# Safe abortion policy provisions in the SADC region: Country responses, key barriers, main recommendations

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**Background.** Abortion is the termination of an already established pregnancy. The abortion may be induced, voluntarily performed or spontaneous, but when it is done by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, it is considered unsafe. The Southern African Development Community (SADC) has a robust policy framework for combating unsafe abortion.
**Objectives.** To examine the relationship between abortion laws and access to safe abortion services in the SADC region as an important and necessary yardstick for measuring the progress of a nation in securing reproductive and sexual health. To analyse the relationship between laws governing abortion, abortion and post-abortion national guidance, and access to safe abortion services by adolescent girls and young women.
**Methods.** A desk review of all legal, policy and national guidelines for all 16 SADC member states was done. Secondary data were collected, and the knowledge, attitudes and practices reflected on abortion surveys were examined in 15 out of 16 of the member states in both rural and urban settings. Sixty-three focus group discussions were held across 15 out of 16 countries, and 127 key informant interviews were held with non-governmental organisations, government ministries and relevant departments in the 15 countries.
**Results.** Countries with restrictive abortion laws are more likely to have a relatively high proportion of unsafe abortions. The results indicated a proportion of unsafe abortions ranging from 43% to 79% for those countries where the legal framework does not lend itself to ease of access**.** Liberal abortion laws and guidelines do not necessarily mean a reduced incidence of unsafe abortions, especially for adolescents, girls and young women. Multiple barriers still exist in practice.
**Conclusion.** Limits and bounds of the law as a tool to enhance safe abortion exist. The importance of alignment of laws, policies and practices is noted, recognising that all may influence and affect access to safe abortion, and in turn, sexual reproductive health rights for women and girls.

*South Afr J Pub Health* 2022;5(3):68-76. https://doi.org/10.7196/SHS.2022.v5.i3.133

The World Health Organization defines unsafe abortion as 'a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards'. Despite this, definitions vary widely according to state laws.[1] There are a number of international movements on women's rights that have called for the recognition of safe abortion as a human right. The Cairo Conference defined reproductive health as 'a state of complete physical, mental and social wellbeing and not merely the absence of infirmity, in all matters relating to the reproductive system and to its functions and processes'.[2] The conference built its base from the 1993 Vienna Conference (World Conference on Human Rights), which acknowledged reproductive and sexual rights as a human right.[3] Approximately 3% of the 19 million unsafe abortions estimated to take place every year happen in developing countries.[4] The estimated abortion rates per 1 000 women aged 15 - 44 years in southern Africa increased from 32 in 1990 - 1994 to 35 in 2010 - 2014.[5]

The Southern African Development Community (SADC) has a robust policy framework for combating unsafe abortion. Outcome 5 of the SADC Sexual and Reproductive Health Rights (SRHR) Strategy (2019 - 2030) aims at reducing unsafe abortion and teenage pregnancies.[6] Death related to unsafe abortion contributes significantly to maternal mortality. In Africa, an estimated 3.9 million unsafe abortions among young girls between the ages of 15 and 19 years lead to death.[6] As many as 24% of all pregnancies in southern Africa end in unsafe abortion.[6] Most SADC countries have conceded that the criminalisation of abortion is dysfunctional.[7]

Most abortion laws in the block were influenced by the colonisers.[8] The evolution of abortion laws in SADC countries has followed three main phases, namely: the customary law phase; the colonial phase; and the post-colonial phase.[1] The last three decades have observed a tolerant liberalisation of abortion laws and a growing perception by states of abortion as not only a major public health concern, but also a matter of human rights and social justice. Despite an abundance of rhetoric of commitment to the realisation of equality and reproductive rights for women, the majority of SADC countries have been slow if not averse to liberalising abortion law. Instead, they have held on to their colonial bequest of unduly restrictive and inaccessible abortion regimes at the cost of oppressing women.[8] When accompanied by adequate provision of healthcare services, liberalisation of abortion law has obviously had a positive effect on unsafe, illegal abortions. There is no country in Africa that has been spared from the calamity of unsafe abortion.

Against this backdrop, assessing access to safe, legal abortion is both an important and necessary yardstick for measuring the progress of nation states in securing reproductive and sexual health. This article, focusing on the SADC region, analyses the relationship between abortion laws and access to safe abortion services. It also provides a discussion on the potential factors that contribute to limited utilisation of safe abortion services. The article ends by providing practical and policy recommendations for reducing unsafe abortion in the region.

## Methods

The present article is based on a regional study on unsafe abortion that was commissioned by SAfAIDS and led by Dr Nedy Matshalaga as a regional team leader with the support of national-level researchers in the SADC member states. An induction meeting for national researchers was conducted in Harare, Zimbabwe. The national researchers went through sessions aimed at standardising appreciation of sexual and reproductive health rights (SRHR) issues and a common understanding of research questions. The regional team researchers pilot-tested the data collection tools as part of the induction for the national researchers. The data collection tools piloted included focus group discussion (FGD) guides, questionnaires for knowledge, attitude and practice (KAP) surveys and key informant interview guides for adolescent girls and young women. A pilot study was conducted in Norton, Zimbabwe, in order to determine the feasibility, utility and appropriateness of data collection tools. The data collection tools were adjusted in accordance with the feedback from the pilot exercise. Overall, the induction allowed the national researchers to have a common understanding of the key themes and purpose of the research.

