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Towards a constitutionally compliant termination of Pregnancy Act in Zimbabwe: Upholding a rights-based approach to abortion

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Abstract

The Zimbabwe Termination of Pregnancy Act, adopted in 1977, is based on an exception to the criminalisation model instead of access to services, and violates women's reproductive health, and their rights to bodily autonomy and integrity. The first part of this chapter traces the evolution of abortion laws in Zimbabwe. The chapter begins by outlining the colonial history of abortion regulation through the common law, and the introduction of the 1977 Termination of Pregnancy Act. This legislative history is assessed against the backdrop of existing indigenous knowledge systems, practices and attitudes towards abortion. The second part gives an overview of the current landscape regarding incidences of unsafe abortion-related mortality and morbidity. The part also examines the application of the Termination of Pregnancy Act, and its impact on abortion access. The analysis will also examine the impact of the African Women's Protocol on national conversations to reform the Termination of Pregnancy Act, and the case for abortion access based on Zimbabwe's constitutional provisions. The chapter finally makes recommendations for legal reform of the Termination of Pregnancy Act in line with Zimbabwe's national, regional and international human rights obligations.

1 Introduction

The Zimbabwe Termination of Pregnancy Act, adopted in 1977, based on an exception to the criminalisation model, must be reformed to fully

provide for the fulfilment of women's rights to health and to protect the rights to bodily autonomy and integrity. The criminalisation of abortion was introduced to Zimbabwe through colonial laws as found in the British Offences Against the Person Act, which was used in multiple colonies in the so-called British empire. This conversative approach of state control over women's bodily autonomy and reproductive health and rights has endured beyond the colonial era.

This chapter considers Zimbabwe's abortion laws and its impact on abortion access. The language in the Zimbabwe Termination of Pregnancy Act (ToP) appears to allow access to legal abortion in conformity with accepted regional standards set out in article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol), which pioneered the recognition of medical abortion as a fundamental human right in an international treaty. However, upon closer critical examination of the procedural barriers and hurdles women face in access to abortion, it is clear that the ToP has shortcomings and requires amendment to ensure meaningful and timely access to legal abortion.

In obliquely making third parties, such as healthcare and judicial professionals, the gate keepers of access to legal abortion; Zimbabwe's abortion laws fail women and fall short of the state's constitutional, regional and international obligations to protect the rights to bodily and psychological integrity, which includes the right to make decisions concerning reproduction, as well as their rights to equality and human dignity.

2 Historical background of abortion in Zimbabwe

Indigenous knowledge systems that relied on plants and other practices to control fertility and, in some instances, provide abortifacient actions, provide evidence of a thriving body of knowledge and practice of family planning and abortion in pre-colonial African societies, including Zimbabwe. A study using ethnographic and historical records from over 400 pre-industrial societies provides evidence of abortion in pre-colonial Africa.[1]

1 M Chiweshe & M Catriona 'Cultural de-colonisation versus liberal approaches to abortion in Africa' (2018) 22 *African Journal of Reproductive Health* 49.

The regulation of fertility using plants through century-old ethnomedicine provides strong evidence of the provision of family planning products and of abortion being practised in pre-colonial Zimbabwean societies.[2] Research established that in traditional knowledge systems, at least 31 plant species are used for antifertility purposes in Zimbabwe.[3] Traditional healers (*n'angas*) and women healers with expert knowledge in women's reproductive health (*nyamukatas*) know the plants with abortifacient activity, which are often administered orally or into the vagina or cervix to induce premature labour.[4]

However, the advent of colonial rule subverted many cultural systems and practices, including traditional healers in whom resided the majority of knowledge on ethnomedicine upon which many African societies relied. The colonial government discredited traditional healers, and the Medical Council of Rhodesia considered it a violation of ethics for a physician to refer a patient to a traditional healer.[5]

In addition to the agenda to dominate, the colonised, colonial governments, including in Zimbabwe, were largely focused on population growth, and having a healthy and self-reproducing population was critical for colonial rule.[6] Indeed, '[w]omen's role as mothers was critical to the survival of the family as well as the settler society at large'.[7] Against this backdrop, abortion was criminalised across the then British colonial empire through the introduction of the British 1861 Offences Against the Person Act (OPA), which shaped Roman-Dutch common law, the colonial law of Zimbabwe.[8]

2 CR Sewani-Rusike 'Plants of Zimbabwe used as anti-fertility agents' (2010) 7 *African Journal of Traditional, Complementary and Alternative Medicines* 253.
3 Sewani-Rusike (n 2) 254.
4 As above.
5 T Cavender 'The professionalisation of traditional medicine in Zimbabwe' (1988) 3 *Human Organisation* 47.
6 U Kufakurinani 'Building a "healthy" empire: White women, race and health in colonial Zimbabwe' in B Poonam (ed) *Medicine and colonial engagements in India and sub-Saharan Africa* (2018) 157.
7 Kufakurinani (n 6) 156.
8 RJ Cook and others *Abortion law in transnational perspective: Cases and controversies* (2014).

