:

- mobilising key national players to plan a campaign to change the law and mobilising women as a way of building a critical mass of support for future law reform, and
- challenging the government to provide abortion services for abortions that are already legal under the existing law.

#### Grounds for legal abortion revisited

- applying the law in a progressive, social way,
- explaining that a risk to health, using the WHO definition, always exists if abortion is not safe, and
- having a network of professional lawyers who can help providers understand the law.

In South Africa, one of the critical values is equality; therefore, services and access to abortion should reflect that. Equality is immediately enforceable, unlike health, which is a progressive right. When we use equality as a basis for advocacy; we know that there should always be things in place to protect this value and to ensure there is no discrimination at any stage of the proposed reforms. Equality is a ground not open to “interpretation”.

However, a rights perspective is often criticised by opponents of safe abortion as “too western” so some context is crucial when thinking of advocacy strategies to call for human rights in relation to abortion, which are in fact universal, not only western at all. Nevertheless, if context does not allow, there are still nuances to interpret equality.

The problem with grounds (which are treated as exceptions to illegality, at least) is that they always lead to some people being left out and are often left open to interpretation, which can be restrictive or open. Widely accepted interpretations can also be reflective of the societal (or lack of) views in a particular context too.

On request – embraces choice and autonomy.

On health grounds – makes it a public health issue.

Lots of grounds might be better than one ground? A range of grounds can open up opportunity for many women, and suggests women are not a homogenous group.

When we create a lot of grounds as “exceptions to illegality”, however, it can make it seem as if some abortions are more acceptable than others.

#### Women being arrested, held in detention, prosecuted, imprisoned

Much more information on this topic in Africa is needed. Here is what the group knew about:

In Malawi, women can spend up to 10 years in prison (pre-trial detention or after a trial?).

In Uganda, the police usually ask for a bribe.

In South Africa, some illegal providers have been arrested but no further action was taken.

In Morocco, the opposition tries to turn certain arguments into ridicule, e.g. saying mental health is not a real health reason because mental health is not recognised and the same for rape.

In Senegal, although the numbers are not high, the two offences of abortion and infanticide account for 38% of the female prison population in Senegal. The number of actual prosecutions has remained

---

<sup>8</sup> See [The law, trials and imprisonment for abortion in Kenya, April 2017](#), and reports about the case from 2018 in the Campaign newsletter: [here](#), [here](#), and [here](#).



low, compared to the number of women in pre-trial detention for suspected infanticide or illegal abortion, which is remarkably high. In 2012, the average duration of detention was nine months.<sup>9</sup>

In Rwanda, nearly one in four women in five prisons studied by Ipas in 2016 were there due to illegal abortion. In December 2016, an Extraordinary Cabinet meeting chaired by President Kagame, pardoned 62 girls and women imprisoned for abortions when they were under the age of 16, described as a gesture of mercy (not of justice). Many of them had become pregnant following sexual abuse. Moreover, rape was widespread during the 1994 genocide in Rwanda, and both the women and the resulting children were often rejected by the community and stigmatised, having to live what one woman called “a life without life”.<sup>10</sup> The absence of legal abortion on grounds of rape was exceedingly destructive.

Arrests are often reported in the media, but the stories are often sensationalist. They provide no background and do not concern themselves with the well-being of the girl/woman or who the person was who did the abortion, or whether it was safe or unsafe, unless the girl/woman has died.

Often for the women who are arrested, there is no legal support and both women and providers can be put in prison with no trial.

Anti-abortion advocates support and push for retaining and extending the criminalisation of abortion.

In Zimbabwe, we say we need to remember that any of us might need an abortion.

We need to campaign for training of providers and guidelines/protocols so that providers know that abortion should be allowed, sometimes even later in pregnancy.

In South Africa, we start with the equality principle because abortion is only for women. If they are unable to access services, that is discrimination against women. The equality principle is immediately realisable, because it is a human right and is entrenched in the law, which makes it mandatory and enforceable, whereas health is progressively realisable because there is space for interpretation, so enforcing it is more long term and a broader issue. Civil rights grounds can also be made realisable.

