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SYNTHESISING LESSONS AND BEST PRACTICES:

Achieving Progress On Abortion Laws, Policies And Practice in Selected African Countries

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1. Introduction

This paper is written against the backdrop of the historical criminalisation of abortion and its causal connection with a heavy burden of unsafe abortion-related mortality and morbidity in sub-Saharan Africa. It is based on two main premises: first, that abortion remains socially stigmatised and legally restricted such that the law is a crucial gateway to safe abortion services in Uganda as elsewhere on the continent; and second, that it is well established that laws that permit abortion on broad grounds impact positively on unsafe abortion-related mortality and morbidity provided the laws are implemented effectively and safe abortion services are available and accessible.

The main objective of the paper is to explore progressive developments in abortion law, policy and practice reforms in selected countries in the African region to identify best practices as well as drawing lessons for Uganda. The selected countries are: Ethiopia, Ghana, Kenya, Mozambique, Rwanda and South Africa.

Each of these countries has reformed domestic abortion law in ways that contribute towards best practices and hold lessons for Uganda. The reforms in these countries serve as a microcosm only rather than an entire picture of the landscape of abortion law reform in the African region.

Virtually all African states, including Uganda, regulate abortion using the law. Whilst abortion remains restricted in all states, it is significant that the last four decades or so have seen the African region incrementally move towards the liberalisation of abortion laws that were inherited from the colonial state.[1] An increasing number of countries now recognise broader grounds for abortion beyond saving the life of the pregnant woman which was the sole ground under colonial laws.[2]

A milestone in the liberalisation of African abortions laws was the adoption in 2003 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) by the African Union. The Protocol inscribes abortion as a human right in a regional treaty.[3] Article 14(2)(c) mandates states to permit abortion where pregnancy poses a risk to the life or health of the pregnant woman or to the life of the foetus, or where pregnancy is a result of sexual assault, rape or incest.

1. *LLB, LLM, LLD, Barrister-at Law, Professor, Centre for Human Rights, University of Pretoria. C Ngwena 'Reforming African abortion laws: the place of transparency' In RJ Cook, J Erdman & BM Dickens Abortion law in transnational perspective: Cases and controversies (University of Pennsylvania Press, 2014) 166-186.
2. C Ngwena 'Access to legal abortion: Developments in Africa from a reproductive and sexual health rights perspective' (2004) 19(2) SA Public Law 328-350.
3. C Ngwena 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women', (2010) 32 Human Rights Quarterly 783.

More than three-quarters of African states (42 out 55) have ratified the Maputo Protocol.[4]

In 2014 the African Commission on Human and Peoples' Rights (African Commission) adopted General Comment No 2 to provide interpretive guidance to states on the normative content of the state obligations arising from the right to safe abortion guaranteed by the Protocol.[5] However, even with this liberal turn, on account of the stigma and controversy around abortion and its historical criminalisation, there is a trend in the African region for liberal abortion laws to remain unimplemented or administratively inaccessible, including in countries that have ratified the Maputo Protocol without reservations on article 14(2)(c).

> Uganda has retained the abortion law inherited from the colonial state. Colonial abortion laws were transplanted from the colonising countries as part of transforming African territories into European possessions. Save for a few British colonies that regulated abortion through received unwritten common law, penal codes were the main regulatory instruments, including in colonial Uganda.[6] Whilst all the former colonising countries have since reformed their abortion laws to allow women to access safe legal services and avoid recourse to unsafe abortions, ironically, some of their former colonies have retained the laws.

Colonial abortion laws had European ecclesiastical origins. Invariably, the laws subscribed to a crime and punishment model for regulating abortion as abortion was regarded as a mortal sin. Saving the life of the pregnant woman was the only defence to a charge of unlawfully procuring an abortion. In addition to the highly restrictive nature of colonial abortion laws, what constituted the defence of saving the life of the pregnant woman was left largely unarticulated, leaving knowledge about the parameters of legal abortion uncertain among health care providers, women seeking abortion and the general public. Uncertainty about the legality of abortion has served to contribute to a social climate that equates abortion with illegality, deterring health care providers from providing services even where the pregnant woman meets the permitted ground for abortion. Likewise, the climate of illegality that pervades abortion deters women and girls from seeking services in the formal health care sector.

Whilst Uganda has retained colonially inherited abortion law in its penal code, it must be stressed that Uganda's penal code is not the sole source of abortion law. The law on abortion in Uganda has multiple sources rather than a single source.[7] Though the domestic penal code has tended to be portrayed as the sole law on abortion, it is juxtaposed with other sources of law. Ugandan laws closely

4. https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLE%27S%20RIGHTS%20ON%20THE%20RIGHTS%20OF%20WOMEN%20IN%20AFRICA.pdf
5. African Commission on Human and Peoples' Rights. General Comment No 2 on Article 14 (1) (a), (b), (c) and (f) and Article 14 (2) (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Adopted by the African Commission on November 28, 2014.
6. Ngwena 'Access to legal abortion' (note 2 above).
7. C Ngwena 'Taking women's rights seriously: using human rights to require state implementation of domestic abortion laws in African countries with special reference to Uganda' (2016) 60(1) Journal of African Law 110-140 at 113.

connected with the legal regulation of abortion can be summarised as: provisions of the Ugandan Constitution (the Constitution), including article 22(2) which, as part of a provision that guarantees a right to life, provides that 'no person has the right to terminate the life of an unborn child except as may be authorised by law'; provisions of the Penal Code Act of Uganda (Penal Code), especially sections 141–43 that proscribe abortion when it is 'unlawfully' procured and section 224 that permits abortion for therapeutic reasons to preserve the life of the pregnant woman; and the common law of abortion in Uganda, which has historically served as a judicial gloss on provisions of the Penal Code.

> When acknowledging the Constitution of Uganda as a source of domestic law on abortion, it is important to go beyond article 22(2) which protects foetal life. It is necessary to factor in broader provisions of the Constitution including the rights that are guaranteed to women, not least the constitutional right to health which has been given fulsome juridical recognition by the Constitutional Court of Uganda.8 Furthermore, international treaties, especially ratified treaties, should be treated as an additional constituent element of the domestic law on abortion in Uganda, even if they are not directly enforceable.

In this regard, it serves well to note that Uganda ratified the Maputo Protocol in 2010, but placed reservations on the abortion provisions in article 14(2)(c).[9] In placing reservations, Uganda stated that 'unless permitted by domestic legislation expressly providing for abortion' it is not bound by article 14(2((c).[10]

Notwithstanding, it is submitted that the reservations cannot be construed as serving to restrict the substantive domestic law on abortion contained in the Constitution, the Penal Code and common law.[11] Equally, the reservations do not preclude drawing human rights standards from other treaties that Uganda has ratified without reservations, including the African Charter on Human and Peoples' Rights (African Charter). The same argument applies to provisions of the Maputo Protocol on which Uganda did not place reservations. They too can constitute persuasive jurisprudence.

The paper is divided into four main parts. The first part is the introduction. It provides an overview of the study. The second part explains the context in which the concept of 'best practices' is used in this paper. The third part examines and evaluates abortion law reforms in the countries selected for study to elicit best practices. The fourth and final part of the paper serves to bring together best practices from the selected countries with a view to drawing lessons for Uganda.

8. Constitutional Petition 16 of 2011 (2020) Constitutional Court of Uganda.
9. Republic of Uganda "Instrument of ratification: Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa" (2010) (draft copy on file with the author).
10. As above.
11. Ngwena 'Taking women's rights seriously (note 7 above) at 113-114.

2. Best Practices

The concept of best practices in this paper is used contextually to mean a set of guidelines or standards in the of laws, policies or practices that are generally accepted as effective in facilitating access to safe abortion for women and girls with unwanted pregnancies. Best practices emanate from multiple sources and are rarely the effort of a single body. Also, they are a process rather than an event as standards are always evolving. Best practices in the provision of access to safe abortion using law and policy are the product of a wide range of actors at global, regional and national levels, including civil society.

The following is a list of current sources of best practices:

- United Nations treaty provisions[12]
- Interpretation of United Nations treaties by treaty-monitoring-bodies in general comments and concluding observations[13]
- Quasi-judicial decisions of United Nations treaty-monitoring bodies[14]
- Enquiries conducted by treaty-monitoring bodies[15]
- UN Special Rapporteur on the right to the highest attainable standard of health
- Universal Periodic Review

12. The right to health in article 12 of the International Covenant on Economic, Social and Cultural Rights has been particularly instrumental.
13. For example: General Recommendation 24 of CEDAW Committee on the right to health in article 12 of the Convention of the Elimination of All Forms of Discrimination against Women; General Comments 12 and 22 of Committee on Economic Social and Cultural Rights on the rights health and to sexual and reproductive health respectively in article 12 of the International Covenant on Economic, Social and Cultural Rights; and General Comment 36 of HRC of the Human Rights Committee on the right to life in article 6 of the International Covenant on Civil and Political Rights.
14. For example: K.L. v Peru, Communication No. 1153/2003, adopted 24 October 2005, U.N. GAOR, Human Rights Committee, 85th Session, U.N. Doc. CCPR/C/85/D/1153/2003, (2005) (underscoring that where domestic law permits abortion, the state has a duty to adopt an effective administrative framework for facilitating the realisation of the permitted ground(s); L.M.R. v Argentina, Communication No. 1608/2007 (2007) (holding CCPR/C/101/D/168/2007, Human Rights Committee (2011) (holding that where a women or girl seeking abortion meets the ground for abortion, she should not be required to seek judicial authorisation as this is an additional burden that is burdensome and militates against timely access to safe abortion services); and L.C. v Peru, Communication No. 22/2009, CEDAW/C/50/D/22/2009, Committee on the Elimination of Discrimination against Women (2011) (holding that where the law permits abortion, the state has a duty to establish a procedure to enable women seeking abortion to realise their entitlements timely, including conducting education and training in the healthcare sector to sensitise healthcare professionals to respond positively to the reproductive health needs of women, and adopting guidelines or protocols to ensure the availability and accessibility of healthcare services, including abortion services).
15. For example, Committee on the Elimination of Discrimination against Women Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women (2018).