### Literature review

The literature review informed all aspects of the regional study on abortions initiated outside health systems. The country assessment on abortion issues entailed document reviews of sources such as national demographic health surveys, member state laws on abortion, national SRH strategies and policies, civil society organisation reports such as Gender Links Barometer reports, police reports and health reports.

### Knowledge, attitudes and perceptions (KAP) surveys on abortion initiated outside health systems

In each of the 15 out of 16 research countries (excepting Tanzania), a KAP survey was conducted among adolescents, girls and young women (AGYW). On average, 200 questionnaires were administered in each country. The survey covered issues around unsafe abortion. At least a quarter of the respondents were male. Given the sensitivity of the subject of abortion and the fact that abortion is illegal in most of the countries, questions on unsafe abortion were about friends of the respondents as opposed to respondents themselves.

### Key informant interviews (KIIs)

A total of 32 KIIs were conducted with strategic informants at national level, including United Nations (UN) agencies (the United Nations Population Fund (UNFPA), UN Women, and the United Nations Educational, Scientific and Cultural Organisation, UNESCO), 50 KIIs with relevant government ministries/departments (ministries of education, ministries of health and youth ministries) and 45 KIIs with civil society organisations who are working in the area of SRHR issues.

### Focus group discussions (FGDs)

A total of 63 FGDs were conducted across the 15 SADC member states, with at least 4 FGDs in each country. At least 1 of these 4 FGDs was with young males, while the remaining 3 were with AGYW. The FGDs explored general opinions on issues of unsafe abortion.

### Data collection

Data were collected in the 15 countries by the qualified national researchers who were trained at induction. They were supported by research assistants and enumerators who had also been trained. Four countries were chosen for monitoring, and programme officers were deployed to do quality control. All interviews were transcribed. One rural and one urban site were chosen in each country.

### Data analysis

All qualitative data from interviews and FGDs were transcribed, translated, catalogued and uploaded for collation. They were systematically reviewed, coded and combined into themes. All KAP survey results were entered into KoBoCollect (open source) for countries where manual surveys were conducted. Data were cleaned and analysed using R Statistical Package (R Foundation for Statistical Computing, Austria).

### Regional validation meetings

Two regional validation meetings were held with stakeholders from member countries to inform the emerging results of the regional study. A regional validation workshop was organised for the SADC member states in Johannesburg, SA, while a separate one for Francophone and Lusophone countries was conducted in the capital of the Seychelles.

### Study limitations

Due to planning challenges about flights, the Comoros and Seychelles national researchers were not able to attend the

initial induction meeting. In order to mitigate this challenge, the regional team leader provided orientation and training online, and during the data collection phase, support was provided to enhance standardisation of data collection methods. Surveys were administered in 15 countries. However, not all questions on abortions were responded to. In Mauritius, many questions were left blank by respondents, mainly due to the sensitivity of abortion in this country. However, the other 14 countries provided information on these variables, making it possible for the regional study to make reasonable judgements on the extent and impact of unsafe abortions in SADC countries.

## Results

Results on laws governing abortion laws in SADC countries were informed by secondary data, interviews with strategic member states' key informants and FGDs with both male and female participants.

### Laws governing abortion

Most penal codes in the SADC countries contain general provisions on the necessity that allows acts that would otherwise be considered illegal to be carried out without punishment when they are necessary to preserve life. Table 1 summarises the conditions under which abortion is permissible in the 16 SADC countries.

Three categories of countries were identified, as follows: countries where abortion is legal with no restrictions; countries with less liberal abortion laws; and those with some strict abortion laws. The results in the table show the following:

(*i*) Abortion is legal only in South Africa (SA) and Mozambique without restrictions.
(*ii*) Countries with less liberal abortion laws (≤5 circumstances under which abortion is permissible) are Madagascar (abortion completely illegal), Angola, Democratic Republic of Congo (DRC), Tanzania, Malawi, Mauritius, Angola, the Comoros and Zimbabwe.
(*iii*) Countries with more liberal abortion laws (≥6 circumstances under which abortion is permissible) are Zambia, Seychelles, Namibia, eSwatini, Botswana and Lesotho.
(*iv*) Countries in the SADC region that do not permit abortion in circumstances of rape are Angola, Madagascar, Malawi and Tanzania.
(*v*) Six out of 16 SADC countries do not permit abortion in circumstances of incest. They are Angola, the Comoros, Madagascar, Malawi, Mauritius and Tanzania.

The results also show that the penal code informs the country abortion laws in 10 out of 16 countries, while the remaining 6 countries have abortion laws informed by either criminal codes, the constitution and/or other abortion-related Acts.