Specifying and limiting the grounds may lead to excluding parts of the population. Women have different reasons why they need an abortion. If you have to specify a ground, what about the women that simply have unwanted pregnancies? We should not put women in boxes.

Because of the opposition, a really wide-ranging law is aspirational. What we can get and have the support of public opinion is the reality. On the other hand, is it worth proposing a bill that will only help part of the population, when you may have to wait for years or even decades until you are able to propose another bill?

### Language around abortion

Use of language regarding abortion (e.g. spontaneous, induced) is important. Medical abortion pills are changing the language too – a nurse or doctor does not “perform” or “carry out” or “do” or “provide” a medical abortion, they provide information and the pills. The pills cause the abortion; it happens in the woman’s body and she manages the process mostly or completely at home. Self-use of MA pills can be done safely without a health professional’s involvement, as long as the woman has bona fide pills and knows how to use them, with back-up from the health system in case of difficulties. This is happening all over the world now, and health systems will need to “catch up” if and when the law allows them to.

Language was also discussed from another perspective. A few people in the group thought we should stop using the word ‘abortion’ altogether because it is too stigmatised. But that partly depends on the local language, each of which uses different words and terminology, e.g. in South Africa the law only uses “termination of pregnancy (TOP)”. IVG in French (literal translation: voluntary interruption of pregnancy) sounds more medicalised vs. avortement (abortion), maybe with less stigma. Moreover, if the process is stigmatised, the word for it is not the main problem.

---

<sup>9</sup> [The law, trials and imprisonment for abortion in Senegal](#), by Nandini Archer et al, April 2018.

<sup>10</sup> <http://www.safeabortionwomensright.org/?s=Rwanda>



There was a suggestion to do research on the terminology used by women in different countries to describe abortion.

#### Examples of important national activities

- One person thought that coalition building is dependent on funding that should be consistent. But in many cases the funding is not there, it is voluntary work or nothing. The opposition has funding and also the support of the Gag Rule.
- Not all abortion providers want to be activists, but some do if they are welcomed, and others can participate in others ways, e.g. by providing data and lobbying the Health Department.
- Training pharmacists is important for providing good information on MA pill use.
- Ensuring that women know their rights and where to find help is also crucial.
- Women who suspect they are pregnant, period is late, etc need to be encouraged to seek early confirmation of pregnancy, and if an abortion is wanted, not to delay.
- Family planning associations need to be involved, they can give information and support, provide MA pills where legal to do so, and post-abortion contraception.

#### Examples of African regional networks to participate in:

- HIV networks
- Solidarity for African Women's Rights
- Sex Rights Africa
- FEMNET
- Ipas Africa Alliance
- Institute for Human Rights and Development in Africa
- Women & Law in Southern Africa – groups in several countries

## CONCLUSIONS AND RECOMMENDATIONS OF THE PARTICIPANTS

We asked participants to write down 5-10 issues that for them were the most important to emerge from this 3-day conversation. These are the ones we received, grouped under two headings:

### 1. Commonalities and differences

- o Safe abortion advocacy work is becoming a global movement.
- o Coalition building is essential to moving forward.
- o A critical mass of support, especially among women and from a range of leaders, needs to be built in order to make change happen on the ground.
- o The majority of the group would opt for no abortion law at all, as a long-term goal. Only Canada has this. Some think there should be a law but with broader grounds than currently possible in Africa, as it would be protective of both women and health professionals to know exactly what was allowed.
- o More evidence-based research is needed to support advocacy strategies, movement-building, and working with religious leaders.
- o Africa-wide networking would be valuable.
- o Learning from each others' experiences is important.
- o Developing strategies for how to decriminalise, which involve more than just changing the law.
- o Train pharmacists and mid-level providers to provide abortion services – MVA and MA.

### 2. Transformative and contested issues

- o Mid-level health professionals and pharmacists as abortion providers: 21<sup>st</sup> century transformations.
- o Transforming the process of seeking/obtaining an abortion – moving abortion care out of hospitals into primary care, replacing D&C with WHO-approved methods, and developing enabling regulations and guidelines.
- o Supporting self-managed abortion with medical abortion pills.
- o Re-interpreting “grounds” for abortion: women often have more than one reason for needing an abortion. Even the most progressive laws create restrictions.
- o Abortions after 20-24 weeks of pregnancy cannot be ignored.
- o Conscientious objection: is it ethical?
- o Multi-sectoral approaches ; knowledge sharing.