- Regional treaties
- Interpretation of regional treaties by treaty-monitoring-bodies[16]
- Decisions of regional courts[17]
- Office of the Special Rapporteur on the Rights of Women in Africa
- Decisions of domestic courts[18]
- Domestic reforms of abortion laws and the steady increase of countries that have been liberalising abortion
- Global consensus statements[19]
- Regional consensus statements[20]
- Sub-regional treaties, agreements and decisions of sub-regional bodies
- Standards and guidelines developed by professional bodies and ministries of health

At a global level, the World Health Organisation (WHO) has been particularly instrumental in documenting and synthesising best practices at the intersection between law, policy and access to services. The most elaborate statement by WHO on best practices in the provision of safe abortion is contained

16. For example, African Commission on Human and Peoples' Rights. General Comment No 2 (note 5 above).
17. For example: Decisions of the European Court of Human Rights in Tysiac v. Poland, Application No. 5410/03, 45 EHRR 42 (2007) (holding that in the light of the criminalisation of abortion, the when regulating abortion, the state has a duty to render the circumstances in which abortion is permitted reasonably clear, and to safeguard the legal rights of women seeking abortion in cases where they are aggrieved by a decision to deny their request; A, B and C v. Ireland, Application No. 25579/05 (2010), [2010] ECHR 2032 (echoing Tysiac, the decision highlights that highlights that even where abortion law is highly restrictive, there is, nonetheless, a duty on the state to take positive steps to implement any permitted ground(s); and RR v. Poland, Application No. 27617/04 (2011) (the decision echoes Tysiac and A, B and C and furthermore highlights the duty if the state to provide an administrative framework to guarantee the applicant adequate and timely access to diagnostic information prior to facilitate decision-making about terminating a pregnancy).
18. For example: R v Bourne [1938] 3 All ER 615 (interpreting the defence of saving the life of the pregnant woman) Crown Court, England (interpreting the defence of saving the life of the pregnant); Christian Lawyers' Assoc. of South Africa v. Minister of Health (1998) 11 BCLR 1434, High Court of South Africa (upholding validity of law permitting abortion as not contrary a right to life guaranteed in a constitution); Christian Lawyers' Association of South Africa v National Minister of Health (2004) 10 BCLR 1086 (T), High Court of South Africa (upholding the validity of statutory provisions that recognise the capacity of minors to give informed consent to termination of pregnancy without the consent or knowledge of their parents); C-355/06 (2006), Constitutional Court of Colombia (inferring a right to abortion as implicit in rights guaranteed to women under a constitution; Case T-388/09 (2009), Constitutional Court of Colombia (enunciating the parameters of the right to conscientious objection to abortion); (Federation of Women Lawyers v. Attorney General (2019). 2019] eKLR, Petition No. 266 of 2015, Decision of June 12, 2019, High Court of Kenya at Nairobi, Constitutional and Human Rights Division (upholding the validity of professional standards and guidelines for the provision of access to safe, legal abortions services pursuant to a right to abortion guaranteed in a constitution).
19. For example: International Conference on Population and Development (1994), Fourth World Conference on Women 1995); World Health Organisation Safe Abortion: Technical and Policy Guidance for Health Systems (Geneva, 2012); and Sustainable Development Goals (2015-2030).
20. African Union Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health (2016-2030).

in a report, Safe abortion: technical and policy guidance for health systems.[21] In chapter four of the report, WHO summarises best practices on law, policy and practices. The main criterion used by WHO to identify best practices is whether a particular law, policy or practices has the effect of removing a barrier to accessing safe abortion services.

At a regional level, General Comment No 2 of the African Commission stands out as an elaborate statement on best practices.[22] The General Comment has particular relevance to the intersection between abortion and the law. General comments clarify the nature and extent of the normative content of ratifying states' treaty obligations.

> By clarifying the obligations of the state as a duty-bearer, general comments necessarily also clarify the corresponding rights conferred on individuals as rights-holders. General comments are particularly important for providing interpretive guidance in areas where there is controversy and human rights remain unprotected as with access to safe abortion.

General Comment No 2 of the African Commission consolidates international human rights best practices in an African regional context.[23] Drawing from General Comment No 14 of the Committee on Economic, Social and Cultural Rights, General Comment No 2 throughout premises the right to abortion on the state obligation to ensure access to reproductive health services that are available, accessible, ethically and culturally acceptable, and of good quality.[24] General Comment No 2 employs 'accessibility' as a holistic normative concept. Accessibility in the General Comment is informed by a notion of substantive equality. It requires the state to ensure access to abortion services on a non-discriminatory basis and in ways that are physically accessible, economically accessible, and in which information is accessible. It is crucial to ensure the availability of quality services without any discrimination, including on the basis of age or marital status.[25]

All state obligations are couched in terms of the obligations to respect, protect, promote, and fulfil the rights guaranteed to women by the Maputo Protocol. The obligations to promote and fulfil are particularly important as many African states presently sit with laws and policies that have not been implemented. States are obliged to attend not just to barriers in law and policy but also the cultural, social, religious, and economic barriers that can stand in the way of women fulfilling their rights.[26] Sensitising and educating communities, religious leaders, traditional and political leaders on sexual and reproductive rights as well as training healthcare professionals is part of how the state ought to fulfil its obligations in the light of stigma associated with abortion.[27] Ultimately, the state must fulfil

21. World Health Organisation Safe abortion: technical and policy guidance (Geneva, 2012). This is a second edition of guidance which was first issued in 2003. WHO is in the process of preparing a third edition of the guidance.
22. African Commission of Human and Peoples' Rights General Comment No 2 (note 5 above).
23. C Ngwena, E Brookman-Amissah & P Skuster 'Human rights advances in women's reproductive health in Africa' (2015) 129 International Journal of Obstetrics and Gynecology 184-187.
24. African Commission of Human and Peoples' Rights General Comment No 2 (note 5 above) para 12.
25. As above, para 29.
26. As above, para 44.
27. As above, para 45.

its duty by allocating sufficient and available resources.[28] The General Comment's ultimate focus on the fulfillment of state obligations reflects Article 26 of the Protocol, which enjoins States to adopt all necessary measures and in particular provide budgetary resources for the "full and effective implementation" of the rights guaranteed by the Protocol.

One of the areas in which the General Comment clarifies abortion provisions of Article 14 is in explicating how abortion grounds should be understood. It is particularly significant to note that, in its conceptualisation of 'health', General Comment No 2 reflects WHO's holistic concept of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[29] Drawing from the technical guidance of WHO, the General Comment explains, for instance, that when determining health as a ground for abortion, the woman's reasons must be taken into account.[30] Furthermore, where the risk to "mental health" is relied upon, it is not necessary to first establish psychiatric evidence.[31] Because nearly half of African states permit abortion on the ground of the pregnant woman's health, this clarification is potentially enabling in most African countries where there are no precedents.

The General Comment clarifies, among other obligations, that states must remove restrictions that are not necessary for providing safe abortion services such as the requirements of multiple signatures, approval by committees before an abortion can be performed, or restricting the performance of abortion to only medical practitioners.[32] Where doctors are scarce - as in most countries in Africa - states should authorise mid-level providers such as midwives and nurses to perform procedures for which they can be trained to perform competently and safely.[33]

The General Comment explains that the right to conscientious objection is subject to positive states duties to ensure that women seeking abortions do not end up not receiving any services at all.[34] States must ensure that the necessary healthcare infrastructure is set up to facilitate referral to other health care providers. In addition, states must ensure that only the health personnel directly involved in the provision of abortion services enjoys the right to conscientious objection and that the right does not apply to institutions. In any event, the right to conscientious objection cannot be exercised where the pregnancy poses a serious risk to the woman or where she requires emergency care or treatment.[35]

This paper essentially adopts the recommendations of WHO and the interpretation of normative state obligations under article 14(4)(c) of the Maputo Protocol in General Comment No 2 of the African Commission as the standards for eliciting best practices from the reforms in Ethiopia, Ghana, Kenya, Mozambique, Rwanda and South Africa and drawing lessons for Uganda.

28. As above, para 45.
29. As above, paras 7 and 38.
30. As above, para 38.
31. As above, para 38.
32. As above, para 58.
33. As above, para 58.
34. As above, para 26.
35. As above, para 26.

Drawing from WHO's recommendations and the interpretive guidance in General Comment No 2 of the African Commission, it is submitted that best practices are abortion laws, policies, procedures or practices that:

- Institutionalise mechanisms for implementing abortion law effectively;
- Interpret the circumstances in which abortion is permitted purposively, to the full extent of the law rather than restrictively;
- Educate key stakeholders about the legality of abortion, including communities, women, health care providers and professionals, legislators, judges, law enforcement officers and policymakers;
- Refrain from censoring, withholding or intentional misrepresentation of abortion-related information by healthcare providers;
- Do not require third-party authorisation such as one or more healthcare professionals, hospital administrator or committee, courts and law enforcement officers to provide further certification of eligibility;
- Respect the autonomy of women to decide and do not require authorisation from or notification of parent or guardian or a woman's partner or spouse where the woman or girl can give informed consent;
- Broaden the range of healthcare professionals who can provide safe abortions services beyond medical practitioners to include skilled mid-level providers such as midwives and nurses for first trimester terminations;
- Do not restrict the range of methods for terminating pregnancy such as through failure to regulate and approve essential medicines;
- Regulate the exercise of the right to conscientious objection to prevent its abuse;
- Do not require mandatory waiting periods for women seeking abortion services;
- Do not require women seeking treatment for complications of illegal abortion to divulge the names of responsible persons;
- Avoid overly restrictive time limits on the gestational period for permitting termination of pregnancy;
- Do not exclude certain groups from provision of abortion services;
- Are accessible to women with unwanted pregnancy including to poor women and adolescents;
- Respect privacy and confidentiality;
- Provide expeditious grievance-remedial procedures for women who are denied abortion services; and
- Generally, respect, protect, promote and fulfil the human rights of women and girls.

In eliciting best practices from the selected countries, the paper goes beyond examining features of the law, policy and practice of providing access to safe abortion. It also considers whether the strategies used to secure reforms in the selected countries yield any best practices and lessons for Uganda.

