Lives worth saving: Abortion care in sub-Saharan Africa since ICPD

A progress report

Ipas

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About Ipas

Ipas is an international nongovernmental organization that has worked for three decades to reduce abortion-related deaths and injuries; increase women's ability to exercise their sexual and reproductive rights; and improve access to reproductive-health services, including safe abortion care. Ipas's global and country programs include training, research, advocacy, information dissemination and the distribution of reproductive-health technologies.

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Executive Summary

In every part of the world, in every era of history, women from all walks of life have obtained abortions to end unintended pregnancies. Despite the history and universality of women's need for safe abortion care, access to abortion is neither socially nor legally sanctioned in many parts of the world. As a result, almost half of the women seeking abortions each year—19 million—must resort to untrained providers working in unsanitary conditions. A quarter of these unsafe abortions occur in Africa.

> *"Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving."*
>
> *- Mahmoud Fathalla, MD, PhD, 1997*

Petterik Wiggers/Hollandse Hoogte

Each year, the failure to meet women's needs for safe abortion services results in nearly 70,000 deaths and untold injuries to women (WHO, 2003). Women in Africa suffer disproportionately and make up 44% of these abortion deaths (WHO, 1998). These deaths are almost entirely avoidable: contraception can greatly reduce the need for abortion and, when properly performed, abortion is extremely safe. Similarly, prompt access to care for the treatment of complications almost always results in a good outcome. Therefore, these preventable deaths represent enormous shortcomings in the delivery of essential health and contraceptive services and the failure of laws, policies, providers, and societies to respond to women's needs.

The International Conference on Population and Development (ICPD) in 1994 recognized sexual and reproductive self-determination as a human right of all women. It promised women more control over their reproductive lives and to eliminate the fundamental causes of pregnancy-related death and illness the world over. Significantly, and for the first time ever, the international community made commitments to address the public-health tragedy of unsafe abortion in Africa and around the world, emphasizing the importance of preventing unsafe abortion through increased availability of contraceptive services and supporting access to safe abortion care where it is legal.

African women could benefit greatly from the improvements in reproductive-health services mandated by ICPD. Pregnancy—wanted or unwanted—poses significant risks for African women. More specifically, they face an extremely high risk of death from unsafe abortion: one of every 150 procedures leads to death compared to one for every 85,000 procedures in developed countries (Population Action International, 2001).

Since 1994, there have been many signs of progress in Africa related to abortion care. Across the continent, important developments have occurred at the national level, ranging from new or expanded postabortion care programs (PAC) to significant debates in several countries about revising the legal restrictions against abortion. Some countries have seen services expand by authorizing and enabling more providers to offer care. This decade has also witnessed a broader spectrum of organizations collaborating for change in this area. Landmark legislation was passed in South Africa in 1996 legalizing abortion for all South African women in the first trimester. Momentum continued with first-ever regional meetings on unsafe abortion held for the Francophone African countries and another for countries across sub-Saharan Africa. And, prompted by the ICPD mandate, the World Health Organization (WHO) published important policy and technical guidance for safe abortion care at all levels of the health-care system. At the same time, other persistent issues in Africa slow or threaten progress toward universal access to important reproductive-health services. Health planners, advocates and activists must take into account factors such as: widespread poverty; crushing debt-burdens; the HIV/AIDS pandemic, which harms more people in Africa than anywhere else; poor health infrastructures; and persistent gender bias, which leaves many women without decision-making power in many areas of their lives, including sex and related health care.

This review of post-ICPD developments in sub-Saharan Africa offers examples of progress in the region in abortion-related care, which is one element of the comprehensive reproductive-health approach endorsed at the 1994 meeting. It is an optimistic account because of the range and growth of relevant initiatives over the decade. Nevertheless, we remain ever-mindful that sustainable progress is uncertain given other pressing public-health issues and the complex social, economic and political environment of the region.

Introduction

Globally, an estimated 46 million abortions are performed each year. Worldwide abortion rates average out to one abortion for every woman on the planet during her reproductive years (Alan Guttmacher Institute (AGI), 1999b). Even in the industrialised world where women have comparatively full access to contraception and health services, women seeking to control their reproduction turn to abortion when contraception fails. In fact, woman throughout the world face virtually the same chance of having an abortion and reasons for having one. However, because of legal restrictions and the social stigma attached to abortion, many women do not have access to safe abortions and instead receive services from untrained and unskilled providers. In Africa, which has some of the most restrictive abortion laws in the world, over four million women undergo unsafe abortions each year, and 34,000 of them die as a result (WHO, 1998). Many others survive but suffer from debilitating morbidities.