## ACKNOWLEDGEMENTS AND THANKS

We would like to give a huge thanks to the organisers of the III Abortion & Reproductive Justice Conference at Rhodes University, in Mkhanda, South Africa – especially Catriona Macleod, Megan Reuvers, and Xolelwa Mbuyephi – who provided unstinting support and handled everything, e.g. registration of our participants, arrangement of accommodation, and booking of flights.

Christina Boateng liaised with the Rhodes people, looked after the participants of our sessions, put together the information pack, and took notes during the sessions. Many thanks also to Pauline Diaz, who participated in all three sessions and also took notes all three days. Without their respective notes, this report would never have been possible.

The participants were a fabulous group to work with, every one. The cumulative knowledge, experience and perspectives they shared were invaluable. We all learned a huge amount.

We wish to give heartfelt thanks to Lana Dakan of the David & Lucille Packard Foundation, for providing the funding that made the preparation for and participation in these workshops possible. With the Foundation's funds, the Campaign supported the participation of Marge Berer and Christina Boateng, as well as eight participants in the workshops and the conference: from Malawi (1), Madagascar (2), Zimbabwe (1), South Africa (1), Benin (1), and Uganda (2). Unfortunately, neither of the participants from Uganda was able to attend at the last minute.

Very grateful thanks also to the Safe Abortion Action Fund for supporting the participation of one of their grantees from Uganda, who very happily did attend.

## AGENDA

<b>DAY 1 – 9 July Monday</b>	3 hours 1:30-3:30, with 30 min break and 4:00-5:00
<b>Introduction</b> Agenda, process, volunteers to take minutes	Marge Berer  Everyone say who they are and answer question 1.1 in one sentence.
<b>I. Overarching aim – decriminalisation of abortion</b>  1. What kind of law on abortion do you want to see? 2. Is it helpful nationally to have a list of common grounds as an all-Africa goal? 3. Are the grounds in the Maputo Protocol the best common goal? <i>Article 14.2.c: protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.</i> 4. Is achieving safe abortion an SRHR issue or a single issue campaign?	Group discussion
<b>II. Current national situations – legal landscape</b>  1. What grounds for abortion are legal under your current laws? 2. How do current laws and policies actually work in practice. 3. Are women and health workers confused about the parameters of the law, and afraid of the possible consequences for breaching it? 4. Who is actively supporting progressive law reform? 5. What is holding back law reform? 6. To what extent do you think it will be possible to make any progressive legal reforms in your current national setting?	Background  #1 There are 6 main grounds internationally – life, physical/mental health, rape/incest, fetal anomaly, socio-economic, on request – with many linguistic permutations. Yet look how many different laws there are. Why?
<b>III. Mapping the opposition – who are they in Africa today?</b>  1. Western vs. African traditional culture – e.g. welcome all the children god gives. 2. Resistance against a “western radical sexual agenda” vs “cultural colonialism” supported by conservative religious organizations from the United States. 3. Understanding the new anti-abortion voice: young people using feminist arguments. 4. Influence of church leaders and faith communities – are they all anti-abortion? 5. Political leaders – which ones? 6. Health professionals – conscientious objection? 7. The rise of the perception that women MUST be mothers. 8. The roots of abortion-related stigma, myths, and misconceptions. 9. Conservative media. 10. International policies like the Global Gag Rule.	Who are they in your country?  What do people think?  What do women think?  What do adolescents think?  Have you ever asked them??