3. Best Practices From Selected Countries

3.1 Ethiopia

3.1.1 Background to abortion law reform

In 2005, a new law on abortion came into force in Ethiopia as part of implementing the Criminal Code of 2004. Until then, abortion was regulated by the Criminal Code of 1957. Though Ethiopia did not inherit colonial abortion law as it was never colonised, nonetheless, the drafting of the Criminal Code of 1957 heavily appropriated influences from Europe as part of an effort to modernise an indigenously developed penal code of the Empire of Ethiopia.[36] Article 534 of the Criminal Code of 1957 permitted abortion where it was 'done to save the pregnant woman from a grave and permanent danger to life or health which is impossible to avert in any other way'. The Criminal Code of 2004 significantly broadens the abortion grounds. Liberalisation of abortion under the Criminal Code 2004 was achieved not as a standalone initiative but as part of a comprehensive revision of a penal code. The Criminal Code of 2004 repeals the Criminal Code of 1957.

> The new abortion law reflects an official realisation that highly restrictive laws under the Criminal Code of 1957 drove women to undergo abortion illegally and in unsafe conditions. Studies conducted and published by the Ethiopian Society of Obstetricians and Gynaecologists and Ipas, a non-governmental organisation, showed that domestic abortion law was not only dysfunctional but was an incentive for unsafe abortion.[37] Based on these findings the Ethiopian Ministry of Health concluded that unsafe abortion was a leading cause of hospital admission for women and mortality and that reform was essential.

According to Ipas, it took five years of advocacy to reform abortion law.[38] Whilst there was religious opposition, support for reform from the government, especially the Ministry of Health, was very strong. The rallying point for reform was reduction of a high burden of unsafe abortion-related mortality which was a shared goal between civil society and stakeholders in the Ministry of Health.[39] To engender the support of the government as well as avoid a backlash through popular resistance against reform, advocacy avoided framing abortion as a rights issue. It was framed as a public health issue.[40]

36. J Graven 'The penal code of the Empire of Ethiopia' (1964) 1(2) Journal of Ethiopian Law 267-298.
37. T Geressu et al Availability and utilisation of comprehensive abortion services in five regional states in Ethiopia (2007).
38. As above.
39. A Blystad et al The access paradox: abortion law, policy and practice in Ethiopia, Tanzania and Zambia' (2019) 18(126) International Journal for Equity in Health 1-15 at 11-12.
40. As above, at 11-12.

3.1.2 Grounds for abortion

Article 545 of the Criminal Code of 2004 criminalises abortion whilst article 551 provides the main exceptions or defences by articulating the circumstances in which abortion is permitted.

Article 551 provides that abortion is not criminally punishable where:

(1). The pregnancy is the result of rape or incest;

(2). The pregnancy endangers the life of the pregnant woman or the child or the health of the pregnant woman or where the birth of the child is a risk to the life or health of the pregnant woman;

(3). The child has an incurable and serious 'deformity'; or

(4). The pregnant woman, owing to a physical or 'mental deficiency' she suffers from or her minority age, is physically as well as mentally unfit to bring up the child to be born; and in cases of grave and imminent danger which can be averted only by an immediate intervention.

3.1.3 Operationalising grounds for abortion

In addition to the provisions of the Criminal Code which liberalise abortion, the Ethiopian Ministry of Health has developed guidelines for the provision of safe abortion.[41] The guidelines clarify the law and practice of providing abortion services under the Criminal Code and move away from a crime and punishment model of regulating abortion. They adopt a 'woman-centred abortion care' approach to ensure that women with unwanted pregnancies are provided with 'choice, access and quality services'.[42] Accessible services mean 'easy-to-reach, affordable and non-discriminatory' services.[43] The guidelines state that when accessing abortion services, a pregnant woman's mental and physical health and her circumstances should be taken into account.[44] The woman does not need to be in a state of 'ill' health.[45] In this way, the guidelines align with WHO's holistic concept of health when determining eligibility for abortion.

The guidelines dispense with burdensome certification requirements for rape and incest. They reiterate and reinforce article 552 of the Ethiopian Criminal Code, which does not require corroboration when abortion is requested on the ground of rape or incest. The guidelines state:

41. Federal Ministry of Health Technical and procedural guidelines for safe abortion services in Ethiopia (2013 2nd Edition). The first edition of the guidelines was issued in 2006.
42. As above, 8-9
43. As above, 9.
44. As above, 8.
45. As above, 10, 12.

> Termination of pregnancy shall be carried out based on the request and then disclosure of the woman that the pregnancy is the result of rape or incest. This fact will be noted in the medical record of the woman. Women who request termination of pregnancy after rape and incest are not required to submit evidence of rape and incest and/or identify the offender in order to obtain an abortion service.[46]

Not requiring corroboration for rape or incest is an important advancement in removing law as a barrier, avoiding secondary victimisation and securing substantive equality for women.[47] The emphasis is on timely access. A woman who is eligible for abortion should be guaranteed access to safe abortion services within three working days.[48] This period is intended to facilitate diagnostic procedures and non-directive counselling.

The guidelines further stipulate that providers of abortion services must secure informed consent for the procedure using a standard consent form. The service provider will not be prosecuted if the information provided by the woman is subsequently found to be incorrect. This proviso provides reassurance to service providers who might otherwise be deterred from rendering lawful services for fear of prosecution.

Another important clarification brought by the guidelines is that they make it mandatory to treat a patient who is suffering from the effects of illegal abortion induced by her or another person. This practice offers meaningful assistance to women who are suffering from the effects of unsafe abortion and might be afraid to access health services. The healthcare professional is under a duty to respect patient confidentiality, unless compelled to breach confidentiality by a court.

The Ethiopian health ministry has the responsibility of authorising public and private facilities where abortion can take place. The guidelines broaden the scope of health care professionals who can perform or prescribe abortion. In addition to doctors, mid-level providers in the form of health officers, clinical nurses and midwives who have the relevant training and skills are recognised as competent to perform first-trimester abortion using medicines or manual vacuum aspiration (MVA).[49]

46. As above, 12.
47. S Mavundla & CG Ngwena'Access to abortion for rape as a reproductive health right: a commentary on the abortion regimes of case study of Swaziland and Ethiopia' in CG Ngwena & ET Durojaye (eds) Strengthening protection of sexual and reproductive health through human rights in the Sub-Saharan region (Pretoria University Law Press, 2014) 61-78.
48. As above Federal Ministry of Health Technical and procedural guidelines for safe abortion services in Ethiopia, 11.
49. As above, 24-25.

3.1.4 Evaluation

The substantial broadening of the grounds of abortion under the Criminal Code of 2004 and the liberal interpretation of the grounds under the guidelines issued by the Ministry of Health have cumulatively created a conducive legal environment. The focus has shifted from a preoccupation about whether the woman meets the grounds for abortion to whether services are available and accessible thus underscoring a reproductive health model rather than a crime and punishment model for regulating abortion.

> The Ministry of Health has made significant progress in rolling out services, educating and training providers on ethical, legal and technical aspects of providing abortion services. The training has involved 'values clarification' workshops to assist health workers with understanding the different social and moral dimensions of abortion so that they can understand better their perceptions and the different perceptions of others whilst respecting the legal entitlements of women seeking access to safe services.

More women and girls are accessing services than under the old law. Although unsafe abortion-related mortality and morbidity remain a major public health danger, it has begun to drop as an increasing number of safe abortions are being performed.[50] However, significant barriers to access remain.[51]

The stigma around abortion continues to be a barrier, holding back women from accessing safe services they are legally entitled to for fear of disclosure in the community or disapproval by providers. Public awareness about the legality of abortion has not been adequately promoted by the state in order to avoid inviting a backlash. Lack of knowledge about the legality of abortion is a reason why significant numbers of women, especially young women, still have recourse to clandestine abortions.

Progress in scaling up the provision of safe abortion services and requisite access appears to have been slow. Ethiopia's population is largely rural and yet services are predominantly located in urban areas. For rural women, especially, public health facilities are often too far away from home and transport is either lacking or unaffordable. There is also a public and private healthcare sector divide in the provision of access. One study revealed that only about 50 percent of the health facilities eligible to offer abortion services were in offering services, with the majority of facilities in the private and non-governmental sector.[52] However, women used predominantly state facilities if they experienced complications from unsafe abortion.[53]

50. H Gebreselassie et al 'Caring for women with abortion complications in Ethiopia: National estimates and future implications' (2010) 36 International Perspectives on Sexual and Reproductive Health 6; S Singh et al 'The estimated incidence of induced abortion in Ethiopia' (2010) 36 International Perspectives on Sexual and Reproductive Health 16.
51. D Bridgman-Packer & S Kidanemariam 'The implementation of safe abortion services in Ethiopia' (2018) 143 International Journal of Gynecology & Obstetrics 19–24 at 22; Blystad et al, note 39 above; Mavundla & Ngwena, note 47 above.
52. Singh et al, note 50 above.
53. Singh et al, note 50 above.

Shortage of trained healthcare professionals and accessible facilities remains a major barrier. Nonetheless, despite subsisting barriers to access, it is significant that Ethiopia has made important strides in tangibly moving away from highly-restrictive law as well as mitigating administrative barriers. Though abortion remains criminalised under the Criminal Code, a reproductive model for regulating abortion is in ascendancy in Ethiopia.

3.2 Ghana

3.2.1 Background to abortion law reform

Independent Ghana inherited from Britain a penal code that criminalised abortion. Provisions of the Criminal Code of Ghana of 1960 which regulated abortion until their repeal in 1985 had been inherited unchanged from the Criminal Code of 1892 of the Gold Coast.[54] In turn, the Criminal Code of 1892 had been modelled on British law. Whilst criminalising abortion, the Code permitted a defence to a charge of unlawfully procuring an abortion when it was performed for rendering 'medical or surgical treatment' to the pregnant woman. Section 67(2) of the Criminal Code of 1960 provided that:

> "Any act which is done, in good faith and without negligence, for the purposes of medical or surgical treatment of a pregnant woman is justifiable, although it causes or is intended to cause abortion or miscarriage, or premature delivery, or the death of the child.