### Unsafe abortions

The results of the KAP survey showed that abortions among AGWY were initiated outside of health systems, and in most cases under unsafe procedures. The abortion survey respondents were asked if they knew of any of their friends who had had abortions outside the recommended health systems. Fig. 1 shows the proportion of respondents who did. Angola, SA and the Comoros are the three leading countries with the highest proportion of AGYW respondents who knew friends who had had abortions outside the recommended health systems. Results from FGDs indicated that most of the abortions conducted outside the recommended health systems were unsafe. The main reasons noted from study results for why AGYW perform illegal abortions were unplanned and unwanted pregnancies emanating from relationship issues, school or career concerns and poor timing.

### Complications arising from unsafe abortion

According to the WHO, as of 2010 - 2014, about three-quarters (77%) of abortions in sub-Saharan Africa are considered unsafe (the sum of less safe and least safe)[12] The main complications arising from unsafe abortion listed included haemorrhage, infection, sepsis, genital trauma and necrotic bowel, which sometimes resulted in deaths. Due to the legal nature of abortion in most SADC countries, access to post-abortion care is limited, as is documentation of cases. From the clinician's perspective, most unsafe abortions presented to the facility with one or more of the following: sepsis, bleeding, pelvic infection, instrumental injury, retained products of conception, uterine perforation, gangrenous uterus, gut injury, generalised peritonitis, septicaemia, septicaemic shock, system or organ failure, weak pulse or low blood pressure, trauma and the presence of a foreign body in the genital tract.

### Abortion and post-abortion national guidance

Some SADC member states have abortion or post-abortion national guidelines that provide guidance on procedures for safe abortion in health systems. In addition, there are specific abortion policies that offer guidance on conducting safe abortions, and provision of post-abortion care. Eight SADC member states – Botswana, Madagascar, Malawi, Mozambique, SA, Tanzania, Zambia and Zimbabwe – have abortion or post-abortion national guidelines that have been developed in the past 5 years. All countries except for the Comoros have some form of policy or guidelines governing safe termination of pregnancy. Table 2 presents the types of abortion or post-abortion national laws.

While a significant number of countries have in place some forms of national guidelines or policies for safe and post-abortion services, the results of the regional abortion study indicated that countries still have very stringent rules that make it difficult for AGYW to access safe abortion services in their countries, especially in countries where unsafe abortion is high. Table 3 presents some of the restrictions in different SADC member states.

### Complications from abortion initiated outside health systems

The regional KAP survey on abortion carried a question on respondents' knowledge of friends who had experienced complications as a result of abortions initiated outside the health system. Fig. 2 shows the results of the analysis from sampled AGYW from the 15 SADC member states. Secondary data have also shown that many countries in the SADC region report complications

**Table 1. Status of abortion legality in SADC countries, January 2019**

| | Reason | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Country | Save woman's life | Economic or social | Fetal impairment | Rape | Incest | Intellectual disability | Mental health | Physical health | Other | Source |
| Angola | Y | N | Y | N | N | N | Y | Y | - | Angola Penal Code 2014 |
| Botswana | Y | N | Y | Y | Y | N | Y | Y | - | Botswana Penal Code 1991 |
| Comoros | Y | N | N | N | N | N | N | Y | Very serious medical reasons | Comoros Penal Code 1995 |
| DRC | Y | N | N | Y | N | N | Y | Y | Sexual assault | Democratic Republic of Congo Penal Code 2004<br>Act of Access to Maputo Protocol 2018 |
| eSwatini | Y | N | Y | Y | Y | Y | Y | Y | Unlawful sexual intercourse with a mentally retarded female | eSwatini Constitution 2005 |
| Lesotho | Y | N | Y | Y | Y | N | Y | Y | - | Lesotho Penal Code 2010 |
| Madagascar | N | N | N | N | N | N | N | N | - | Madagascar Penal Code 1998 |
| Malawi | Y | N | N | N | N | N | N | N | - | Malawi Penal Code article 149 |
| Mauritius | Y | N | Y | Y | N | N | Y | Y | - | Mauritius Criminal Code Act 2012 |
| Mozambique | Y | N | Y | Y | Y | N | Y | Y | - | Mozambique Penal Code 2013 |
| Namibia | Y | N | Y | Y | Y | Y | Y | Y | - | Namibia Abortion and Sterilisation act 1975 |
| Seychelles | Y | Y | N | Y | Y | Y | Y | Y | Defilement | Termination of Pregnancy Act 1994 |
| SA | Y | Y | Y | Y | Y | Y | Y | Y | - | South Africa Choice of Termination of Pregnancy Act No. 92 of 1996 |
| Tanzania | Y | N | N | N | N | N | N | N | - | Tanzania Penal Code |
| Zambia | Y | Y | Y | Y | Y | Y | Y | Y | Risk of injury to the physical or mental health of any existing children of the pregnant woman. Defilement. | Zambia Penal Code 2014 |
| Zimbabwe | Y | N | Y | Y | Y | N | N | Y | Sexual intercourse in contravention of section 4 of the Sexual Offences Act (chapter 9:21), which prohibits extra-marital sexual intercourse or immoral or indecent acts committed with an intellectually handicapped person. | Zimbabwe Abortion Law 1977 |

SADC = Southern African Development Community; Y = yes; N = no; DRC = Democratic Republic of Congo; SA = South Africa.