In Zimbabwe (then Rhodesia) and other countries under British rule, the OPA and its interpretation were transplanted to all British colonies.[9] Under section 58 of the OPA, any attempt or act to 'procure miscarriage of any woman whether she be or be not with child' was punishable by life in prison. While the language of the OPA was unequivocal in its criminalisation of abortion, in the 1938 English case of *Rex v Bourne*[10] the Court clarified that abortion was lawful in cases where, in a doctor's opinion, the continuance of pregnancy would serve to make the 'woman a physical and mental wreck'. Despite the *Bourne* decision, uncertainty about exceptions to the OPA in actual medical practice persisted. Lord Silkin, speaking before the UK Parliament in 1965 on the need for a clear abortion law to replace OPA, noted that despite the court decision *Rex v Bourne,*

> there is still a considerable element of doubt and uncertainty as to what the law is. In fact, a number of doctors – about two every year – have been convicted since the first decision in 1938. They have been sentenced to up to three years' imprisonment and struck off the roll of doctors. It may well be that the view was taken that they did not honestly believe that the mother's life was in danger, but it certainly creates a strong element of doubt among doctors as to the present state of the law.[11]

Guided by *Bourne*, abortions in then Rhodesia were performed by gynaecologists, after access to the procedure had been recommended by a general practitioner and a psychiatrist.[12]

The evolution of the law of the land from the OPA to the introduction of the current Termination of Pregnancy Act of 1977 was a long road in which white women of the colonies were the key advocates for public health in general, and in later years for women's maternal and reproductive rights.[13] Concerned at first, principally with the health of

9 C Ngwena *Human rights and African abortion laws: A handbook for judges* Ipas Africa Alliance (2014) para 3.3, https://www.ipas.org/wp-content/uploads/2020/07/AAHRALE14-NgwenaAlliance2014.pdf (accessed 17 December 2022).

10 *R v Bourne* [1938] 3 ALL ER 615, [1939] 1 KB 687, Crown Court of England and Wales.

11 HL Deb 30 November 1965 vol 270 cc1139-241, https://api.parliament.uk/historic-hansard/lords/1965/nov/30/abortion-bill-hl (accessed 17 December 2022).

12 DR Seager Commissions of Inquiry in a Rapidly Changing Society, Zambesia, 1978 VI (i) 61.

13 Kufakurinani (n 6) 173.

children in the colonies of then Southern Rhodesia, in the late 1920s, white women formed advocacy organisations such as the Federation of the Women's Institutes of Southern Rhodesia (FISWR) and the National Council of Women of Southern Rhodesia (NCWSR), which actively engaged in public health advocacy, including addressing issues of maternal healthcare access.[14] On the surface, the work of FISWR and NCWSR appeared to benevolently advocate equality in access to public health services and approaches for both European and African populations, However, FISWR and NCWSR have been criticised for only being concerned with the rights of white women. [15]

It was during this era of the emergence of the family planning movement that the colonial government created a commission of inquiry to look into the legal framework for the termination of pregnancy. The commission was mandated to investigate and report on the 'need for legislation to make provision for termination of pregnancy under strictly controlled conditions', and if such legislation was deemed necessary, to make recommendations.[16]

The women's organisations in Southern Rhodesia became involved in discussions on family planning inviting international speakers and spreading the knowledge to fellow white women.[17] The commission of inquiry does not indicate the nature of the contributions by women's organisations, but it appears that white women's organisations lobbied for and submitted their contributions calling for the enactment of a more liberal law on abortion.[18] In fact, the commission report noted that 'the evidence indicated that many – perhaps the majority of – younger Rhodesians wish to see abortion laws liberalised'.[19]