Figure 1

Whether a woman lives in a developed or a developing country, her average chance of having an abortion is much the same.

WORLD

DEVELOPED COUNTRIES

DEVELOPING COUNTRIES

0 5 10 15 20 25 30 35 40

Annual abortions per 1,000 women 15–44

Legal Illegal

Developed countries are defined as all of Europe, Australia, Canada, Japan, New Zealand and the United States; developing countries are all the rest.

Reproduced with the permission of The Alan Guttmacher Institute from: The Alan Guttmacher Institute. *1999. Sharing responsibility: Women, society and abortion worldwide.* New York and Washington DC, AGI.

Paradoxically, laws that seek to restrict the use of abortion often produce the opposite effect. They do not make it safe or rare, but drive it underground, making it more dangerous. Conversely, treating abortion openly brings quality and regulatory standards. In Western Europe, where abortion is broadly legal and widely available, as are sexuality education and modern contraceptives, unsafe abortion rates are negligible. In Africa, rates of unsafe abortion are significantly higher than in Western Europe, sexuality education and access to contraceptives remain limited for broad segments of the population, and the risks of injury or death from a clandestine abortion are significantly greater (AGI, 1999b; Åhman and Shah, 2002). In both regions, women are preventing or managing unwanted pregnancies: in Western Europe women have better access to safe contraception and safe abortion as needed; in Africa, many women's choices are bleaker and, if necessary, they will risk their lives to end an unintended pregnancy.

At the landmark 1994 International Conference on Population and Development (ICPD) held in Cairo (also called the "Cairo conference"), 179 countries negotiated a "Programme of Action" (POA), which set out specific guidelines to transform reproductive-health services into more client-centred programs, recognizing reproductive self-determination as a right of all women. Significantly, and for the first time ever, the international community recognized and promised to address the public-health tragedy of unsafe abortion in Africa and around the world, with an emphasis on the importance of preventing unsafe abortion through increased availability of contraceptive services, and where legal, to safe abortion care (see box, page 8). At

Figure 2

Estimated annual incidence of unsafe abortion in Africa

United Nations Region	Estimated number of unsafe abortions	Incidence ratio (unsafe abortions per 100 live births)	Incidence rate (unsafe abortions per 1000 women aged 15-49)
World	19,000,000	14	12
More developed nations	500,000	4	2
Less developed nations	18,500,000	15	15
Africa	4,200,000	14	22
Eastern Africa	1,700,000	16	29
Middle Africa	400,000	9	20
Northern Africa	700,000	15	15
Southern Africa	200,000	16	16
Western Africa	1,200,000	13	24
Europe	500,000	7	3
Asia*	10,500,000	14	11
Latin America & Caribbean	3,700,000	32	26
North America	negligible	—	—
Oceania*	30,000	12	15

* Japan, Australia and New Zealand have been excluded from the regional estimates, but are included in the total for more-developed nations

Source: Åhman and Shah, 2002.

a subsequent meeting in 1999 to review ICPD progress, this commitment was strengthened by adding a mandate for governments to train and equip providers to make such care accessible.

This report reviews the past ten years in Africa and highlights successes and obstacles to achieving ICPD's key abortion care recommendations, culminating with reflections and recommendations for the future. The key sections of the report, which mirror the ICPD recommendations, include:

- Highlighting unsafe abortion as a public-health problem for the region
- Provision of quality postabortion care services
- Improving and expanding access to contraceptive services
- Improving access to safe legal abortion services
- Taking other measures to ensure women's health
- The challenges to achieving safe abortion care in Africa
- The way forward

ICPD paragraph 8.25

In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortions.

ICPD+5 paragraph 63iii

….In circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health.

1. Highlighting Unsafe Abortion as a Major Public-Health Concern

Giacomo Pirozzi / Panos Pictures

"All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public-health concern..."

In the decade since ICPD, much has happened in Africa to bring the topic of unsafe abortion out of the shadows and into the realm of policy and health planning discussions at the regional and national levels. At the same time, other approaches including news articles or community awareness campaigns have sought to increase public awareness and action around the issue. Through meetings, the creation of new networks, and the development of new policies and strategies, there is now broader understanding and concern about addressing the problem of unsafe abortion across Africa.

Policy developments

- In July 2003, the **Assembly of the African Union** approved the "Protocol to the African Charter on Human and Peoples' Rights Relating to the Rights of Women" calling for the protection and advancement of women's reproductive rights, including access to abortion for reasons including sexual assault, incest and others. The Assembly urged all member states to sign and ratify the protocol, which is the first human rights document to formally recognize abortion as a reproductive right (African Union, 2003).