At the time that the Criminal Code was drafted, saving the life of the pregnant woman was generally regarded as the only permitted defence in jurisdictions that had inherited colonial abortion law. However, the Criminal Code was different in that it provided a broader therapeutic defence that is not limited to saving the life of the pregnant woman. Its antecedents, such as the Offences against the Person Act, did not expressly provide a defence. It had been left to common law to fill in the gap. In 1938 in the Bourne case, an English court held that the word 'unlawfully' in the 1861 Act implies that there are circumstances in which it is lawful to procure an abortion.[55]

The court said that abortion is not unlawful if it is performed to preserve the life of the woman and that preserving life should be understood broadly to also cover preventing a very serious danger to the physical or mental health of the pregnant woman. However, though the ruling in Bourne significantly liberalised abortion law, the degree to which the ruling was followed in the colonies was not always clear. In providing in its penal code a therapeutic defence without qualifying the risk posed to the woman's health or life, Ghana can be described as a pioneer in the liberalisation of abortion not just on the continent but also globally.

54. FL Poole-Griffiths 'The law of abortion in Ghana' (1973) 10 University of Ghana Law Journal 103.
55. R v Bourne [1938] 3 All ER 615.

Notwithstanding the liberal orientation of the abortion provisions of the Criminal Code of 1960, the state did not take any steps to implement the law. Abortion remained clouded by a climate of illegality. This served to deter health care providers from providing services for fear of prosecution. It also fuelled recourse to unsafe abortion leading to calls to implement the law. The law was revised in 1985 by PNDCL 102.[56]The revision took place under a military government. It is not clear what influenced the revision.

3.2.2 Grounds for abortion

Law PNDCL 102 of 1985 which is incorporated into section 58 of a consolidated Criminal Code of 1960 permits abortion in the following circumstances: where the pregnancy is a result of rape, incest, or 'defilement'; risk to the physical or mental health of the pregnant woman; and foetal health.

In one sense these grounds can be understood as further liberalisation of abortion law to the extent that they go beyond risk to the physical and mental health of the pregnant woman. In another sense, it can be argued that the grounds articulated under the 1985 law were not substantive additions as they were already implicit in what constitutes the physical or mental health of the woman if the holistic concept of health developed by the World Health Organisation is used.

The liberalisation of abortion in 1985 was ahead of many of its counterparts in the African region. However, on account of the cumulative effect of the stigma surrounding abortion, perceptions by health care providers and the public that abortion is illegal and the lack of implementation of the law by the state, the abortion law of 1985 at first yielded little to women seeking safe abortions. The revised law failed to translate into access to services and make a positive impact on the burden of unsafe abortion-related mortality and morbidity. This failure spurred an initiative that was led by the Ghanaian Ministry of Health in 2006 to adopt guidelines to guide healthcare providers and professionals in the provision of safe, legal abortion services. The guidelines are in their third edition.[57]

3.2.3 Operationalising the grounds for abortion

The Ghanaian guidelines are written in clear and accessible language with hindsight of the common misconceptions about the illegality of abortion under domestic law. When explaining the grounds for abortion, the guidelines subscribe to a holistic concept of reproductive health. They have been shaped by the objective of transcending a crime and punishment model in favour of a reproductive health model. They draw their inspiration from commitments made by the governments under International Conference on Population and Development, and from the guidelines on safe abortion developed by WHO.

56. Criminal Code Amendment, PNDCL 102, incorporated into a consolidated Criminal Code of 1960.
57. Ghana Health Service Prevention and management of unsafe abortion: comprehensive abortion care services, Standard and guidelines (Republic of Ghana and Ghana Health Service, 2012).

The guidelines clarify to health providers how the legal grounds for abortion should be applied in the health care sector. The guidelines also seek to remove burdensome requirements such as requiring psychiatric certification before eligibility for abortion on the ground of mental health, or forensic evidence before eligibility on the ground of rape or incest. In respect of rape, incest and defilement, the guidelines state that no evidence of the commission of these acts is required before the provision of abortion and that 'a client's word is sufficient'.[58] On abortion requested on the ground of mental health, the guidelines provide the following clarification:

> Mental health refers to a state of emotional, psychological and social wellbeing and not merely the absence of disease in matters relating to mental function. A continuing pregnancy may put a client's mental health at risk. Mental health is essential to personal welfare, family and interpersonal relationships and the individual's contributions to the community or society. No psychiatric assessment is required in order to obtain legal abortion.[59]

The guidelines attend to other pertinent rights and obligations associated with the provision of abortion. For example, they address conscientious objection and underline that only those 'directly' involved in the performance of abortion procedures can exercise the right to conscientious objection. Furthermore, conscientious objection is subject to a legal duty to refer the woman to an 'accessible' provider of abortion services. Regarding minors, the guidelines encourage rather than require parental involvement. They recognise that some minors who are capable of consenting to abortion may choose not to involve their parents.[60]

The guidelines explain that there is a right to conscientious objection but it is subject to the state's duty to ensure availability of services and provider's duty to refer the patient to accessible services.[61] The right does not apply where treatment is necessary to preserve the woman's health or life. Furthermore, the right cannot be exercised to deprive minors of access to treatment as this is constitutionally prohibited by article 28(4) of the Constitution of Ghana.[62]

Another important area of clarification relates to who is recognised as competent to perform or prescribe abortions. Section 58 of the Criminal Code expressly recognises medical practitioners only. The guidelines, on the other hand, recognise that mid-level providers can perform abortions in the first trimester.[63]

3.2.4 Evaluation

The grounds for abortion under the Criminal Code are enabling. The guidelines are designed to

58. As above, 16.
59. As above, 16.
60. As above, 17.
61. As above, 17.
62. As above, 17.
63. As above, Appendix 2.

promote transparency in implementing the permitted grounds. They emulate best practices, including the practices recommended by WHO.[64] Equally, the guidelines are consistent with the guidance provided in General Comment No 2 of the African Commission. What is lagging behind, however, is implementation. Substantial barriers to access remain.[65]

The legality of abortion has become more widely known among providers of abortion services. Notwithstanding, Abortion care remains highly stigmatised, including by providers. Though more providers are now willing to provide services in the private sector, the public sector, which serves the majority of women, especially poor women and adolescents, has yet to forthrightly promote awareness about the legality of abortion or meaningfully operationalise access. In any event, there is an urban-rural chasm even for services in the private sector. This leaves women and girls in rural locations doubly disadvantaged.

3.3 Kenya

3.3.1 Background to abortion law reform

Kenya mirrors Uganda in inheriting abortion law contained in a penal code that was introduced during the colonial era. The British introduced to their East Africa colonies a penal code that was adopted from the Indian Penal Code which had been drafted to serve as a model for regulating crimes in British colonies. Under the Penal Code of Kenya, which is still extant, 'unlawfully' procuring abortion is a crime. Sections 158 and 159 criminalise abortion whilst section 240 provides the defence. Section 240 states:

> A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case. (emphasis added)

Until the adoption of a new constitution in 2010, following a constitutional review process, provisions of the Penal Code were treated as the main source of domestic abortion law. Though section 240 provided a defence, Kenyan authorities did not take any steps to implement abortion law through, for example, clarifying what constituted 'preserving the mother's life'. In 1938 in the Bourne case, an English court had judicially expanded the deference to include preservation of the pregnant woman's

64. P Aniteye & SH. Mayhew 'Globalisation and transitions in abortion care in Ghana' (2019) 19 BMC Health Services Research 185.
65. DA Aladago et al 'The consequences of abortion restrictions for adolescents' healthcare in Ghana: the influence of Ghana's abortion law on access to safe abortion services' (2019) 6(1) UDS International Journal of Development 1-9.

health.[66] In 1959, in the case of Mehar Singh Bansel v R, the now-defunct East African Court of Appeal followed Bourne.[67] However, Kenyan authorities remained oblivious or indifferent to these juridical developments. No step was taken to clarify the application of section 240, raise awareness about the legality of abortion or establish administrative procedures for providing safe abortion services. Consequently, the Penal Code created a general climate of the illegality of abortion which fuelled unsafe abortions.[68] It has served to deter health practitioners from providing services they believe are lawful for fear of prosecution or police harassment.

The regulation of abortion by the Penal Code must now be read subject to provisions of the Constitution of 2010. The Constitution of 2010 was adopted following wide public consultation. When contrasted with its predecessor that had been adopted at independence, the Constitution of 2010 constitutes a paradigm shift in constitution-making, including aligning domestic fundamental rights with international human rights, adopting monism in the interpretation of international treaties, recognising socioeconomic rights such as the right to health as justiciable rights and redressing the constitutional invisibility of gender equality.

During the making of the Constitution of 2010, organisations and institutions opposed to abortion, in particular the Catholic Church, sought, through campaigns, to oppose abortion by constitutionally ringfencing foetal rights. The opposition was countered by women's rights groups. The outcome was a compromise. Each side was able to get a concession as apparent from article 26 of the Constitution which guarantees a right to life.

It states:

1. Every person has the right to life.
2. The life of a person begins at conception.
3. A person shall not be deprived of life intentionally, except to the extent authorized by this Constitution or other written law.
4. Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency medical treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

Pitting the right to life of a foetus against the abortion rights of the woman in constitutional provisions is tantamount to contradictory reform. It can be a very deliberate and powerful way of sending mixed signals about the legality of abortion and substantively undermining any given abortion rights. It can lead to uncertainly about the permitted circumstances among providers and women seeking services. Article 26(4) came without guidance as to its application. It was not followed by legislation.

66. R v Bourne (note 55 above).
67. Mehar Singh Bansel v R (1959) EALR 813,
68. Centre for Reproductive Rights In harms way (2012).