14 As above.
15 As above.
16 Seager (n 12) 61.
17 U Kufakurinani 'White women and domesticity in colonial Zimbabwe, c.1890 to 1980' PhD thesis, University of Zimbabwe, 2015 185, https://ir.uz.ac.zw/jspui/bitstream/10646/2980/1/Ushehwedu%20Kufakurinani%20-%20White%20women%20and%20domesticity%20in%20Colonial%20Zimbabwe%2C%201890%20-%201980.pdf (accessed 19 December 2022).
18 Kufakurinani (n 6) 186.
19 D Serger 'Essay review: Commissions of inquiry in a rapidly changing society' (1978) 6 *Zambezia* 61, https://pdfproc.lib.msu.edu/?file=/DMC/African%20Journals/pdfs/Journal%20of%20the%20University%20of%20Zimbabwe/vol6n1/juz006001009.pdf (accessed 19 December 2022).

However, in July 1976, the government of Southern Rhodesia's Commission of Inquiry into the Termination of Pregnancy in Rhodesia published its recommendations for more restrictive and conservative access to abortion, to be permitted under the following conditions:

- where the continuation of the pregnancy constitutes a danger to the life of the mother and termination is necessary to ensure her life;
- where the continuation of the pregnancy constitutes a serious threat to the physical health of the mother and termination is necessary to ensure her continued health;
- where the continuation of pregnancy creates a great danger of serious and permanent damage to the mother's mental health and termination is necessary to avoid such danger;
- where there exists a serious risk on scientific grounds that the child to be born will suffer from a mental or physical defect so that he will be seriously handicapped;
- where the child is conceived as a result of rape or incest;
- where the mother is an 'idiot or imbecile'.[20]

The Parliament of Rhodesia, acting on the Commission's findings, introduced legislation addressing abortion in December 1976. The Termination of Pregnancy Act 29 of 1977 (ToP Act) took effect on 1 January 1978, purportedly expanding abortion access, allowing the procedure under three conditions: if the pregnancy endangers the life of the woman or threatens to permanently impair her physical health; if the child may be born with serious physical or mental 'defects'; or if the foetus was conceived as a result of rape or incest. The latter two conditions were not conditions previously available for access to a legal abortion. However, a lack of clarity and additional hurdles to accessing abortion under these two grounds, discussed in the next part, rendered the reforms superficial as they failed to result in meaningful access for those who needed services. After Zimbabwe's independence in 1980, the new government retained the ToP Act.

3 Abortion in post-colonial Zimbabwe

The criminalisation of abortion in post-independent Zimbabwe has resulted in a proliferation of anti-abortion policies, which erroneously view abortion access as external to the provision of *sexual and reproductive*

20 As above.

health and rights and integrated family planning services. For example, the national family planning strategy for 2016 to 2020 mentions abortion as something to be prevented through the provision of access to sexual reproductive health services and integrated family planning services.[21] As a result of the failure to integrate abortion services as part of basic health care, the World Health Organisation Africa (WHO Africa) reports that abortion accounts for 25 per cent of all maternal deaths in Zimbabwe, where the rate of abortions for women aged 15 to 49 years is 17 for every 1 000 women.[22]

The high number of maternal deaths attributable to unsafe abortions results from the legal restrictions on abortion stated in the ToP Act, and the criminalisation of abortion outlined in the Criminal Law Codification and Reform Act Chapter 9:23 (Criminal Code).[23] These two pieces of legislation are in direct violation of Zimbabwe's regional and international treaty obligations to ensure unrestricted abortion access for all women as a right to health – first, by providing very narrow access in terms of the written law; second, by providing virtually no access in execution of the law in practice;[24] and, third, criminalising women and girls that attempt to undergo abortions and providers who dare to provide the service.

Section 4 of the ToP Act permits legal abortion in three very narrow circumstances: where the continuation of pregnancy would endanger the woman's life or physical health; where there is a serious risk that the child will suffer physical or mental defect; or where conception was a result of unlawful intercourse. [25] In the ToP Act, unlawful intercourse

21 Ministry of Health, Government of Zimbabwe 'Zimbabwe National Family Planning Strategy 2016-2020' (2016) 7, https://fp2030.org/sites/default/files/Zimbabwe-National-FP-Strategy-2016-2020_9.12.16.pdf (accessed 17 December 2022).

22 WHO Africa 'Enhancing capacity of Zimbabwe's health system to reduce abortion related maternal deaths' (10 March 2020), https://www.afro.who.int/news/enhancing-capacity-zimbabwes-health-system-reduce-abortion-related-maternal-deaths (accessed 17 December 2022).