<b>DAY 2 – 10 July</b>	3.5 hours, 8:30-10:00 and 10:30-12:30 with 30 min break
<b>I. Advocacy and strategies for countering the opposition</b>  1. Is it really a pro-life/pro-choice debate – or is this binary narrative false and limiting? 2. Finding new ways to confront a society not willing to understand the issues surrounding abortion. 3. How to advocate for safe abortion services in a religious context, moving beyond religious/secular divides. 4. Making people aware how common abortion is – many wives and daughters and sisters and mothers of people we know, including of those who are anti-abortion, have had abortions. Not everyone wants many children and a lot of women have died having a lot of children. 5. How to lead a cultural change on the need for abortion? Who are the priority audiences? 6. Mobilising youth to take on leadership. 7. Myth-busting regarding misleading claims – e.g. if you have an abortion you won't be able to have any (more) children. That may be true if you have a dangerous abortion and your uterus has to be removed to save your life. Sharing accurate information. 8. Making people aware how safe abortion is. 9. Monitoring and addressing the opposition in UN forums – the role of the Africa Group.	Group discussion
<b>II. Current situation – abortion services</b>  <b>Background</b> 1. Are any legal abortion services being provided in your country? Where? By whom? To whom? 2. Is there post-abortion care? Where is it available? Is it saving lives, fertility and health, and if yes, for which women? 3. What methods of abortion are women using? Who is helping them have abortions? Are abortions getting safer (killing fewer women)? 4. What training do health care providers receive for providing MVA, VA or medical abortions? What about training in emergency obstetric care for abortion complications? 5. Are medical abortion pills changing this picture? 6. To what extent are safe abortion information hotlines and internet-based providers helping women to have safer abortions – in Nigeria, Morocco, Kenya, Malawi, Sudan (see: <a href="http://www.safeabortionwomensright.org/safe-abortion-3/safe-abortion-information-hotlines">www.safeabortionwomensright.org/safe-abortion-3/safe-abortion-information-hotlines</a> ).	Group discussion
<b>III. Medical abortion pills – Why they are subversive of the status quo of unsafe abortions and support women in situations of clandestinity.</b>  1. Agency, control, autonomy 2. Advantageous due to privacy and limited or no need to visit a health professional or clinic/hospital. 3. They support reproductive justice and bodily autonomy goals and meet women's need for abortion in the absence of health system/legal/political support. 4. They can make abortions very early, as soon as a woman misses her period. 5. Self-use of abortion pills is very safe and effective as long as women have access to bona fide pills and know what the right doses and regimens are.	Group discussion

- 6. They can be provided in the health system at community and primary care level and/or directly by pharmacists. Training to provide them is short and simple, and there are even online courses.
- 7. Their use has reduced deaths and serious morbidity from dangerous abortion methods since they first became available, e.g. in Brazil since 1989.
- 8. Misoprostol is an inexpensive, generic medication available over the counter in many countries. It is available in most countries. Mifepristone is available only in 40 countries as it is used only for abortion, whereas misoprostol has other obstetric and non-obstetric uses.
- 9. Mifepristone and misoprostol are on the WHO Essential Medicines List.
- 10. WHO has published details of the most effective dosages and regimens at different stages of pregnancy. It is possible to make misoprostol very effective through repeated doses where mifepristone is not readily available – new guidance is expected (soon).

**Limitations of access to medical abortion pills??**

- 1. What are these in Africa, e.g. irregular supply and cost of pills, and pills and other unknown medications that are not bona fide, women and health professionals with little or no information on where to find them or how to use them. National registration and approval of medical abortion pills is complicated due to restrictive abortion laws.

**Self-use of MA pills – are fears justified?**

- 1. Is monitoring of self-use of medical abortion pills necessary if women know they can safely seek follow-up care if they think they need it? No.
- 2. Is it extremely helpful to have a national phone line where women can ring if they are uncertain everything is happening as it should do? Yes.
- 3. If women have incorrect information on how to use the pills, is it dangerous? Life-threatening, almost never. Incomplete abortion with too little a dosage, yes. Risk from overdosing, no.
- 4. The role of pharmacists and other non-facility-based providers of medical abortion pills in legally restrictive settings is crucial. With simple training, they can provide a national service and make all the difference.
- 5. Telemedicine is proving very popular and highly successful in Australia and the USA. They are doing the same thing as the feminist internet providers (WHW, WOW, safe2choose) on a more localised basis. This is especially valuable for rural women.