In 2012 concern about the lack of implementation of article 26(4) prompted the Kenya National Commission on Human Rights to make recommendations to the state to operationalise abortion rights and services.[69] it recommended that the Ministry of Health should develop and implement standards and guidelines for the provision of abortion services, promote public awareness of the legality of abortion under the Constitution, and train and educate healthcare professionals about their duties and rights in respect of the provision of legally mandated safe abortion services. Through the Ministry of Medical Services Kenya adopted guidelines for implementing abortion law: Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya (2012).[70]

The guidelines seek to enable trained healthcare professionals who are involved in the provision of services to know about their duties as well as rights under the new law. They also seek to inform and educate women seeking an abortion about their entitlements under the law. In 2013 the Director of Medical Services withdrew the guidelines. The withdrawal was political as it was prompted by the government's anti-sentiments rather than constitutionally legitimate considerations. In Federation of Women Lawyers v. Attorney General (2019) the decision to withdraw was successfully challenged by civil society.

A High Court declared the withdrawal unconstitutional and ordered the state to reinstate them. The court underscored the importance of Ministerial Guidance in enabling women seeking an abortion to acquire knowledge about the lawfulness of abortion and thus exercise their constitutional right to reproductive health.

3.3.2 Grounds for abortion

The grounds for abortion are stipulated in article 26(4) of the Constitution and clarified in the Standard and Guidelines. Abortion is permitted if: it is a medical emergency; pregnancy poses a risk to the life, physical or mental health of the pregnant woman or if it is permitted by any other written law. Given that the defence of preserving the life of the pregnant woman under section 240 of the Penal Code was understood in a narrow medical sense, article 26(4) substantially liberalises the grounds for abortion notwithstanding that it does not explicitly recognise socioeconomic circumstances as grounds for abortion. The generous interpretation given to article 26(4) by the Standards and Guidelines and the court in Federation of Women Lawyers v. Attorney General permits taking into account socioeconomic circumstances when determining physical or mental risk to the health of the pregnant woman.

Significantly, that both the Standards and Guidelines and the High Court of Kenya have adopted WHO's holistic concept of health to interpret the health ground in article 26(4). Though rape, incest and 'defilement' are not listed in the Constitution, they are, nonetheless, implied in the health ground. Indeed, the court has stated that prohibition of abortion under the Penal Code is inconsistent with the

69. Kenya National Commission on human rights Realising sexual and reproductive rights in Kenya: a reality or myth (2012).
70. Ministry of Medical Services Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya (2012) (Standard and Guidelines).

Constitution as its effect is to restrict constitutionally guaranteed rights. It follows that though Kenya has expressed reservations on article 14(2)(c) of the Maputo Protocol, in practice, its new domestic law aligns with the Protocol as reservations do not restrict rights guaranteed under domestic law.

3.3.4 Operationalising abortion grounds

Kenya has followed countries like Ghana and Ethiopia in developing guidelines for the implementation of abortion law. The Standards and Guidelines are modelled on best practices to promote a reproductive health model of provision of access to services. They generally adhere to global standards such as the standards recommended by WHO and were summarised in the second part of this paper. Significantly, they provide for a liberal application of the grounds for abortion. They underscore that 'trained health professionals' who can provide treatment for the termination of pregnancy are limited to doctors.

They also include mid-level providers with competent skills such as clinical officers, midwives and nurses. Conscientious objection to abortion is addressed to explain its limits and the professional duty of referral to ensure that women are not deprived of treatment. In one respect, however, the Kenyan Standards and Guidelines depart from best practices. In respect of minors – those under 18 years, they require health providers to seek the consent of a parent or guardian.[71] It would have been preferable for consent to be based on the capacity to give informed consent than on chronological age as is more consistent with respecting the evolving capacity of minors.

3.3.5 Evaluation

The liberalisation of abortion by the Constitution has promoted open debates about access to safe abortion services. The law is strictly speaking no longer a barrier as the grounds are enabling. The constitutional recognition of mid-level providers as competent to provide abortion services is another strength in Kenyan law. However, the public still perceives abortion as a crime. More needs to be done by the state to promote awareness of the constitutionality of abortion, including repealing the provisions of the Penal Code that criminalise abortion and replacing them with legislation that is consonant with the Constitution and educating the public.

Like in Ghana, there is a conspicuous gap in Kenya between law and practice. The burden of unsafe abortion-related mortality and morbidity has remained largely undented by the new law.[72] Notwithstanding the recognition of the right to health in the Constitution, cost is a major barrier. Whilst the law is now enabling and services are increasingly available in the private sector, services are yet to be accessible in the public sector where they are needed most by women and girls who do not have the means to access the private sector.

71. Standards and Guidelines, as above 14.
72. SF Mohamed et al 'The estimated incidence of induced abortion in Kenya: a cross-sectional study' (2015) 15 BMC Pregnancy and Childbirth 185.

> An empirical study conducted five years after the adoption of the Constitution concluded in the light of a significantly high abortion mortality and morbidity rate that the law had not translated into improved service delivery.[73] The withdrawal of the Standards and Guidelines in 2012 substantially undermined progress on implementing the new law ushered in by the supreme law of the land.[74] Though in 2019 the High Court ordered their reinstatement, the state has yet to show commitment to abide by the order.

3.4 Mozambique

3.4.1 Background to law reform

State regulation of abortion in Mozambique is a colonial bequest. It began with article 358 of the 1886 Penal Code of Portuguese East Africa which became Mozambique at independence. Article 358 criminalised abortion. It derived from the abortion provisions of the Penal Code of Portugal of 1852 which, in turn, was modelled on the French Penal Code.[75] On the face of it, article 358 criminalised abortion absolutely. Notwithstanding, it was accepted by jurists that saving the life of the pregnant woman was a defence. This defence was understood narrowly to exclude circumstances where the life of the pregnant woman is not in grave danger.[76]

At independence, Mozambique inherited article 358. In 1981, on account of the association of article 358 with a heavy burden of unsafe abortion-related mortality and morbidity, the new government adopted a policy in the form of a non-statutory agreement to broaden access to safe abortion services.[77] The Ministry of Health reached an agreement (ministerial agreement) with the Department of Obstetrics and Gynaecology of the Central Hospital of Maputo to authorise abortion in the first twelve weeks of pregnancy for contraceptive failure. The final decision as to whether a woman seeking abortion satisfied the criteria of the agreement was to be made by a hospital committee.

The ministerial agreement was subsequently extended to other central hospitals and provincial hospitals in the country. Under the agreement, providers of abortion were not only doctors, but also appropriately trained mid-level providers, who in the context of Mozambique are assistant medical officers, maternal and child health nurses, and midwives. Certainly, the ministerial agreement was a bona fide attempt to radically reform abortion outside the formal legal framework. The provision of contraceptive failure as a justification for abortion had the potential to substantially broaden access. Equally significant was the recognition of midlevel providers as abortion providers in a country where

73. As above.
74. E Opondo Perspectives of an SRHR advocate on the impact of the Global Gag Rule in Kenya (2020) 28(3) Sexual and Reproductive Health Matters 1.
75. Ngwena 'Access to legal abortion' (note 2 above).
76. As above.
77. M Victor Agadjanian "Quasi-legal" abortion services in a sub-Saharan setting: profile and motivations' (1998) 24 International Family Planning Perspectives 111; A Libombo 'Mozambique abortion situation: country report, paper for the conference on expanding access: midlevel providers in menstrual regulation and elective abortion care', South Africa, 2–6 Dec. 2001, available at http://www.tingsene.se/expacc/reports/MozambCR.html (accessed on October 8, 2021).

doctors are scarce. Despite these enabling features, the ministerial agreement was only partially successful in guaranteeing Mozambican women with accessible services.

Access to services was limited by the fact that not all hospitals in Mozambique were covered by the ministerial agreement. Moreover, access to authorised facilities depended on whether the woman needing a service knew that a particular hospital was authorised, and whether that hospital was geographically accessible. Studies have confirmed that a majority of Mozambican women lacked knowledge about the availability and location of abortion services.[78] For those women who knew about the location of services, other factor, especially economic constraints, deterrent certification procedures, and fears about lack of confidentiality posed obstacles.[79]

Another shortcoming of the ministerial agreement is that it only authorised abortions performed in the first twelve weeks of pregnancy, implicitly leaving the Penal Code to apply in pregnancies older than twelve weeks. While the first trimester is medically the safest stage for inducing an abortion, nonetheless, a comprehensive abortion service should equally cater for the provision of abortion after the first trimester. Vulnerable women, including adolescents, are frequently unable to access safe legal abortion in the first trimester.[80]

Above all, the ministerial agreement could only be a temporary solution. It did not replace the need for transparent and comprehensive reform of article 358. The Penal Code remained the official law in a country where abortion was widely believed to be illegal by the general public. Because the agreement had no force of law, it could be constitutionally challenged as an invalid exercise of executive power by the Ministry of Health. In any event, its informal nature failed to reassure providers that they could provide access to services without fear of prosecution.

In 2014, Mozambique reformed article 358. The reform was preceded by a convergence of interest between mainly women's rights organisations and the Ministry of Health to treat unsafe abortion as, foremost, a public health issue. From 2006 up to the time the government agreed to reform abortion, there were public consultations.[81] The options for reform became mainly a choice between a standalone reform of article 358 or a comprehensive reform of the penal code to concomitantly revise an archaic criminal law measure that was failing to address the needs of Mozambicans long after the colonial era. A coalition was formed between all the main proponents for reform of the penal code. In the specific sphere of abortion, the coalition succeeded in persuading the government to adopt radical reform and allow abortion on request in the first trimester. Although the proposal to reform abortion law was opposed, especially by the Catholic Church, religious opposition was not vociferous.[82] Religious opposition did not translate into popular opposition against the reforms.

78. F Machungo et al 'Reproductive characteristics and post-abortion health consequences in women undergoing illegal abortion in Maputo' (1997) 54 Social Science & Medicine 1607; MF Gallo et al 'An assessment of abortion services in public health facilities in Mozambique: women's and providers' perspectives' (2004) 12 Reproductive Health Matters 218.
79. As above.
80. MB Usta et al 'Who is excluded when abortion access is restricted to twelve weeks? Evidence from Maputo, Mozambique' (2008) 16(31) Reproductive Health Matters 14.
81. Human Dignity Trust Reform of discriminatory sexual offences law in the Commonwealth and other jurisdictions: case study of Mozambique (2019).
82. As above.