23 G Murewanhema and others 'Towards the decriminalisation of abortion in Zimbabwe: A public health perspective' Public Health Pract (Oxf) 24 February 2022 3, 100237. doi: 10.1016/j.puhip.2022.100237. PMID: 36101761; PMCID: PMC9461515.

24 MG Madziyire and others 'Severity and management of post-abortion complications among women in Zimbabwe: A cross-sectional study (2016) 8 *BMJ Open* 2.

25 Sec 4 Termination of Pregnancy Act 29 of 1977 (ToP Act).

means rape, incest or certain other unlawful intercourse as defined under the Criminal Law Amendment Act.[26]

The process for obtaining a legal abortion is bureaucratic, lengthy and cumbersome, involving courts and medical institutions, making access for women and girls difficult to obtain in a timely manner. First, the woman must submit an affidavit to a magistrate in the jurisdiction where she wants to obtain an abortion, stating that she is a victim of unlawful intercourse[27] and requires an abortion. Once the magistrate is satisfied, they will certify to the superintendent of the medical institution to provide the services that

(a) the woman has lodged a complaint with 'the authorities' regarding the unlawful intercourse;
(b) the magistrate believes 'on a balance of probabilities' that unlawful intercourse took place and the pregnancy reasonably possibly resulted from that unlawful intercourse; this determination would be made after an examination of any relevant documents submitted to him by the authorities and after such interrogation of the woman concerned or any other person as he may consider necessary; and
(c) the patient is related within the prohibited degree to her aggressor, in the case of incest.

In cases where the woman's life or physical health is threatened or there is a risk of foetal deformity, the superintendent must obtain certification from two other physicians that the abortion is necessary.[28] Presumably, requiring multiple medical professionals to provide permission for abortion services evinces a concern that lawful justifications for abortion will be misapplied and/or fraudulently abused. This requirement represents a heavy burden on women seeking lawful abortion services.

Where there is an emergency, the superintendent's permission may not be required, as long as a report is provided to the Secretary of Health within 48 hours.[29] Violating these procedures may result in a fine and/or up to five years' imprisonment.[30] Section 5(1) of the ToP Act also states that abortion services may be legally offered at 'designated institutions'

26 Sec 2 ToP Act.
27 Sec 5(4) ToP Act.
28 Secs 5(1)-(2) ToP Act.
29 Sec 7 ToP Act.
30 Sec 12 ToP Act.

only, defined as state hospitals or any other institutions declared designated institutions in accordance with the Act.[31]

Section 5(1) of the ToP Act hinders women's access to abortion and goes against WHO guidance on the provision of access to services. Forcing women to only access abortions through designated institutions denies women the ability to obtain outpatient abortion services, and limits accessibility. The WHO is clear that access to safe abortion is a key step towards avoiding maternal deaths and injuries, and has stated that services may be safely provided where there is good-quality primary care and outpatient services, which also involves self-management.[32] Medical abortions and vacuum aspiration may be safely provided by any properly trained non-physician clinicians such as midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors and others, and recommends against regulation on who can provide and manage abortion that is inconsistent with WHO guidance.[33]

Conscientious objection in section 10 of the ToP Act presents another major barrier to access to legal abortion in Zimbabwe. The provision provides that no medical practitioner or nurse or person employed in any other capacity at a designated institution shall be obliged to participate or assist in the termination of a pregnancy. The same law fails to provide for an obligation to ensure referral.

4 The Termination of Pregnancy Act and women's constitutional rights: A case for reform

The impact of the barriers to safe and legal abortion were conspicuously highlighted in the tragic case of *Mapingure v Minister of Home Affairs*[34] decided in the Supreme Court of Zimbabwe in 2014. Mapingure was attacked and raped by robbers at her home. She immediately lodged a report with the police and requested that she be taken to a doctor in order to access medication to prevent pregnancy and any sexual infections. Due to delays at the police station, and the refusal by doctors

31 Sec 2 ToP Act.
32 WHO 'Abortion care guideline' (2022), https://apps.who.int/iris/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1&isAllowed=y (accessed 17 December 2022).
33 WHO (n 32) xxviii and ch 3, generally.
34 Judgment SC 22/14, https://zimlii.org/zw/judgment/supreme-court-zimbabwe/2014/22 (accessed 17 December 2022).