- Building upon the momentum generated by ICPD, and seeking to strengthen and expand action on unsafe abortion across the continent, the first-ever regional conference on unsafe abortion was held in Ethiopia in 2003. **The regional consultation, "Action to Reduce Maternal Mortality in Africa"** included Ministers of Health, parliamentarians, health professionals, non-governmental organizations (NGOs) and religious representatives from across the continent. The conference communiqué called on governments to fund programs addressing unsafe abortion and to review and revise laws in accordance with international agreements. International donors were urged to provide direct support to safe abortion care programs (Action to reduce maternal mortality in Africa, 2003) (see page 31).

- The **WHO Regional Office for Africa (WHO-AFRO)** developed the "Reproductive Health Strategy for the Africa Region 1998–2007," which was adopted by

the African Health Ministers at their 1997 meeting and is intended for use by AFRO's 46 member states and partners as they develop program priorities in the area of reproductive health. The document mentions unsafe abortion as a cause of maternal mortality and includes an objective related to reduced rates of morbidity and mortality resulting from unsafe abortion in its strategic framework (WHO Regional Office for Africa, 1998).

Planning for service delivery

- The first-ever regional conference on unsafe abortion and postabortion care (PAC) for countries in Francophone Africa was held in Senegal in 2002. Participants from 14 countries reviewed information about the impact of unsafe abortion in their region, heard about relevant research and programs in other countries and laid out plans for implementing their own PAC programs. The conference significantly raised the profile of and commitments to PAC in the Francophone region, and launched the **Francophone PAC Initiative**. As a result, preliminary PAC program planning and implementation is actively underway in seven countries in the region (IntraHealth, 2003).

- In 2001, an international meeting examining the role of midlevel providers[1] in abortion care was held in South Africa. Representatives from Kenya, Mozambique, South Africa and Zambia worked with delegates from six other non-African countries at the meeting **"Expanding Access: Advancing the Role of Midlevel Providers in Menstrual Regulation and Elective Abortion Care."** Conference delegates, including midlevel providers, researchers, and Ministry of Health representatives, shared experiences, developed a list of key recommendations for involving more midlevel providers in abortion care, and produced a conference statement arguing that access to abortion care will be greatly enhanced by the authorization and inclusion of midlevel providers in that care (Ipas and IHCAR, 2002). An educational video was also produced, using voices and opinions from the conference participants, to share their experiences more broadly (Ipas, 2002).

Advocacy for abortion access

- **Amanitare**, the African Partnership for Sexual and Reproductive Health and Rights of Women and Girls, has launched a ten-year (1999–2009) initiative to implement reproductive health and rights strategies in Africa based on recommendations from the ICPD, the 1995 Beijing Fourth World Congress on Women, and the 1993 World Conference on Human Rights. Amanitare is the first African regional network of women activists focused on sexual and reproductive rights, and its members endorse the importance of women's right to fully control their fertility. Their main activities include advocacy against gender-based violence, focusing on the needs of adolescents, and integrating a rights perspective into reproductive-health service delivery (Amanitare, 2003).

- Medical professionals have also taken up the mantle of addressing unsafe abortion. In 1997, the biannual meeting of the **Confederation of African Medical Associations and Societies (CAMAS)** focused exclusively on unsafe abortion. With a goal of reducing abortion-related maternal mortality, the resulting communiqué called upon governments to review and amend existing laws and policies and urged member associations to become active in training a range of health providers in PAC (CAMAS, 1997).

- In the past decade, a growing number of networks concerned with advancing women's reproductive health in Africa have provided venues for awareness raising and strategy development regarding unsafe abortion. These include the **International Planned Parenthood Federation, AFRO, the Ipas Africa Alliance for Women's Health and Rights,** and the **Regional Prevention of Maternal Mortality Network.**

2. Improving and Expanding High-Quality Postabortion Care Services

Fred Hoogervorst / Panos Pictures

"In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions."

Until and unless restrictive abortion laws change, unsafe abortions will continue and women will suffer. Recognizing this, the ICPD POA includes recommendations for governments and others to provide the necessary compassionate and curative care for women suffering complications of poorly performed abortions. High-quality, accessible emergency treatment for abortion complications is a tested, effective and key strategy for saving women's lives and reducing maternal mortality (WHO, 1994). Yet while estimates suggest that one-third of women who have an unsafe abortion will experience complications, fewer than half of these women will receive medical treatment (AGI, 1999b).