**Table 2. Condition for access to safe abortion in different SADC countries**

| Country | Authorisation of health professionals | Authorisation in specially licensed facilities only | Judicial authorisation for minors | Judicial authorisation for case of rape | Police report required in case of rape | Parental consent required for minors | Spousal consent | Compulsory waiting period | Compulsory counselling |
|---|---|---|---|---|---|---|---|---|---|
| Angola | | Y | Y; <18 | Y | N | N | N | Y; 3 days | Y |
| Botswana | Y; 2 doctors | Y | N | N | N | N | N | N | N |
| Comoros | Y; 2 doctors | N | N | N | N | N | N | N | N |
| DRC | Y; 3 doctors | N | N | N | N | Y | N | N | N |
| eSwatini | Y; 1 doctor | N | N | N | N | N | N | N | N |
| Lesotho | Y; 1 doctor | N | N | N | N | N | N | N | N |
| Madagascar | N | N | N | N | N | N | N | N | N |
| Malawi | N | N | N | N | N | N | N | N | N |
| Mauritius | Y; 3 doctors | Y | Y; <18 | N | Y | N | N | N | N |
| Mozambique | Y; conflict* | | Y; <16 | N | N | N | N | N | N |
| Namibia | Y; 2 doctors | Y | N | Y | N | N | N | N | N |
| Seychelles | Y; 3 doctors | Y | N | Y | N | N | N | N | N |
| SA | Y; variable† | Y | N | N | N | N | N | N | N |
| Tanzania | N | N | N | N | N | N | N | N | N |
| Zambia | Y; 3 doctors | N | Y; <18 | N | N | N | N | N | N |
| Zimbabwe | Y; 2 doctors‡ | | | Y | | | | | |

SADC = Southern African Development Community; Y = yes; N = no; DRC = Democratic Republic of Congo; SA = South Africa.
*The Penal Code states that two health professionals different from the one by whom or under whose direction the abortion will be undertaken must verify the circumstances that make the abortion not punishable in a medical certificate, written and signed before the intervention. By contrast, the 2018 Ministerial Decree on abortion states that the circumstances must be certified by a doctor or health professional qualified for this purpose.
†One doctor/midwife/nurse-midwife (from 13 to 20 weeks) and two doctors/midwifes/ nurse-midwifes after 20 weeks.
‡Two doctors except in emergency.

**Table 3. Abortion/post-abortion guidelines and policies for SADC member states 2019**

| Country | Abortion/post-abortion national guidelines | Any related policies and/or guidelines |
|---|---|---|
| Angola | N | Angola Medical Ethics Code 2000; National Program of Essential Medications 2008 |
| Botswana | Y | Comprehensive Post Abortion Care Reference Manual, Ministry of Health; Botswana Essential Drug List 2012; Botswana Sexual and Reproductive Health Policy Guidelines |
| Comoros | N | - |
| DRC | N | Medical Ethics Rule; Essential Medicines List 2010 |
| eSwatini | N | National Policy on Sexual and Reproductive Health 2005; Standard Treatment Guidelines and Essential Medicines List of Common Medical Conditions |
| Lesotho | N | Lesotho Essential Medicines List 2005 |
| Madagascar | N | Health Code 2011; Reproductive Health Norms and Procedures 2006; List of Medications 2014; List of Medications 2014; National Family Planning Policy 2008-2012 |
| Malawi | Y | Malawi Standard Treatment Guidelines 2015; Post-Abortion Care Strategy, Ministry of Health |
| Mauritius | N | Medical Council Act, 1999 |
| Mozambique | Y | Clinical guidelines on abortion and post abortion care, 2017; Ministerial Decree on abortion, 2017; National Medicines Form 2007 |
| Namibia | N | Namibia Essential Medicines List; Namibia Standard Treatment Guidelines 2011 - First ed |
| Seychelles | N | Termination of Pregnancy Act; Seychelles List of Basic Essential Medicines Ministry of Health 2010 |
| SA | Y | Standard Treatment Guidelines and Essential Medicines List for South Africa, May 2017; Regulations related to Choice of Termination of Pregnancy Act; Medicines and Related Substances Control Act No.101 of 1965 as amended by inter alia |
| Tanzania | Y | Comprehensive Post-Abortion Care Guideline Training Manual 2016; Standard Treatment Guidelines and Essential Medicines List |
| Zambia | Y | Register of Marketing Authorisations, 2015; Essential Medicines List, 2013; Standard Treatment Guidelines, Essential Medicines List and Essential Laboratory Supplies; Zambia Standards and Guidelines for Comprehensive Abortion Care 2017 |
| Zimbabwe | Y | National Guidelines for Post-Abortion Care May 2018; Essential Medicines List and Standard Treatment Guidelines for Zimbabwe, 2011; Register for Approved Human Medicines, 2015 |

SADC = Southern African Development Community; Y = yes; N = no; DRC = Democratic Republic of Congo; SA = South Africa.