to administer medication in the absence of a police report of rape, the 72 hours within which she could have received post-rape care lapsed. When Mapingure's pregnancy was medically confirmed, she sought a lawful termination in terms of the ToP Act. A prosecutor and magistrate erroneously told her that she could not acquire the magisterial certificate required for termination until the rape trial had been completed. When she eventually obtained a certificate of termination on 30 September, it was no longer safe to carry out the termination, and Mapingure was forced to give birth on 24 December 2006.[35]

Mapingure sued the Minister of Home Affairs, the Minister of Health and Child Welfare and the Minister of Justice, Legal and Parliamentary Affairs as respondents before the High Court, which ruled that it was not the mandate of the officials involved to advise on the right procedures to follow to ensure that a victim received access to abortion services.[36] On appeal, the Supreme Court ruled that the procedure to access safe and legal abortion lacked sufficient clarity,[37] and directed that the respondents put in place measures to improve accessibility.[38]

The Supreme Court in its judgment did not address the fact that the cumbersome statutory procedure violated women's rights in the Constitution of Zimbabwe, namely, the right to access basic healthcare services, including reproductive healthcare services;[39] the right to personal security[40] and privacy;[41] and the right to be free from cruel, inhuman and degrading treatment.[42]

The certification procedure violates women's rights to emergency medical treatment and reproductive services in terms of section 76(1) of the Constitution. The Public Health Act 11 of 2018 reaffirms the

35 N Chingore 'Judgment in *Mapingure v The State*: A step forward for women's rights or a token gesture' 8 April 2014, https://www.southernafricalitigationcentre.org/2014/04/08/judgment-in-mapingure-v-the-state-a-step-forward-for-womens-rights-or-a-token-gesture/ (accessed 17 December 2022).
36 As above.
37 *Mapingire* (n 35) 28-29.
38 *Mapingire* (n 35) 26.
39 Sec 76(1) Constitution of Zimbabwe, 2013.
40 Sec 52(b) Constitution of Zimbabwe.
41 Sec 57(e) Constitution of Zimbabwe.
42 Sec 53 Constitution of Zimbabwe.

constitutional right to medical emergency treatment[43] and prohibits doctors from denying same.[44]

Although Zimbabwe has no definition of what constitutes a medical emergency or emergency medical treatment, South Africa and Kenya, which also recognise the right to emergency medical treatment, have provided definitions that provide useful analysis for understanding the context of the right. The Kenyan Health Act 21 of 2017 defines a medical emergency as 'an acute situation of injury or illness that poses an immediate risk to life or health of a person or has potential for deterioration in the health of a person, or if not managed timely would lead to adverse consequences in the well-being'.[45]

Arguably, abortion access meets the condition of a medical emergency given the need for timely access to the treatment as a measure for the avoidance of the 'adverse consequences in the well-being' of women. The United Nations Human Rights Committee has noted that states should ensure that legal restrictions do not impel women to resort to clandestine abortions that endanger their lives and health.[46]

The South African High Court in the case of *Soobramoney v Minister of Health, KwaZulu-Natal*[47] defined the meaning of medical emergency in terms of section 27(3) of the South African Constitution, as a 'dramatic, sudden situation or event which is of a passing nature in terms of time. There is some suddenness and at times even an element of unexpectedness in the concept 'emergency medical treatment.'[48]

Critics of the judgment have argued that medical experts and not judicial bodies should define what constitutes a medical emergency.[49]

In response to the ruling in *Dobbs v Jackon's Women's Health Organisation*,[50] which ended the right to freely access abortions, the

43 Preamble to Public Health Act.
44 Sec 33(1) Public Health Act.
45 TW Burkholder, HB Bergquist & LE Wallis 'Governing access to emergency care in Africa' (2020) 10 *African Journal of Emergency Medicine* 52.
46 UN Human Rights Committee, Concluding Observations on the 6th periodic report of Morocco, 1 December 2016, UN Doc CCPR/C/MAR/CO/6 (2016) para 21.
47 1998 (1) SA 765 (CC).
48 E Kramer '"No one may be refused emergency medical treatment" – Ethical dilemmas in South African emergency medicine' (2008) 1 *South African Journal of Bioethics and Law* 53.
49 Kramer (n 48) 54.
50 https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf (accessed 19 December 2022).