Postabortion care (PAC) includes improvements in the emergency management and clinical procedure for treating abortion complications and establishing services in existing outpatient areas in health-care facilities in order to decrease the time women wait for care. Most PAC programs have focused on the replacement of dilatation and curettage (also called D&C, or sharp curettage) with manual vacuum aspiration (MVA), a safer and less costly technology, and linking women to family-planning counselling and services, with the goal of preventing repeat unwanted pregnancy and abortions. Since the timing also provides an opportunity to reach women who might not otherwise seek health care, PAC programs have also tried to offer or link to other reproductive-health services. Building upon lessons learned in various service-delivery models and settings during the past two decades and the increased urgency and legitimacy offered for improved abortion-related care by the Cairo POA, the Postabortion Care Consortium, a group of international NGOs committed to promoting PAC as a critical public-health approach, has developed a list of five elements of successful PAC programs (Corbett and Turner, 2003) (see box, page 13).

The growth in PAC programming in Africa has been significant since 1994. In the past decade, efforts have been undertaken in many countries including **Benin, Burkina Faso, Ethiopia, Ghana, Kenya, Malawi, Mali, Niger, Nigeria, Senegal, South Africa, Tanzania, Uganda, Zambia** and **Zimbabwe.** Many have been undertaken in public-sector health systems, and most have focused on improving emergency care for abortion complications with linkages to

contraceptive and other services. Examples of specific trends and related challenges in Africa over the past decade follow.

Provision of clinical and regulatory guidance

Several countries have put in place new health standards and guidelines that give more recognition to unsafe abortion and make provisions for stronger PAC programming.

- In the mid-1990s, **Ghana** created a new Reproductive Health Service Policy and Standards in which the prevention and management of unsafe abortion and the provision of PAC is featured as one of the four key priorities (Ghana Ministry of Health, 1995).

- In **Nigeria**, where unsafe abortion contributes significantly to the large number of maternal deaths each year, the Federal Ministry of Health issued a new Reproductive Health Policy in 2001 that calls for reducing maternal mortality and morbidity by 40% through increased access to quality and affordable maternal and child health services including PAC (Federal Republic of Nigeria, 2001).

- In **Kenya**, where unsafe abortion has also been estimated to cause one-third of all maternal deaths, the Ministry of Health's *Reproductive Health and Family Planning Policy Guidelines and Standards for Service Providers* issued in 1997 states that all district-level hospitals should provide PAC services to ensure that women suffering from unsafe abortion have prompt access to care (Government of Kenya, 1997).

Essential Elements of Postabortion Care

Community and service provider partnerships

- Prevent unwanted pregnancies and unsafe abortion
- Mobilise resources to help women receive appropriate and timely care for complications of abortion
- Ensure that health services reflect and meet community expectations and needs

Counselling

- Identify and respond to women's emotional and physical health needs and other concerns

Treatment

- Treat incomplete and unsafe abortion and potentially life-threatening complications

Family planning and contraceptive services

- Help women practice birth spacing or prevent an unwanted pregnancy

Reproductive and other health services

- Preferably provided on-site, or via referrals to other accessible facilities in provider's network

Source: Postabortion Care Consortium Community Task Force, 2002.

Expanding use of better technology

A significant measure of progress in the past decade has been the broader distribution of the MVA technology. At present, MVA instruments are available in over 20 countries in Africa, and there is increasing demand for the instruments. In contrast, at the time of the ICPD, MVA was used in only a handful of countries, and mostly in pilot and small-scale hospital-based programs.

Vacuum aspiration has been shown to be safer than D&C for early uterine evacuation, and the manual vacuum technique is particularly appropriate for low-resource settings and decentralised health-care systems (Greenslade et al., 1993). WHO recommends MVA over D&C for evacuation of the uterus (WHO, 2000). WHO has also endorsed the use of MVA at the primary-care level where trained personnel are available (WHO, 1995; WHO, 2003).

However, the use of sharp curettage persists, even in countries such as Kenya and Nigeria with sizeable and long-lived PAC training and service-delivery programs. While a representative national survey in Nigeria found that three-quarters of physician abortion providers use MVA and over half of providers who treat abortion complications use MVA (Henshaw, et al., 1998), a separate study in northern Nigeria found that twice as many procedures were still performed with D&C than with MVA (Fetters and Jolayemi, 2002). And in Kenya, a recent study in two provinces found that while MVA is the preferred technology at public-sector facilities offering PAC, it is not as prevalent in private or mission-affiliated facilities (Onyango et al., 2003). Other factors affecting the use of MVA in both Kenya and Nigeria include the absence of supplies at health-care facilities and a sense by providers that their training in MVA was not sufficient (Fetters and Jolayemi, 2002; Onyango et al., 2003).