as a result of unsafe abortion. A study conducted in Botswana in a hospital from January to August 2014 showed that in 619 patients, with a mean age of 27 years, the majority (95%) reported spontaneous abortion, while 3.9% had induced abortions. Two-thirds (67%) were admitted as a result of incomplete abortions followed by inevitable abortion. Self-induced abortion and delayed uterine evacuation of more than 6 hours were found to have a significant association with post-abortion complications (*p*-values of 0.018 and 0.035, respectively).[10] In the DRC, about a quarter of the 146 700 abortions that took place in 2016 resulted in complications that led to women/girls seeking treatment in a health facility.[11] In Malawi, it is estimated that between 6% and 18% of abortions outside the health system are associated with severe complications. Out of 141 000 abortions in the country, 60% resulted in complications that required attention from a health service provider.[12]

### Death from abortion complications

Fig. 3 provides KAP survey results for respondents who knew anyone who had died from abortion complications in the 15 SADC member states. While the majority of countries reported relatively low proportions of respondents who knew someone who had died of complications emanating from unsafe abortion, in Angola, Zambia and Malawi, the proportion was >25% of the respondents.

## Discussion

### Countries with restrictive abortion laws are more likely to have high proportions of unsafe abortion

Countries with restrictive abortion laws (Madagascar, Malawi, the Comoros, Angola and Tanzania) are more likely to have a relatively high proportion of unsafe abortions.[11] The results from the regional survey (minus Tanzania) indicated a high proportion of unsafe abortion, ranging from 43% to 79% for all 15 countries. This suggests that having good legal frameworks in place also does not guarantee ease of access to safe abortion services. The Guttmacher Institute notes that studies have demonstrated that severely restricting abortions does not reduce abortions rates, but instead affects the safety of the procedure,[11] which can be seen in the number of countries where respondents knew someone who had died from an abortion. Countries with more restrictive abortion rates present with significantly higher rates of deaths from

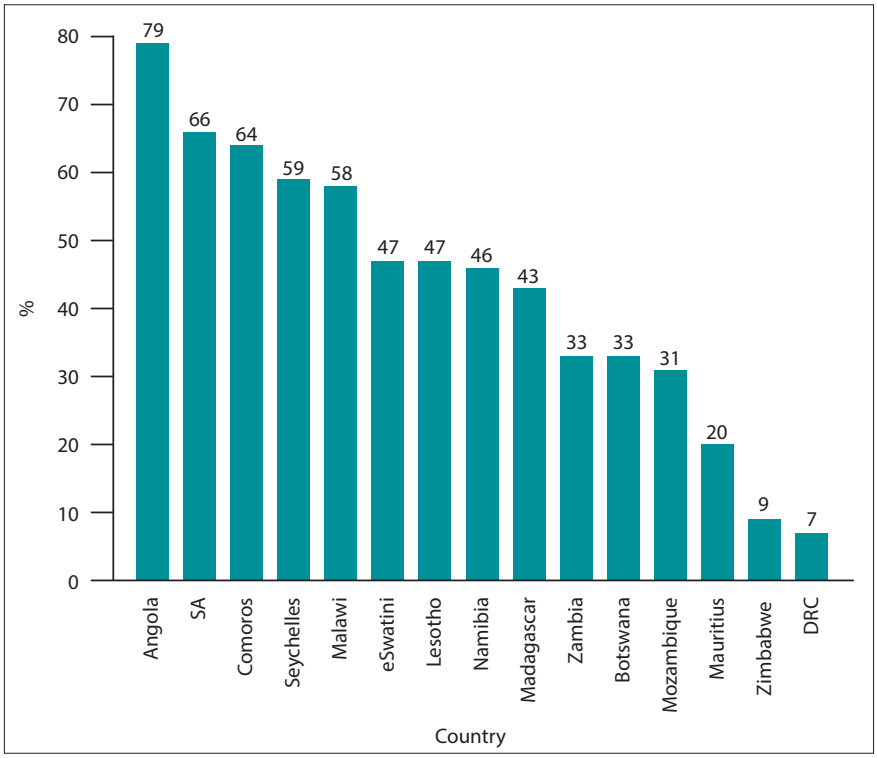


*Fig. 1. Respondents who know someone who has had an abortion initiated outside the health system. (SA = South Africa; DRC = Democratic Republic of Congo.)*