United States government has been forced to categorise abortion access as an acceptable form of emergency medical treatment. The US Secretary for Health and Human Services moved to define abortion access as included in emergency medical care under the Emergency Medical Treatment and Active Labour Act (EMTALA). In a letter issued to states,[51] Secretary Xavier Becerra wrote:[52]

> Emergency medical conditions involving pregnant patients may include, but are not limited to, ectopic pregnancy, complications of pregnancy loss, or emergent hypertensive disorders, such as preeclampsia with severe features.[53] Stabilising treatment could include medical and/or surgical interventions (eg, abortion, removal of one or both fallopian tubes, anti-hypertensive therapy, methotrexate therapy etc), irrespective of any state laws or mandates that apply to specific procedures.

Enforcing judicial administrative procedures for legal abortions, and denying women's and girls' access to unrestricted abortion services, violates section 53 of the Zimbabwean Constitution which prohibits cruel, inhuman and degrading treatment and torture, and section 51 which protects the right to inherent dignity. The Committee Against Torture has repeatedly advised that restrictions on access to abortion constitute torture and ill-treatment in healthcare settings.[54] Further, the prohibition against torture and ill-treatment in article 7 is to protect both the dignity and the physical and mental integrity of the individual.[55] The Human Rights Committee in the decision of *KNLH v Peru* deemed that the denial of a therapeutic abortion is a violation of the individual's

51 The US Secretary for Health and Human Services letter to providers 11 July 2022 2, https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf (accessed 17 December 2022).

52 As above.

53 As above.

54 Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 24 February 2016, UN Doc A/HRC/31/57/Add.1 (2016) para 614, https://www.ohchr.org/sites/default/files/HRBodies/HRC/RegularSessions/Session31/Documents/A-HRC-31-57-Add-1-_E%2C_F%2C_S_only-.docx (accessed 17 December 2022).

55 UN Human Rights Committee (HRC) CCPR General Comment 20: art 7 (Prohibition on torture, or other cruel, inhuman or degrading treatment or punishment), 10 March 1992, para 5, https://www.ohchr.org/en/resources/educators/human-rights-education-training/general-comment-no-20-prohibition-torture-or-other-cruel-inhuman-or-degrading-treatment-or (accessed 17 December 2022).

right to be free from ill-treatment.[56] Similarly, in the decision of *LMR v Argentina* it was found that LMR's rights to be free from inhuman and degrading treatment and her rights to privacy were violated when she was unable to access termination services, after she was only able to obtain the required judicial authorisation when her pregnancy had already reached 20 weeks, at which point no public facility could perform the abortion.[57]

In addition to violating the right to dignity and freedom from torture, the ToP Act and section 60 of the Criminal Code, which criminalises abortion, violate section 52(b) of the Constitution of Zimbabwe which provides that 'every person has the right to bodily and psychological integrity, which includes the right ... to make decisions concerning reproduction'. The constitutional right to privacy is also infringed upon by the legal framework governing access to abortion in Zimbabwe. Forcing victims to go through a lengthy process through various public institutions[58] before receiving services, and subjecting women who undergo abortions without statutory approval to criminal proceedings, arbitrarily interferes with privacy rights.[59] Victims are forced to share private medical information regarding the circumstances of rape with the various government offices before which they must appear, in order to access abortion services. Victims of sexual violence may for many reasons not be ready to institute legal proceedings against their aggressor(s), or to deal with the complexities involved in legal processes. The fear that confidentiality will not be maintained deters many women – particularly adolescents and unmarried women – from seeking safe, legal abortion services, and may drive them to clandestine, unsafe abortion providers, or to self-induce abortion.[60]

56 *KL v Peru* CCPR/C/85/D/1153/2003, Communication 1153/2003, https://www.escr-net.org/caselaw/2016/kl-v-peru-ccprc85d11532003-communication-no-11532003 (accessed 17 December 2022).

57 *LMR v Argentina* CCPR/C/101/D/1608/2007, https://www.escr- net.org/sites/default/files/Decision.pdf (accessed 17 December 2022).

58 In terms of sec 5(4) of the ToP, victims must prepare an affidavit, appear before a magistrate for certification, and then present the certification to the superintendent of a hospital before obtaining an abortion.

59 HRC General Comment 36 (2018) on art 6 of the International Covenant on Civil and Political Rights, on the right to life, 30 October 2018, UN Doc CCPR/C/GC/36 (2018) para 8, https://www.ohchr.org/sites/default/files/Documents/HRBodies/CCPR/CCPR_C_GC_36.pdf (accessed 17 December 2022).