**IV. Advocacy for, access to and availability of safe abortion services**

- 1. How to advocate effectively to position medical abortion pills as a safe method to meet women’s need for safe abortion.
- 2. Communication strategies towards the public, adolescent girls and women, and community-based and primary care level health care providers, especially pharmacists, nurses and midwives.
- 3. The major concern of youth is the high price of MA pills and limited availability, especially for those in rural settings. How to address this?
- 4. Who should provide abortion services in a legally reformed setting? How to move from here to there?
- 5. How to increase access to abortion, especially in public health services, in order to serve the most women. Role of private/non-profit clinics. Reducing unsafe abortions through access to information, training to provide MVA and MA, and setting up/offering abortion services.
- 6. Harm reduction approaches through extending access to misoprostol: Uruguay example, others.

Group discussion

<b>DAY 3 – 11 July</b>	3 hours, 9-10 and 10:30-12:30 with 30 minute break
<p><b>I. Advocacy strategies until law reform and access to services can be achieved</b></p> <ol style="list-style-type: none"> <li>1. Progressive and purposive interpretation and application of current restrictive abortion laws in Africa.</li> <li>2. Abortion access strengthening within current legal frameworks – particularly improving access for adolescents and for those pregnant as a result of rape or incest.</li> <li>3. Responding to arrests and imprisonment, dealing with conflict at police stations and in the courts, providing free legal representation to all health workers and women who need it.</li> <li>4. Educating health workers on abortion law and policy and how they can avoid conflict with the law.</li> <li>5. Implement harm reduction measures – what are these?</li> <li>6. Work to destigmatise abortion within a criminalised context.</li> <li>7. Seek to make national SRH policies to explicitly include safe abortion.</li> <li>8. Other?</li> </ol>	Group discussion
<p><b>II. Mobilising key national players</b></p> <ol style="list-style-type: none"> <li>1. Achieving a critical mass of support – how?</li> <li>2. Coalition building across political affiliations: NGOs, women’s groups, health professionals’ associations, media, legal people, human rights people, policymakers, parliamentarians, health system managers, finance people, pro-choice traditional and faith leaders.</li> <li>3. Building a grassroots movement of women. +++</li> <li>4. Youth engagement – who? why? what? how?</li> <li>5. Role of media, information and communication in this process. By whom? How? To whom?</li> </ol>	Group discussion
<p><b>III. Advocacy strategies for decriminalisation of abortion</b></p> <ol style="list-style-type: none"> <li>1. ACPHR Decriminalization of Abortion Campaign: An African solution to African problems? – How do we as civil society organisations participate in and influence this work?</li> <li>2. Strategies tried at national level that have or have not succeeded.</li> <li>3. Advocating for safe abortion on human rights grounds or public health grounds?</li> <li>4. What to do when human rights principles are condemned as a “foreign/western” concept.</li> <li>5. Making unsafe abortion a political priority for policy action – addressing the state.</li> <li>6. How do we articulate, communicate, and document our arguments for liberalization of laws (in order to effectively reach our audiences and build a consensus).</li> <li>7. Using litigation.</li> <li>8. Exposing the reality of infanticide where abortion is not available.</li> <li>9. Learning from best practices from countries that have successfully passed liberal abortion laws.</li> <li>12. Mobilising resources (technical and financial) for campaigns.</li> <li>13. Existing interventions are mostly urban-oriented, leaving out members of the peri-urban and rural communities despite policy frameworks being favourable. How to focus on them too.</li> <li>14. Gathering and disseminating women’s stories and the stories of service providers, e.g. at meetings, in publications or videos, on the web and/or social media.</li> </ol>	Group discussion



<p>16. Local women's meetings to share experiences and raise the issues locally.</p> <p>17. Public meetings.</p> <p>18. Strategic assessment – working with WHO to do a national assessment of law, policy and services in order to draw up a national strategy and implementation plan.</p>	
<p><b>IV. Regional networking</b></p> <p>1. Coordinating a regional level advocacy campaign – what does it take? Is this a priority? Why or why not? How to go about it?</p> <p>2. Regional dynamics: abortion battles.</p> <p>3. Revisiting working with ACPHR.</p>	<p>Concrete proposals</p>
<p><b>V. Next steps, for example:</b></p> <p>1. Follow-up meeting(s) at regional, sub-regional and/or national level to explore these issues in more depth, possibly in English, French and Portuguese?</p> <p>2. Research needs – regional/national – e.g. comparative of laws, trials/imprisonment, medical abortion access and use, quality/extent of post-abortion care.</p> <p>3. Information creation and sharing – blogs, research and discussion papers during the second half of 2018 for publication by the Campaign 2019.</p> <p>4. Proposals for national/regional action in support of abortion law reform, building public support, and coalition building.</p>	<p>Group discussion</p>