3.4.2 Grounds for abortion

The reforms of 2014 constitute partial decriminalisation of abortion. Article 166 of the Penal Code criminalises abortion whilst article 168 provides exceptions to criminalisation. Abortion can be performed by a doctor or competently trained mid-level providers if in the opinion of the provider any of the following grounds are met:

- Risk to the life of the pregnant woman
- Risk of severe and irreversible injury to the mental or physical health of the pregnant woman;
- Risk of death or a severe and lasting injury to the body or the mental or physical health of the pregnant woman and abortion is performed in the first 12 weeks of pregnancy;
- The foetus is likely to suffer from incurable severe disease or congenital disability, and the abortion is carried out in the first 24 weeks of pregnancy;
- The foetus is not viable;
- Chronic-degenerative disease
- Rape or incest, and the abortion takes place within the first 16 weeks of pregnancy; or
- On request in the first 12 weeks of pregnancy

3.4.3 Operationalising grounds for abortion

In 2017, through a decree, the Ministry of Health adopted standards and guidelines on safe abortion services.[83] The standards and guidelines draw on the WHO standards to address aspects such as obtaining informed consent, protecting confidentiality, conscientious objection and ensuring that services are available and accessible.

3.4.4 Evaluation

Abortion law reforms have been given legal imprimatur unlike the position under the ministerial agreement of 1981. In a legal sense, the law is no longer a barrier, even allowing for the restrictive gestational limits. The new grounds for abortion are inclusive. Mozambican reforms offer abortion on grounds wider than the Maputo Protocol, which the country has ratified. By permitting abortion on request in the first trimester. Mozambique has joined Cape Verde, South African and Tunisia in radically reforming abortion law. In practice, however, barriers remain and the country still carries a heavy burden of unsafe abortion.

The law has yet to translate into meaningful access for the majority of women.[84] The state has not been adequately forthcoming in promoting awareness of the legality and availability of services. Many providers continue to believe that abortion is illegal. Also, opposition to abortion among providers

83. Ministerial Decree No 60 of 2017.
84. M Frederico et al 'Induced abortion: a cross-sectional study on knowledge of and attitudes toward the new abortion law in Maputo and Quelimane cities, Mozambique' (2020) 20 BMC Women's Health 129.

remains significant. Rural women are particularly disadvantaged. They tend to be unaware of the location of services or located far away from facilities that follow an urban-rural divide. Cost is a major impediment to access.

3.5 Rwanda

3.5.1 Background to abortion law reform

Abortion law in Rwanda can be traced back to the law the country inherited at independence in 1962. Though Rwanda began its colonial life as a German colony it was parcelled to Belgium by the League of Nations following the First World War and the defeat of Germany. Belgium introduced to Rwanda a penal code that was modelled on the penal code of France. The code criminalised abortion but allowed a defence of the necessity to save the life of the pregnant woman.

As with the other African countries, the colonially-spawned criminalisation of abortion in Rwanda is causally connected with a heavy burden of unsafe abortion-related morbidity and mortality.[85] Civil society in Rwanda has been successful in persuading the government to treat abortion as a serious public health issue and reform abortion to allow for broader grounds for abortion. Among other strategies, campaigners have used the plight of women imprisoned for unlawful abortions to raise awareness about the iniquities of the criminalisation of abortion.[86] Though religious organisations and the Roman Catholic Church especially, have opposed reform, they have not succeeded in preventing it altogether.

In 2012, Rwanda withdrew its reservations on article 14(2)(c) of the Maputo Protocol which authorises abortion. It also reformed the Penal Code of Rwanda to allow abortion on the grounds of defilement, rape, forced marriage, incest, risk the health of the pregnant woman and risk to the life of the foetus thereby seeking to align its domestic law with state obligations under the Maputo Protocol.[87] The reforms were part of a comprehensive revision of the penal code

On account of sustained civil society campaigns, in 2018, the abortion provisions of the Penal Code were revised further and implemented through a Ministerial Order of 2019.[88] The Ministerial Order clarified as well as broadened the grounds for abortion. An important concession made by the government was the removal of the requirement to obtain a court order before services could be provided for abortions on the ground of rape, incest or forced marriage. The Ministerial Order underscores the protection of confidentiality. It also slightly relaxes the position with minors to allow abortion if the minor is accompanied by a parent or guardian and allowing the views of the minor to be heard where there is disagreement. These reforms aside, there have also been presidential pardons for women convicted on charges of unlawful abortions.[89]

85. N Hodoglugil et al Making Abortion Safer in Rwanda: Operationalization of the Penal Code of 2012 to Expand Legal Exemptions and Challenges (2017) 21(1) African Journal of Reproductive Health 82.
86. C Umuhoza et al Advocating for safe abortion in Rwanda: how young people and the personal stories of young women in prison brought about change (2013) 21(41) Reproductive Health Matters 49-56.
87. Organic Law No 01/2012/OL of 2012.
88. Ministerial Order No 002/MoH/2019 of 2019.
89. J Pafs et al 'Implementing the liberalized abortion law in Kigali, Rwanda: Ambiguities of rights and responsibilities among health care providers' (2020) 80 Midwifery 1-6.

3.5.2 Grounds for abortion

Under article 3 of the Ministerial Order of 2019, abortion is permitted if the following grounds are met:

- The pregnant person is a child;
- Rape;
- Forced marriage;
- Incest; or
- Risk to the health of the pregnant person or the foetus.

Article 4 of the Ministerial Order prescribes gestational limits. It provides a gestational limit of 22 weeks except where the pregnancy poses a risk to the health of the pregnant woman.

3.5.3 Operationalising grounds for abortion

Only doctors are authorised to perform abortions. The Minister of Health is the licencing authority in terms of public or private facilities where abortion services can be provided.[90] The Ministerial Order provides that the person requesting abortion is not required to produce corroborating evidence.[91] This provision is exemplary and consistent with the repeal of the requirement of obtaining a court order before services can be offered. In respect of rape especially, it avoids protracted delays caused by requiring women to first go through law enforcement agencies and the courts.

Not withstanding broadening of grounds for abortion and the repeal of the requirement to obtain a court order for rape, incest and forced marriage, the Ministerial Order has not dispensed with burdensome certification procedures. In respect of abortion on the grounds of risk to the health of the pregnant woman or foetus the Ministerial Order requires confirmation of the risk by at least two medical doctors, one being a specialist in the area of obstetrics and gynaecology. The requirement of two doctors to approve eligibility and the fact that only doctors are recognised as competent to perform abortions leave Rwanda, which has a scarcity of doctors, with no realistic prospect of meaningfully rolling out services.

3.5.5 Evaluation

Rwanda had made important gains in reforming abortion law. The reforms which began in 2014 and were augmented by the Ministerial Order of 2019 have facilitated the development of protocols for the provision of abortion services, training of health providers, licencing of abortion medicines and a more open climate for public discussion on abortion However, the reformed law has yet to be realised by the majority of women seeking abortion services.[92] Whilst the new grounds for abortion are enabling, the certification procedures are cumbersome. There is a need to further reform the law to recognise the competence of mid-level providers in a country where doctors are scarce. Abortion is still perceived as illegal by many providers and the general public. The state must do more to destigmatise abortion by promoting public and professional awareness about legal abortions and the availability of services.

90. Article 5 of Ministerial Order No.002/MoH/2019 of 8 April 2019.
91. Article 3 of Ministerial Order No.002/MoH/2019 of 8 April 2019.
92. Hodoglugil et al (note 85 above); Pafs et al (note 89 above).

3.6 South Africa

3.6.1 Background to abortion law reform

The Choice on Termination of Pregnancy Act of 1996 (CTOPA) is South Africa's main legal instrument for regulating abortion.[93] It replaces the Abortion and Sterilization Act of 1975 (ASA).[94] South Africa is the first African state to reform abortion law in ways that are aimed at respecting, protecting and fulfilling the human rights and freedoms of women and girls with unwanted pregnancies.[95] Whilst Tunisia is significant for being the first African state to introduce reforms to decriminalise abortion in 1973, the reforms were, nonetheless, anchored in a national policy to control population growth rather than human rights.[96]
The influence of human rights in the CTOPA is visible in the manner in which the Act places the protection of gender equality, reproductive health and the autonomy of women to make decisions about reproduction at the centre of regulating abortion. The preamble to the CTOPA sets the tone for the Act's human rights orientation by stating, inter alia, that

> "Recognising that the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programmes and services;
>
> This Act therefore repeals the restrictive and inaccessible provisions of the Abortion and Sterilization Act, 1975 (Act 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

The CTOPA was enacted to achieve a paradigm shift in the regulation of abortion – a shift from a historically embedded crime and punishment model to a reproductive health rights model.[97] The CTOPA goes well beyond the confines of decriminalisation of abortion. It recognises that the state has a duty not only to permit reproductive autonomy, but also to provide the means with which to exercise reproductive autonomy, including the provision of requisite health services. The Act captures the essence of the paradigm-changing normative values that were adopted under the Programme of Action at the International Conference on Population and Development[98] and Platform for Action at the Fourth World Conference on Women[99] to mark the global emergence of reproductive health as a human right.

93. Choice on Termination of Pregnancy Act No 92 of 1996.
94. Abortion and Sterilization Act No 2 of 1975.
95. Ngwena 'Access to legal abortion' (note 2 above) at 330-331.
96. I Maffi Abortion in Post-Revolutionary Tunisia: Politics, Medicine and Morality (Berghahn Books, 2020)
97. C Ngwena 'Access to safe abortion as human right in the African region: Drawing lessons from emerging jurisprudence of United Nations treaty monitoring bodies' (2013) 29 South African Journal on Human Rights 399-428 at 406.
98. UN Population and Development Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994 (1994).
99. UN Platform for Action and Beijing Declaration, Fourth World Conference on Women, Beijing, China, 4-15 September 1995 (1995).