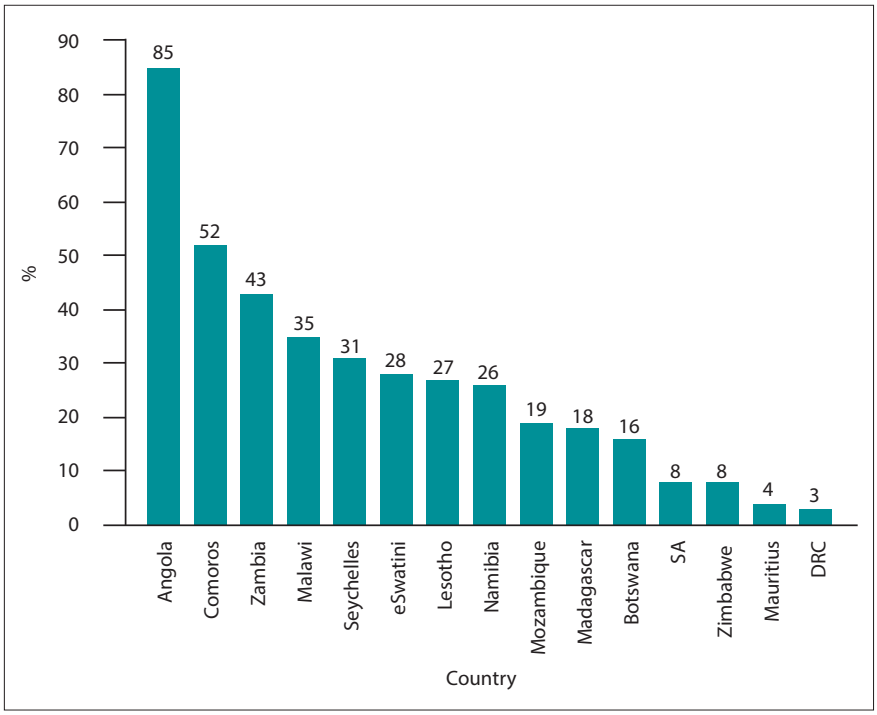


*Fig. 2. Respondents who know someone who has had complications from unsafe abortion. (SA = South Africa; DRC = Democratic Republic of Congo.)*

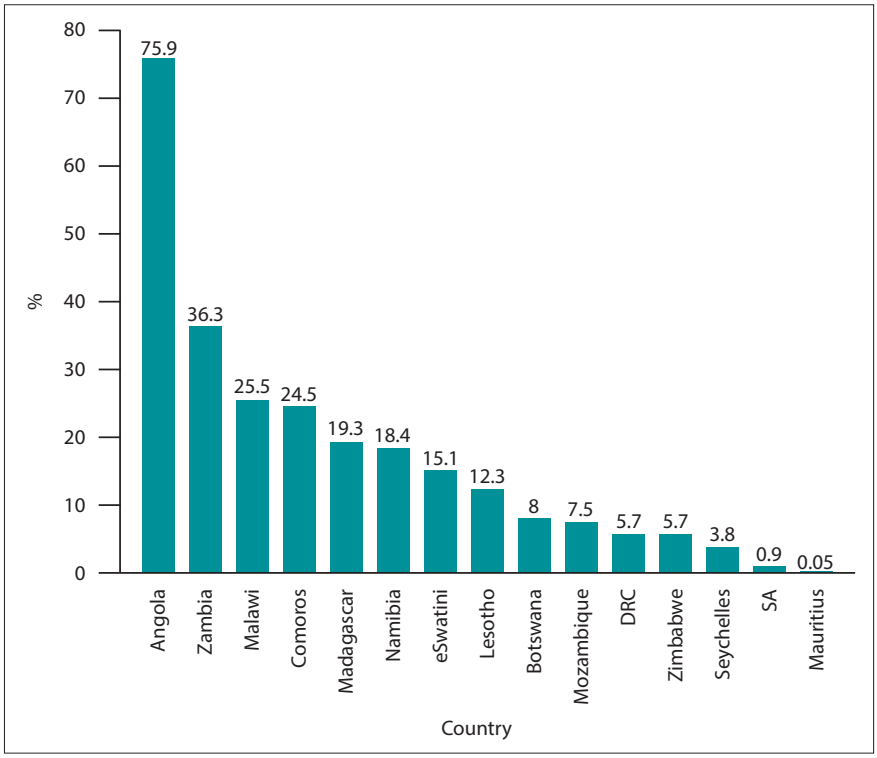


*Fig. 3. Respondents who know someone who has died from complications of unsafe abortion. (SA = South Africa; DRC = Democratic Republic of Congo.)*

unsafe abortions. In 2016, the DRC reported 47 700 abortions that had complications that required attention in health facilities.[13] In the same year, 37 900 women obtained treatment in health facilities for abortion-related admissions.[14] A study conducted in 2000 in Temeke district in Dar es Salaam showed that 60% of patients admitted because of incomplete abortion reported that the abortions had been induced. About 88% of these women were <24 years old, while 55% were <20 years, suggesting that abortion more often happens among younger than older women.[15] This situation is true for this SADC study, as supported by the cases explained for the different countries.