60 WHO (n 32) 43.

The lengthy administrative procedure and criminalisation of abortion in Zimbabwe violate the non-discrimination clause in the Constitution. Ultimately, rural women are more likely to be disadvantaged by the restrictive legal frameworks affecting abortion access.[61] Requiring judicial authorisation in the jurisdiction where treatment is sought may disproportionately burden some women, particularly rural women. There is a perception that judicial authorisations may reduce criminal sanctions. However, requiring judicial authorisation encourages women to seek out unsafe, illegal abortions – especially in areas where magistrates are practically inaccessible or where the procedure takes an unnecessary long time. As a result, judicial authorisation requirements may actually increase the incidence of illegal abortion, and resulting criminal sanctions.

Most recently in 2024, in *Women in Law in Southern Africa and Talent Forget v Minister of Health and Child Care and Ors* (HH 552-24), the High Court of Zimbabwe found that section 2(1) of the ToP is unconstitutional and invalid. The court ruled that the definition of 'unlawful intercourse' must include marital rape and intercourse with minors, aligning with the constitutional protections for children and the criminalisation of marital rape. This decision aims to provide legal access to abortion for victims of marital rape and minors, addressing issues of teenage pregnancies and associated health risks. The decision acknowledges the vulnerability of children and married women in situations of sexual exploitation and abuse, providing them with legal avenues to protect their reproductive health. It marks an incremental step towards ensuring comprehensive reproductive rights for women in Zimbabwe.

However, the continued existence of the ToP Act and the Criminal Code not only is unconstitutional, but violates Zimbabwe's international and regional legal obligations with regard to women's human rights.

61 I Shah and others 'Access to safe abortion: Progress and challenges since the 1994 International Conference on Population and Development (ICPD)' (2014) 10, https://www.unfpa.org/sites/default/files/resource-pdf/Safe_Abortion.pdf (accessed 17 December 2022).

5 Zimbabwe's international human rights obligations with respect to abortion

Zimbabwe is a state party to several continental and global treaties that provide for the obligations to respect, protect and fulfil the right to health and other related rights in the context of reproductive health. The obligation to respect human rights and the right to health, in particular, imposes a duty on states requiring them to abstain from interfering in socio-cultural and socio-economic rights.[62] In the context of the right to health and abortion, this may be looked upon as a state's responsibility not to limit or obstruct access to reproductive health services based on any discrimination.[63] Under the obligation to protect, the state is required to regulate and control third party activities associated with the right to health, which includes legislative measures as well as other necessary steps that the government has to adopt in order to prevent third parties from intervening in the right to health.[64] The obligation to fulfil necessitates the state to take steps to actually implement the right to health, including policy making, the provision of public health infrastructure, the training of professionals, immunisation, making underlying determinants of health equally accessible to all, and other measures. [65]

The right to health and other related rights to advance reproductive health are provided for in multiple conventions. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol),[66] the International Covenant on Economic, Social and Cultural Rights (ICESCR)[67] and the Convention

62 Maastricht Guidelines on Violations of Economic, Social and Cultural Rights para 6, https://www.refworld.org/docid/48abd5730.html (accessed 17 December 2022).

63 See United Nations Office of the High Commissoner of Human Rights, https://www.ohchr.org/en/instruments-and-mechanisms/international-human-rights-law (accessed 17 December 2022).

64 See United Nations Office of the High Commissoner of Human Rights, https://www.ohchr.org/en/instruments-and-mechanisms/international-human-rights-law (accessed 17 December 2022).

65 ESCR Committee General Comment 14, 2000 para 36.

66 African Women's Protocol, http://www.achpr.org/instruments/womenprotocol/# 14 (accessed 14 July 2024.

67 International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

on the Elimination of All Forms of Discrimination Against Women (CEDAW)[68] are particularly significant.

The African Women's Protocol grounds abortion access within the context of health rights by stating that any woman whose physical or mental health is under threat should have access to safe abortion.[69] In expounding on the right to abortion in its General Comment 2, the African Commission on Human and Peoples' Rights (African Commission) notes that states should ensure the availability, accessibility, acceptability and good quality reproductive health care, including safe abortion for women, with sensitivity to the reality of women in all contexts.[70]

In General Comment 22 the Committee on Economic, Social and Cultural Rights (ESCR Committee) reiterated states' obligation 'to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure the full realisation of the right to sexual and reproductive health'.[71]