State regulation of abortion in South African began with transplanted Roman-Dutch common law. The first general pronouncements were introduced in the seventeenth century with the introduction of Roman-Dutch common law as part of the colonisation of South Africa. The transplanted common law criminalised the procurement of abortion except where it was necessitated by saving the life of the pregnant woman. A major limitation with colonially inherited abortion law was that the circumstances in which the defence applied were left unclear beyond the knowledge that it applied to saving the pregnant woman from immediate death. To clarify abortion law, the National Party government set up a commission of enquiry to examine the case for a new law on abortion.[100] The findings and recommendations of the enquiry culminated in the ASA.

The ASA was enacted with two main objectives: first, to extend the grounds for performing legal abortion beyond the parameters of the common law defence of the necessity to save the life of the pregnant woman; and second, to rule out the provision of abortion on demand or on the grounds of social or economic circumstances.[101]

> The ASA permitted abortion in the following circumstances: (a) where the continued pregnancy endangered the life of the pregnant woman or constituted a serious risk to her physical health; (b) where the continued pregnancy constituted a serious threat to the pregnant woman's mental health and created a danger of permanent damage to her mental health; (c) where there was a serious risk that the child to be born would suffer a physical or mental defect of such a nature as to be irreparably 'handicapped', or (d) where the pregnancy is a result of unlawful sexual intercourse including rape, incest or intercourse with a mentally disabled female.[102]

As part of the objective to rule out the provision of abortion on demand or on the grounds of social or economic circumstances, the ASA employed stringent language to denote the prerequisites for abortion. Requirements such as that there be a serious risk to the physical health of the woman, or danger of permanent damage to her mental health, or a serious risk of the child's being irreparably handicapped signalled an extremely conservative approach to reform. But even more indicative of restrictive orientation were the exacting certification procedures. Abortion could not be procured unless an application had been made by the doctor intending to perform the abortion and approved by a medical superintendent.

As a prerequisite to approval, there had to be certification by two medical practitioners, excluding the practitioner performing the abortion, to the effect that the practitioners believed bona fide that the woman satisfied the prescribed grounds. Furthermore, one of the practitioners was required to have practised for at least four years. Where the abortion was on the grounds of mental health, one

100. Commission of Enquiry into the Abortion and Sterilization Bill of 1974 Proc R162 GG 3974 of 6 July 1973. Reg Gaz 1812.
101. C Ngwena 'The history and transformation of abortion law in South Africa' (1998) 30(3) Acta Academica 32-68 at 37.
102. Section 3 of ASA.

of the certifying practitioners had to be a psychiatrist employed by the state. Immediately following the abortion procedure, the superintendent was required to submit details of the abortion, including the name and address of the patient, to the then Department of National Health and Population Development. Confidentiality was not respected under the ASA.

The certification provisions of the ASA paid similarly scant regard to sparing victims of rape or incest any further trauma. Where abortion was sought on the grounds of rape or incest, there was a requirement that one of the certifying practitioners be the district surgeon who examined the woman following a complaint lodged with the police. In addition, a magistrate had to issue a certificate to the effect that:

i). A complaint had been lodged with the police, or in cases where the woman had not complained, that there was a good and acceptable reason why a complaint had not been lodged; and

ii). That on the balance of probabilities, the magistrate was satisfied that unlawful intercourse had taken place.

The impact of the ASA was discriminatory in intersecting ways. The grounds for abortion which were inscribed and calibrated in highly restrictive language served to deter rather than facilitate abortion and do did the burdensome certification procedures. During the operation of the ASA, only 800 to 1200 mainly white middleclass women qualified for legal abortion.[103] Not surprisingly, the bulk of abortions took place outside the law. According to conservative estimates, during the operation of the ASA, 44 000 mainly black and poor women, had recourse to unsafe, illegal abortion each year.[104]

Unofficial estimates put the number of clandestine abortions much higher, at 120 000 per year or more.[105] An average of 425 women died from the effects of unsafe abortion and thousands more were rendered seriously ill or disabled.[106] Each year, the public health sector performed, on average, 33 000 hysterectomies to treat the complications of unsafe abortion.[107]

The CTPA is part of a larger project to transform South Africa from its legacy of colonialism, apartheid and social injustice to a new democratic dispensation that seeks to achieve social justice for historically marginalised and disadvantaged groups. It draws its immediate impulse from the Constitution of the country. The South African Constitution is committed to substantive equality and the eradication of systemic inequalities. The Constitutional Court has interpreted section 9 – the equality clause of the Constitution – as meaning substantive equality. Substantive equality is a departure from formal

103. SA Strauss Doctor, Patient and the Law (Van Schaik,1991) 214.
104. South African Institute of Race Relations 1997. South Africa Survey 1996/97 (South African Institute of Race Relations, 1997) 492.
105. The Star, 6 October 1996, 'Countrywide protests over new bill'.
106. South African Institute of Race Relations South Africa Survey 1995/96 (South African Institute of Race Relations, 1996) 227–8.
107. South African Institute of Race Relations South Africa Survey 1995/96 (South African Institute of Race Relations, 1996) 227–8.

equality.[108] It signifies an expansive notion of equality aimed at securing equality in fact and not merely de jure equality.

Support for substantive equality in reproductive health, including access to safe abortion, does not only come from section 9 of the Constitution. It also comes from s 12(2) of the Constitution which guarantees everyone a right to bodily and psychological integrity, and also a 'right to make decisions concerning reproduction', thus, unambiguously affirming reproductive autonomy. Section 27(1) of the Constitution, reinforces the constitutionalisation of reproductive autonomy by guaranteeing everyone a right of access to healthcare services, which includes 'reproductive healthcare services.

3.6.2 Grounds for abortion

The CTOPA trimesterises the grounds for abortion. It provides for abortion on request in the first 12 weeks of pregnancy.[109] There is no requirement to furnish supporting reasons. Mere request and consent on the part of the woman suffice. During the first trimester, abortion may be performed not only by a medical practitioner, but by a midwife or nurse who has undergone a prescribed training.

In the second trimester (13th to the 20th week of pregnancy), the CTOPA provides for abortion if a medical practitioner, in consultation with the woman, is of the opinion that any one of the following conditions is satisfied: that the continued pregnancy would pose a risk of injury to the woman's physical or mental health; that there exists a substantial risk that the foetus will suffer from a severe physical or mental 'abnormality'; that the pregnancy resulted from rape or incest; or that the continued pregnancy will significantly affect the social or economic circumstances of the woman.[110]

Abortion is also available after the 20th week of gestation and up to term, providing that a medical practitioner, in consultation with another medical practitioner or a midwife, is of the opinion that the continued pregnancy will endanger the woman's life, or result in severe malformation of the foetus, or pose a risk of injury to the foetus.[111]

3.6.3 Operationalising grounds for abortion

Pregnancy can only be terminated with the 'informed' consent of the pregnant woman.[112] The term 'woman' means a female person of any age.[113] Therefore, in addition to adults, the CTOPA recognises the capacity of a minor to consent to an abortion without the consent or consultation of the parent or guardian provided the minor can give 'informed' consent.[114] Where a minor is seeking termination, there is an obligation on the practitioner or midwife to advise the minor to consult with a parent, guardian or family member.[115] However, the minor may choose to do otherwise. Neither parental consultation nor parental consent is a precondition.

108. C Ngwena 'Accessing Abortion under the Choice on Termination of Pregnancy Act: Realising substantive equality' (2000) 25(3) Journal for Juridical Science 19-44.
109. Section 2(1)(a) of the CTOPA.
110. Section 2(1)(b) of the CTOPA.
111. Section 2(1)(c) of the CTOPA.
112. Section 5 of the CTOPA.
113. Section 1 of the CTOPA.
114. Section 5 of the CTOPA.
115. Section 5 of the CTOPA.

This provision has been tested in court. In Christian Lawyers' Association of South Africa v National Minister of Health, it was held that a minor who has the maturity to understand the nature of a procedure to terminate a pregnancy and its implications has the requisite legal capacity to give informed consent under the CTOPA.[116] Capacity to consent is determined by the maturity to understand what termination of pregnancy entails and not by chronological age. In this way, the CTOPA recognises the evolving capacity of mino

In addition to medical practitioners, the CTOPA permits mid-level providers to perform an abortion. Midwives and nurses who have been trained to perform abortions are recognised has having professional competence to perform abortions in the first trimester. There is sufficient evidence to support the professional competence of mid-level providers to provide abortions safely in the first trimester.[117] The CTOPA provides that termination of pregnancy may only take place only at a facility designated by the Minister of Health.[118]

The Act does not address the question of conscientious objection directly other than providing that a woman who requests termination of pregnancy from a medical practitioner or mid-level provider shall be informed of her rights under the CTOPA.[119] It was taken as implicit by the framers of the Act that, since the Constitution unambiguously recognises freedom of conscience, it would be superfluous to include it in the Act. Health workers' right to conscientious objection to abortion is not specifically acknowledged under the CTOPA, it is nonetheless, implicitly accommodated under the Constitution by a range of provisions. Failure to recognise the right of health care workers to conscientious objection in respect of abortion would constitute a violation of the rights to equality, fair labour practices, human dignity, freedom of conscience, religion, thought, belief and opinion and the freedom to practice religion under the Constitution.

The CTOPA departs from the intrusive reporting requirements of ASA. While there is a requirement to record abortions and for the person in charge of a facility offering abortion to notify the Department of Health, it is provided that the notification must be confidential.[120] Notification should not include the name and address of the woman.

3.6.4 Evaluation

The law no longer serves as a barrier to safe abortion. The emphasis has shifted from a focus on determining whether abortion is a crime to providing accessible services. The CTOPA has withstood two legal challenges brought by opponents of abortion. The first challenge was in 1998 in Christian Lawyers' Association of South Africa and Others v the Minister of Health and Others.[121] A group of

116. Christian Lawyers' Association of South Africa v National Minister of Health (2004) (10) BCLR 1086 (T), High Court of South Africa.
117. S Barnard et al 'Doctors or mid-level providers for abortion' (2015) 7 Cochrane Database of Systematic Reviews, 7, CD011242; S Jeejeebhoy 'Can nurses perform manual vacuum aspiration (MVA) as safely and effectively as physicians? Evidence from India' (2011) 84(6). Contraception 615-621.
118. Section 3 of the CTOPA.
119. Section 6 of the CTOPA.
120. Section 7 of the CTOPA.
121. Christian Lawyers' Association of South Africa and Others v the Minister of Health and Others 1998 (4) SA 1113 (T).

organisations promoting Christian faith and morals sought to impugn the validity of the 1996 Act under the Constitution. The plaintiffs sought an order to declare the Choice on Termination of Pregnancy Act void under the Constitution. They argued, as Pro-life proponents have argued elsewhere, that human life begins at conception and abortion terminates such life.