### Where conditions for a legal abortion have been met, including existence of national guidelines and policies for safe abortion, many women still experience barriers in accessing the service

Having in place abortion and post-abortion national guidelines is anticipated to increase access to safe abortion. Eight countries in southern Africa have put in place national guidelines for abortion and post-abortion care (Botswana, Malawi, Madagascar, Mozambique, SA, Tanzania, Zambia and Zimbabwe). A review of secondary data on access to safe abortion services noted that access to safe abortion services is limited, largely owing to inefficient service from the judiciary, police or health sector. Legalised abortion does not necessarily mean safe and accessible abortion. Even in countries where the law permits abortion on broad grounds, procedural barriers such as compulsory waiting periods, authorisation/consent requirements, restrictions on abortion providers and facilities or mandatory medical authorisations may prevent or undermine access to services, as do the lack of protocols on how to get a legal abortion, and weak judicial systems to implement the law. The conditions for accessing safe abortion are hindered by the need to fulfil stringent requirements, such as getting reports from two to three doctors (depending on country), and proving beyond doubt that the conditions are in line with the legal provisions. While measures such as two to three doctors' reports can be met by those living in urban settings, the conditions are more difficult for women living in rural settings where, in many cases, areas are not well served by doctors. In four countries (Angola, Namibia, Seychelles and Zimbabwe), safe abortion after rape is only permissible after proof of judiciary authorisation. Often, there is limited information shared on procedures to follow. Most countries that permit abortions (with or without restrictions as to reason) place limits on the period during which the procedure may be obtained. An additional difficulty is that there is often ambiguity on how to calculate the beginning of the pregnancy.[16] Some of the conditions include: (*i*) restrictions on performing institutions or personnel; (*ii*) medical approvals/authorisation; (*iii*) the discretion of the judge; and (*iv*) spouse/partner authorisation.

In countries where abortion is legal, services for post-abortion care are limited. This may cause complications resulting in death. Stigma by health technicians and community members in post-abortion care facilities discourages potential patients from seeking services. Women in Madagascar face multiple barriers to access to post-abortion care and family planning services. From a policy perspective, current legislation and practices contribute to restricted environments for provision and use of these services. Only 40% of the Malagasy population live within 5 km of health service providers.[17] Even women who live close to health centres are often unaware of post-abortion care, and face stigma from communities and providers. At the facility level, poor-quality care, a lack of privacy, negative norms and attitudes, long waiting times and inappropriate fees are barriers to services.[17] In SA, there are many challenges associated with the implementation of the Choice on Termination of Pregnancy Act No. 92 of 1996 (CTOP). There are disparities in accessing facilities that offer safe abortions by province and by urban or rural setting, with rural settings having less access to such services. Women seeking such services face a lack of accessible information on where to obtain services. There are also reports of stigma from health personnel, which discourages intending patients. Both clinical and

administrative staff broadly invoke conscientious objection to avoid and obstruct all stages of abortion services.[18] The high number of conscientious objectors is noted to contribute to high levels of unsafe abortion. Another source also noted that while the CTOP was significant for women's reproductive rights and health, realisation of the full benefits of the legal provision remains a huge challenge owing to limited facilities for offering safe abortion services.[19]

Other barriers for accessing safe abortion across most countries, especially in rural sub-population groups, include:

- inability to access facilities due to distances from facilities or police stations for those living in rural settings
- limited knowledge on the provisions of the abortion laws and steps to be taken to access safe abortion
- the cost associated with travel and other costs for following up rape cases
- inadequate capacities for the preservation of forensic evidence from cases of rape
- access to legal services to prove evidence of rape.

## Conclusion

The SADC region has a robust policy framework for addressing teen pregnancies, unsafe abortion and reducing maternal mortality to 70 per 100 000 by 2030. The 16 SADC member states have differing legal provisions governing legality of abortion. Only in 2 countries (SA and Mozambique) is abortion legal. Only 3 out of 16 SADC countries have decriminalised abortion. To a large extent, there is a need for most SADC countries to work towards liberalisation of abortion laws. Eight out of 16 SADC countries have in place abortion and post-abortion national guidelines aimed at management of post-abortion services. This article has noted that in countries with liberal laws and abortion and post-abortion national guidelines, there still remain many limitations to easy access to safe abortion by those requiring such services. There are still stringent legal requirements that limit easy access to safe abortion in most countries. Stigma and negative attitudes of health service providers and communities are a mitigating factor in accessing safe abortion services. In countries with enabling legal provisions for safe abortion, including the existence of abortion and post-abortion national guidelines, factors such as limited health facilities, limited information and knowledge of legal provisions and location of appropriate health centres limit access to safe abortion. The analysis also observed that AGYW have unsafe abortions mainly owing to the fact that their reasons for abortion (wrong timing, and relationship and school concerns) often do not fit with the legal justifications for accessing safe abortion services. Unsafe abortion also significantly contributes to high rates of maternal mortality.

In order for the SADC region to accomplish the aspirations of the SRHR Strategy 2019 - 2030, much still needs to be done by member states. The following are the key recommendations emerging from the analysis of the study results:

- SADC member states should consider domestication of the SADC SRHR strategy in order to enhance member state commitments to operationalise the strategy in their countries.
- States should consider speeding up the liberalisation of abortion laws to potentially reduce the high rates of unsafe abortion and maternal mortality rates.
- States should harmonise laws and policies on unsafe abortion across all the SADC countries, ensuring that countries without abortion and post-abortion laws develop such guidelines.
- SADC member states should consider increasing access to cheap and affordable contraceptive services for the youth, and work towards removing barriers to access SRH information.
- States should increase awareness on the legal and policy provisions on abortion among the general population, especially AGYW, who are the main users of safe abortion services.
- SADC member states should address the many limitations to access to abortion and post-abortion services in member states, including increasing health centres that offer services.
- SADC member states should consider decentralising post-abortion care and youth-friendly SRH services to rural communities, who often face access and affordability challenges.