## SOME RECOMMENDED READING

### **The law, trials and imprisonment for abortion in Senegal**

by Nandini Archer et al, April 2018, International Campaign for Women's Right to Safe Abortion  
<http://www.safeabortionwomensright.org/wp-content/uploads/2018/04/The-law-trials-and-imprisonment-for-abortion-in-Senegal-April-2018.pdf>

### **The law, trials and imprisonment for abortion in Kenya**

by Alice Finden et al, April 2017, International Campaign for Women's Right to Safe Abortion  
<http://www.safeabortionwomensright.org/wp-content/uploads/2018/02/Kenya-report-updated-NA-Feb.pdf>

### **Roots of Change: A step-by-step advocacy guide for expanding access to safe abortion**

by Ipas, 2018  
<http://www.safeabortionwomensright.org/ipas-roots-of-change-a-step-by-step-advocacy-guide-for-expanding-access-to-safe-abortion/>

### **Seeking Social Change in the Courts: Tools for Strategic Advocacy**

by Mónica Roa with Barbara Klugman, Women's Link Worldwide, 2018  
<http://www.safeabortionwomensright.org/womens-link-worldwide-seeking-social-change-in-the-courts-tools-for-strategic-advocacy/>

### **Abortion narratives: moving from statistics to stories**

by Lisa Hallgarten  
[Lancet](http://www.thelancet.com), 9 May 2018

### **The WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes**

World Health Organization, 2007  
[http://apps.who.int/iris/bitstream/handle/10665/69883/WHO\\_RHR\\_07.7\\_eng.pdf;jsessionid=C019AB7B9BF79EFA8A23C9D42A47F35A?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/69883/WHO_RHR_07.7_eng.pdf;jsessionid=C019AB7B9BF79EFA8A23C9D42A47F35A?sequence=1)

### **A strategic assessment of unsafe abortion in Malawi**

by Emily Jackson, Brooke Ronald Johnson, Hailemichael Gebreselassie, Godfrey D Kangaude, Chisale Mhango  
Reproductive Health Matters, 2011;19(37)  
<https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2811%2937563-5>

### **Complications with use of misoprostol for abortion in Madagascar: between ease of access and lack of information**

by Dolorès Pourette, Chiarella Mattern, Rila Ratovoson, Patricia Raharimalala  
[Contraception](http://www.contraception.org) Medical Abortion Special Edition, 2018;97(2), p116–121

### **Abortion in two francophone African countries: a study of whether women have begun to use misoprostol in Benin and Burkina Faso**

by Carine Baxerres, Ines Boko, Adjara Konkobo, Fatoumata Ouattara, Agnès Guillaume  
[Contraception](http://www.contraception.org) Medical Abortion Special Edition, 2018;97(2), p130-36

### **Political priority for abortion law reform in Malawi: transnational and national influences**

by Judith Daire, Maren O Kloster, Katerini T Storeng  
[Health & Human Rights Journal](http://www.healthandhumanrights.org), Abortion & Human Rights, Special Edition, 15 March 2018

### **Medical abortion can be provided safely and effectively by pharmacy workers trained within a harm reduction framework: Nepal**

by Anand Tamang, Mahesh Puri, Sazina Masud, Deepak Kumar Karki, Diksha Khadka, Minal Singh, Poonam Sharma, Subash Gajurel  
[Contraception](http://www.contraception.org) Medical Abortion Special Edition, 2018;97(2), p.137-43

[Contraception](http://www.contraception.org): Special Issue on Medical Abortion, February 2018 (16 papers)

[Health & Human Rights Journal](http://www.healthandhumanrights.org), Special Section on Abortion and Human Rights, June 2017