Furthermore, they argued that section 11 of the Constitution which guarantees "everyone" a right to life, also applies to a foetus from the moment of conception. The corollary was that a foetus was a bearer of constitutional rights and that the Act was thus repugnant to section 11 of the Constitution because it permits the killing of human life. The court rejected the arguments. It held that a foetus does not have a legal persona under the Constitution. The court did not consider the guarantee of rights to 'everyone' to be compatible with recognising a foetus as a holder of constitutional rights because that would effectively nullify the status of women as constitutional rights holders.

The second challenge was in 2004 in Christian Lawyers' Association of South Africa v National Minister of Health.[122] The court was asked by an association of Christian lawyers to declare provisions of section 5 of the CTOPA unconstitutional on the grounds that they permit minors to consent to termination of pregnancy without parental consent. The plaintiffs argued that to permit minors to consent to an abortion without parental consent was contrary to the best interests of the minors. The court rejected the argument. It stressed that section 5 of the CTOPA is intended to recognise the evolving capacities of minors.

Abortion services and been rolled out and scaled up. The new law has impacted positively on access to services and abortion-related mortality and morbidity began to fall substantially.[123] Abortion stigma has been substantially ameliorated. At the same time, it serves well to highlight that even with radical reform of abortion and allowing abortion on request in the first trimester, unsafe abortion has been substantially reduced rather than eradicated. Factors that militate against access to safe legal services include: ignorance about the availability and location of services; inadequate or geographically inaccessible services especially for rural women and girls; abuse of conscientious objection by healthcare providers; persistent stigma around abortion; and the fear of reprimand from providers at public health facilities.[124]

122. Christian Lawyers' Association of South Africa v National Minister of Health, note 116 above.
123. J Benson 'Reductions in abortion-related mortality following policy reform: evidence from Romania, South Africa and Bangladesh' (2011) 8 Reproductive Health 39; M Flavler et al Safe abortion in South Africa: "We have wonderful laws but we don't have people to implement those laws" (2018) 143 International Journal of Gynecology & Obstetrics 38-44
124. MC Engelbrecht et al 'The Choice on Termination of Pregnancy Act: some empirical findings' (1999) 23(2) Curationis 4-14; SJ Varkey & S Fonn How far are we? Assessing the implementation of abortion services: A review of literature and work-in progress. Durban: Health Systems Trust, 2000).

4. Best Practices From The Selected Countries And Lessons For Uganda

4.1 Introduction

Ethiopia, Ghana, Kenya, Mozambique, Rwanda and South Africa have all reformed abortion laws to liberalise have that were first spawned by the colonial state. The path to reform has been varied and yet it also demonstrates commonalities. Individually as well as collectively, the selected countries represent successes as well as failures in abortion law reform. From their successes, Uganda can learn about best practices. Equally, from their failures Uganda can learn about what pitfalls to avoid. The following is a summary of best practices as well as lessons for Uganda

4.1.1 Full or partial decriminalisation

The path to reform has been mainly a choice between full and partial decriminalisation. South Africa is an exception in fully decriminalising abortion. Ethiopia, Ghana, Mozambique, and Rwanda have retained criminalisation of abortion in their penal codes whilst broadening the grounds for abortion. Kenya occupies a unique position. It has retained on paper a penal code that criminalises abortion subject to the defence of saving the life of the pregnant woman alongside a constitution that expressly regulates abortion by protecting foetal life whilst concomitantly permitting abortion on grounds that are much broader than the penal code.

> A lesson for Uganda to draw on the path to reform is that whilst learning from other countries, Uganda must chart its own path to explore strategies that have realistic prospects of succeeding in its own political, social and legal context. The experience of reform in the selected countries is that the African state has been more receptive to partial rather than full decriminalisation in order to appease constituencies that are opposed to abortion, especially the Church. The experience of the majority of selected countries also indicates that the when civil society advocates for reform, the African state is more receptive to public health than rights arguments. South Africa is an exception in that a rights approach was used successfully to effect radical reform. However, this was in the context of a country that was undergoing a historic transition from apartheid to democracy. The prevailing political climate was transformative and ripe for widescale reform across all socioeconomic spheres.

In Ethiopia, Ghana, Kenya, Mozambique and Rwanda, abortion remains located in a penal code It should be borne in mind that when abortion is partially rather than fully decriminalised, it is harder to destigmatise abortion and to dispel the perception of abortion as illegal. Part of the success of South

African reforms lies in fully decriminalising abortion and transcending a crime and punishment model for regulating abortion. Full decriminalisation does not mean that stigmatisation will be eradicated. Rather it means that health professionals can provide services without fear of prosecution and harassment by law enforcement agencies. Women and girls too, can seek services without fear of prosecution.

4.1.2 Indispensability of accessible services

It is important to guard against any assumption that liberalisation of abortion law is synonymous with safe abortion services. Legislation on its own cannot guarantee services that are available, accessible and of good quality. The law might permit liberal access, but the material and policy environment might at the same time be forbidding. The experiences of Ghana, Kenya, Mozambique and Rwanda, especially, shows it is possible to have a liberal abortion law co-existing with a lack of accessible services. Over and above decriminalisation, the policy environment, and the capacity of health services, especially, the public health services to deliver accessible abortion care are crucial considerations.

For abortion services to be accessible, they must be available, geographically and economically accessible, of good quality, and culturally acceptable to the women who need them. Skilled providers must be trained, available and willing to provide the services without stigmatising those who seek services. The women who need abortion services must be aware of their entitlement to the services as well as the location of the services. All these considerations are integral aspects of an enabling environment for the provision of safe, legal abortion services. Among the selected countries, only Ethiopia and South Africa have made progress in meaningfully translating legal reforms into access to abortion services for women and girls who depend on the public health care sector.

4.1.3 Grounds for abortion

The selected countries underscore that to transcend the legacy of highly restrictive abortion laws bequeathed by the colonial state, it is necessary to broaden the grounds for abortion unambiguously. All the selected countries have broadened their grounds for abortion beyond saving the life of the pregnant woman to include the pregnant woman's health, foetal health and unlawful sexual intercourse. Exceptionally, Mozambique and South Africa permit abortion on request in the first trimester.

Except for Mozambique and South Africa which permit abortion on request, the ground with the most potential for enabling eligibility in all the selected countries is the risk to the 'health' of the pregnant woman. When interpreted holistically as envisaged by WHO, the health ground has the capacity to be inclusive and accommodate the reasons why most women choose to terminate their pregnancy. Kenya provides an example of a jurisdiction with jurisprudence that has followed WHO's holistic concept of health when interpreting health as a ground for abortion.

4.1.4 Certification procedures

Despite liberalising abortion laws, certification procedures have not been necessarily reformed. They continue to be barriers especially in countries that only recognise doctors as competent to perform abortions. Requiring at least two doctors to approve an abortion request, sets abortion law reform on a path of failure in a region where doctors are scarce. Only Ethiopia and South Africa provide models for certification procedures that are not cumbersome.

4.1.5 Recognition of mid-level providers

Laws and policies inherited from the colonial state only recognised the competence of doctors. Unless mid-level providers are recognised as competent to terminate pregnancies, then access to abortion services is assured of failure in a region where doctors are scarce. Through law or policy in all the selected countries except Rwanda recognise the competence of appropriately trained mid-level providers to perform abortions. Ethiopia, Ghana and Mozambique recognise mid-level providers through policy. Kenya and South Africa do so legally through the constitution and legislation, respectively. The experience of both South Africa and Ethiopia shows that in African settings, mid-level providers are indispensable to rendering effective access to abortion services.

4.1.6 Recognition of competence of minors to consent

The majority of the selected countries require parental consent in respect of minors Only South Africa provides unambiguous legal recognition of a minor's capacity to consent. In environments where abortion has been historically criminalised and stigmatised, the failure to provide clear regimes for recognising the evolving capacities of minors serves as a major barrier to safe services for adolescent girls.

4.1.7 Conscientious objection

Health professionals serve as gatekeepers to services. The selected countries have taken steps to develop guidelines to explain the parameters of the right to conscientious objection to ensure that the right is not abused or exercised to the detriment of women seeking services they are legally entitled to. Also, all the selected countries have accepted the need to educate health care professionals about the ethics in abortion as 'values clarification' exercises.

4.1.8 Standards and guidelines

On account of the controversy surrounding abortion, the selected countries show that where abortion has been liberalised but is still located in a penal code, it is necessary for the ministry that provides health services to adopt and issue professional guidelines to providers of services to explain in clear language the circumstances in which abortion is permitted a well as to provide a protocol for rendering services. The selected countries also demonstrate that in developing professional guidelines, African ministries of health have been receptive to adopting standards and guidelines that represent global best standards especially those recommended by WHO.

4.1.9 Courts

Courts have generally not been visible in abortion law reform. In the majority of selected countries, courts have not been used to secure reform law, defend foetal rights or defend abortion rights. South Africa and Kenya are the exceptions. The South African cases upholding the validity of abortion rights under the Choice on Termination of Pregnancy Act underscore that on account of the moral controversy surrounding abortion, laws that guarantee abortion rights remain the target of legal contestation by highly organised opponents of abortion. The Kenyan decision, on the other hand, demonstrates the importance of defending abortion rights guaranteed under domestic law in response to an executive that is deliberately undermining the implementation of abortion services.

4.1.10 Civil society

In all the selected countries civil society has played role in galvanising abortion law reform and promoting the implementation of access to services.

4.1.11 Religious opposition

Religious opposition to reforming abortion law to broaden access is a guaranteed phenomenon. However, even in those countries where the Church has been influential in opposing reform, it has not been successful in preventing reform. At most, it has prevented radical reform.

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