**Declaration.** None.

**Acknowledgements.** The authors acknowledge using findings from research originally commissioned by SAFAIDS. The research findings were complemented by secondary data.

**Author contributions.** Equal contributions.

**Funding.** SAFAIDS paid a small honorarium to the authors to write the article.

**Conflicts of interest.** None.

1. Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM (editors). Williams Gynecology, 3rd ed. New York: McGraw Hill, 2016 . https://obgyn.mhmedical.com/content.aspx?bookid=1758&sectionid=118167822 (accessed 3 August 2020).
2. United Nations. 2018 Report of the International Conference on Population and Development. A/94/10/18. Programme of Action. New York: UN, 2018. https://www.un.org/en/development/desa/population/events/pdf/expert/27/SupportingDocuments/A_CONF.171_13_Rev.1.pdf (accessed 10 August 2020).
3. UN Women. Action for Equality, Development and Peace. Beijing: UN, 1995. https://www.un.org/womenwatch/daw/beijing/platform/health.htm (accessed 3 August 2020).
4. Glasier A, Gülmezoglu AM, Schmid GP, Moreno CG, Van Look PF. Sexual and reproductive health: A matter of life and death. Lancet 2006;368(9547):1595-1607. https://doi.org/10.1016/S0140-6736(06)69478-6
5. Gender Links. Voice and Choice Barometer 2019. Johannesburg: Gender Links, 2019. https://genderlinks.org.za/wp-content/uploads/2019/08/Chap4-Baro2019-ABORTfin.pdf (accessed 3 August 2020).
6. Southern Africa Development Community. Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019 - 2030. Gaborone: SADC, 2019. https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/07/SADC-SRHR-Strategy-2019-2030-for-public.pdf (accessed 3 August 2020).
7. Cook RJ, Dickens BM, Bliss LE. International developments in abortion law from 1988 to 1998. Am J Public Health 1999;89(1999):579-586. https://doi.org/10.2105/AJPH.89.4.579
8. Ngwena C. An appraisal of abortion laws in southern Africa from a reproductive health rights perspective. J Law Med Ethics 2004;32(4):708-717. https://doi.org/10.1111/j.1748-720x.2004.tb01976.x
9. Sai F. International commitment and guidance on unsafe abortion. AfrJ Reprod Health 2004;8(1):15-28. https://www.jstor.org/stable/3583301 (accessed 3 August 2020).
10. Tadele M, Habte D, Tsima BM, et al. High levels of post abortion complication in in a setting where abortion service is not legalised. PLoS ONE 2017;12(1):e0166287. https://doi.org/10.1371/journal.pone.0166287
11. Guttmacher Institute. Factsheet Abortion in Africa. Washington, DC: Guttmacher Institute, 2018. https://gutmacher.org/sites/default/files/factsheet/ib_aww-africa-pdf (accessed 6 August 2020).
12. Polis CB, Mhango C, Philbin J, Chimwaza W, Chipeta E, Msusa A. Incidence of induced abortion in Malawi, 2015. PLoS One 2017;12(4):e0173639. https://doi.org/10.1371/journal.pone.0173639
13. Ngwena C. An appraisal of abortion laws in southern Africa from a reproductive health rights perspective. J Law Med Ethics 2004;32(4):708-717. https://doi.org/10.1111/j.1748-720X.2004.tb01976.x

14. Gebremedhin M, Semahegn A, Usmael T, et al. Unsafe abortion and associated factors among reproductive aged women in sub-Saharan Africa: A protocol for a systematic review and meta-analysis. Syst Rev 2018;7:130. https://doi.org/10.1186/s13643-018-0775-9
15. Ganatra B, Gerdts C, Rossier C, et al. Global, regional, and subregional classification of abortion by safety, 2010 - 14: Estimates from a Bayesian hierarchical model. Lancet 2017;390(10110):2372-2381, https://doi.org/10.1016/S0140-6736(17)31794-4
16. International Planned Parenthood Federation Africa Region 2020. Database on DHS from 1990 to 2016. IPPF Africa region. www.ippfar.org (accessed 3 August 2020).
17. Post-Abortion Care Family Planning Project, USAID, Engender Health. Madagascar PAC-FP Country Brief. Washington, DC: PAC-FP2020. https://www.postabortioncare.org/sites/default/files/Madagascar-PAC-FP.pdf (accessed 3 August 2020).
18. Favier M, Greenberg JMS, Stevens M. Safe abortion in South Africa: "We have wonderful laws but we don't have people to implement those laws". Int J Gynecol Obstetr 2018;143(S4):S38-S44. https://doi.org/10.1002/ijgo.12676
19. Harries J. Abortion services in South Africa: Challenges and barriers to safe abortion care: Health care providers' perspectives. PhD thesis. Cape Town: University of Cape Town, 2010. http://hdl.handle.net/11427/10623 (accessed 6 August 2020).

*Accepted 13 June 2022.*