## RESOURCES PROVIDED AFTER THE MEETING BY SOME OF THE PARTICIPANTS

From Satang Nabaneh

[Legal Grounds III: Reproductive and Sexual Rights in Sub-Saharan African Courts](#)

by Godfrey Dalisto Kangaude, Pretoria University Law Press, 2017

From Chrispine Sibande

Malawi: [Termination of Pregnancy Bill, 20...](#)

From Pauline Diaz

[Maputo Protocol: should we settle for any abortion law?](#)

Blog, by Pauline Diaz, safe2choose, 19 October, 2018

From Nancy Chong

[Prescribing Chaos on Global Health: The Global Gag Rule 1984-2018](#)

by CHANGE Center for Health and Gender Equity, June 2018

## PARTICIPANTS

Mandivavarira Mudarikwa, Legal Resources Centre, South Africa	Mandy@lrc.org.za
Jessica Marie Newman, Yale University, USA	Jessica.newman@yale.edu
Jacqueline Nassimbwa, Center for Health, Human Rights and Development (CEHURD), Uganda	nassimbwa@cehurd.org
Kristen A Daskilewicz, Gender Health and Justice Research Unit, University of Cape Town, South Africa	Kristen.a.daskilewicz@gmail.com
Satang Nabaneh, Centre for Human Rights, Faculty of Law, University of Pretoria, South Africa	satang.nabaneh@gmail.com
Louise Carmody, Amnesty International, Southern Africa Regional Office	Louise.carmody@amnesty.org
Talent Jumo, Katswe Sistahood, Zimbabwe	katswesistahood@gmail.com
Judith Daire, Curtin University, Australia	judith.daire@curtin.edu.au
Faith Nassozi Kyateka, Marie Stopes Uganda	Faith.n.kyateka@mariestopes.or.ug
Pauline Diaz, safe2choose, Kenya	pauline@safe2choose.org
Deborah Ewing, AIDS Foundation of South Africa	DeborahEwing@aids.org.za
Chrispine Gwalawala Sibande, former Director, Coalition for the Prevention of Unsafe Abortion (COPUA), Malawi	chrispinesibande@gmail.com
Mamitiana Jenny Rakotoarisoa, Decriminalisation Advocacy Lead, YouthFirst, Madagascar	jeni@youthfirstmadagascar.org ; jeni040617@gmail.com
Vania Kibui, Regional Policy Manager, Ipas Africa Alliance, Kenya	kibuiv@ipas.org
Judith Okal, Ipas Africa Alliance, Kenya	Kimbol@ipas.org
Lovatiana Andriamboavonjy, Nifin'akanga, Madagascar	lovatiana.andriamboavonjy@gmail.com
Kelly Blanchard, Ibis Reproductive Health, USA	kblanchard@ibisreproductivehealth.org
Tshegofatso Bessenaar, Ibis Reproductive Health, South Africa	tbessenaar@ibisreproductivehealth.org
Musa Yiga, COHERINET, Uganda	coherinet@gmail.com
Imameleng Masitha, Sexual & Reproductive Justice Coalition, South Africa	imameleng@gmail.com
Sonia Naik, Howtouseabortionpill.org, Lusaka, Zambia	Sonia@howtouseabortionpill.org
Tambudzai Gonese, Southern Africa Litigation Centre, South Africa	tambudzaig@salc.org.za

Noah Musoke, Voda Uganda	vodauganda@yahoo.co.uk
Tina Razafinimanana, CEO, Youth First Madagascar	tina@youthfirstmadagascar.org
Caroline Wanjiru Tatua, Ipas Africa Alliance, Kenya	tatuac@ipas.org
Nancy Chong, Planned Parenthood Association of Zambia	nancychong1995@gmail.com
Dintie Tayiru Sule, SAVE-Ghana, Ghana	sule@saveghana.org
Emma Kaliya, Malawi Human Rights Resource Centre, Malawi	emmakaliya@yahoo.co.uk
Clara Lungu, Women in Law in Southern Africa Research and Education Trust, Malawi	lunguclara@gmail.com
Roland Eddie Mhlanga, South Africa	rolandeddie@yahoo.co.uk
Three participants from the Department of Social Development, South Africa	