Article 12 of CEDAW guarantees women's rights to health. In relation to women's sexual reproductive health rights in article 12, the CEDAW Committee noted that '[t]he obligation to respect rights requires states parties to refrain from obstructing action taken by women in pursuit of their health goals', and amend legislation criminalising abortion.[72] The CEDAW Committee has raised concerns regarding the ToP Act which criminalises abortion and limits access for women to safe abortions.[73] The Committee urged Zimbabwe to enable women's access to comprehensive

68 https://www.un.org/womenwatch/daw/cedaw/ (accessed 17 December 2022).
69 Art 14(2)(c) African Women's Protocol.
70 African Commission General Comment 2 on arts 14(1)(a), (b), (c) and (f) and arts 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa para 53, https://www.achpr.org/legalinstruments/detail?id=13 (accessed 17 December 2022).
71 ESCR Committee General Comment 22 on the right to sexual and reproductive health (art 12 of the International Covenant on Economic, Social and Cultural Rights), UN Doc. E/C.12/GC/22 (2016) para 45.
72 General Comment 2 (n 70).
73 Committee on the Elimination of Discrimination Against Women, Concluding Observations: Zimbabwe (1998) para 159, https://www.un.org/womenwatch/daw/cedaw/cedaw25years/content/english/CONCLUDING_COMMENTS/Zimbabwe/Zimbabwe-CO-1.pdf; CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Zimbabwe, 1 March 2012, UN Doc CEDAW/C/ZWE/CO/2-5 (2012) paras 33-34, https://www2.ohchr.org/english/bodies/cedaw/docs/co/cedaw-c-zwe-co-2-5.pdf (accessed 17 December 2022).

health services in line with its treaty obligations by decriminalising abortion in all cases, ensuring access to safe abortion and post-abortion services in all parts of the state party, as well as confidentiality in the administration of such services.[74]

Zimbabwe is obligated to take all appropriate measures to eliminate discrimination against women in rural areas and ensure access to adequate healthcare facilities, including information, counselling and services in family planning.[75] Providing abortion only in designated institutions restricts access as rural women might not be able to travel to the facilities, precluding access to lawful services.

Section 60(1) of the Criminal Code, which criminalises abortion, must be repealed, in line with the guidelines outlined in the African Women's Protocol and findings of various treaty bodies, namely, the African Commission,[76] the UN Human Rights Committee and the CEDAW Committee.

6 Recommendations

Zimbabwe is obligated by its Constitution and regional and international treaty obligations to undertake reforms to create an enabling environment for women to enjoy, without restriction, the right to abortion, which is a right to health. Thus, it must institute reforms that will remove any barriers that exist in law and practice.

In summary, the following recommendations are offered for reform of the Zimbabwe law:

Establish procedural guidelines to procuring legal abortion

- Accompanying clear and unambiguous procedural guidelines on lawful termination of pregnancy should be created through a nationwide public policy or clarified in a statutory instrument. These guidelines should be in simple language and translated into local languages and widely disseminated through public media tools.

74 Committee on the Elimination of Discrimination against Women, Concluding Observations: Zimbabwe (2020) paras 39-40, https://www.ohchr.org/en/documents/concluding-observations/cedawczweco6-committee-elimination-discrimination-against-women (accessed 17 December 2022).
75 Art 14(2) CEDAW.
76 General Comment 2 (n 70).

Streamline procedure for accessing an abortion

In the ideal situation courts should not be part of the process to obtain an abortion, but in the interim:

- Once a magistrate receives a request for a certificate to obtain abortion, the judgment should be expedited and decided within 24 hours.
- Once the legal grounds have been established, the magistrate certification should provide immediate access upon presentation at any healthcare centre, without need for further sign-off or review by a medical superintendent.
- Certification from the medical superintendent should be removed.

Legally mandate referral procedures where conscientious objection occurs

- Where medical personnel are unable to perform the abortion procedure for one reason or the other, they should be legally required to provide the women with referrals to the closest hospitals where they can obtain the required services within 24 hours of refusal of service.

Increase public awareness

- The state should commit to educating the public and authorities (such as the police and the judiciary) on legal abortion, the circumstances under which it is performed and the guidelines to procuring legal abortion. All personnel with victim-friendly units within police stations should be trained in abortion rights and act as a resource and advocate women and girls seeking abortion access.

Establish best practices to providing legal abortion services

- Legal termination of pregnancy should be carried out on request. In the absence of universal access to abortion services, lawful termination of pregnancy should be made as accessible as possible.

Decriminalise abortion

- Abortion should be expunged from the Criminal Code and not be treated as a crime.

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