Enabling midlevel providers to offer postabortion care

Globally, training in abortion care—including PAC—and the authorization to provide this care have focused primarily on physicians. In Africa, other types of health professionals are both more numerous and more geographically dispersed than physicians. In many settings, a majority of health services, particularly those offered outside of major urban centres, are delivered by other cadres of providers—for example, midwives, clinical officers and physician assistants. The sheer numbers of these midlevel providers, as well as their proximity to broader communities and their experience in delivering primary-health services, suggest they are well-placed and sometimes already well-skilled to offer critical abortion services. Pilot programs to train midwives in PAC were undertaken in **Kenya, Ghana** and **Uganda** in the mid-1990s. All showed that midwives could competently provide quality PAC services in decentralized settings (Billings et al., 1999; Kiggundu, 1999; Yumkella and Githiori, 2000). Subsequently, governments in Kenya and Ghana as well as **Nigeria** have endorsed the training of midwives in this care, including initiatives involving private-sector midwives.

Creating relevant curricula

Another important strategy has been to effect change in the curricula used to train medical personnel.

- In **Ethiopia**, PAC has been incorporated into the training curriculum for all appropriate cadres of providers, including community health workers. These new materials will now be used in all five of the country's health training colleges and universities (Ipas, 2003a; Yirgu et al., 2003).

- In **Nigeria**, a nationwide initiative has updated the medical school curriculum used in federal teaching hospitals to better address reproductive health and rights. The new curriculum includes PAC and safe legal abortion, among other issues (Oye-Adeniran, 2003). The Nursing and Midwifery Council of Nigeria has also revised its training curriculum to incorporate PAC and begun training midwife tutors at schools of midwifery throughout the country in PAC.

Scaling-up postabortion care services

- Significant progress toward ensuring that all women have access to PAC services has been made in **Ethiopia, Ghana, Kenya** and **Nigeria,** where decentralisation of training and service delivery have steadily progressed. Efforts are also underway in many

other countries to expand services to more women, including in **Malawi**, **Niger**, **Senegal**, **Tanzania**, **Zambia** and **Zimbabwe**.

- The breadth of experience with PAC programs in Africa over the past 15 years prompted a review and examination of expansion efforts at an international conference entitled "Taking Postabortion Care Services to Scale" held in Mombassa, Kenya, in 2001. The workshop brought together approximately 140 professionals from 21 countries to discuss viable, practical strategies to improve access to and quality of comprehensive, sustainable PAC services. During this workshop, country teams exchanged lessons learned and developed action-oriented, locally based strategies to make PAC services more widely available in their countries. They also used this forum to strengthen in-country and international alliances, thus increasing their capacity to expand PAC services within their respective settings (EngenderHealth and Ipas, 2001).

Community involvement to reduce unsafe abortion

- In **Kenya**, the Community Based Abortion Care (COBAC) project has taken the approach of involving all health-care providers—from traditional practitioners to western trained medical doctors—in solving the problem of unsafe abortion. By raising awareness of the dangers of unsafe abortion among various sectors of the community, and by building referral networks among different types of providers regardless of formal training, the COBAC program is working to reduce the incidence of unsafe abortion and gain women prompt access to the type of care they need (Mukenge, 2003).
- In **Senegal**, a pioneering program has been launched in one district to make PAC services known and accessible at the community level. For the first time, PAC patients from rural health huts are being referred to health posts and then to the health centre for PAC services. Specialised training for providers at all levels of this chain has helped with prompt referral. In addition, women are benefiting in their communities from the provision of contraceptive re-supplies, now offered at health posts and health huts as a result of the training program (Corbett and Nelson, 2003).

Avoiding future unwanted pregnancies with postabortion family-planning services

Providing contraceptive services to women treated for abortion offers the promise of helping women prevent repeat unwanted pregnancies and abortions. A study in **Kenya** found that delivering contraceptive counselling services to women at the time of treatment was preferable to referring women to family-planning services located elsewhere (Solo et al. 1999). Similarly, by offering contraceptives to women at the time of treatment in **Zimbabwe**, researchers were able to document that the provision of on-site postabortion family-planning counselling and services (PAFP) resulted in increased contraceptive use, fewer unplanned pregnancies, and few repeat abortions (Johnson et al., 2002). However, despite the compelling logic of PAFP, other studies and reports show that this is a weak area of many PAC programs. Challenges to implementing successful PAFP include limited availability of contraceptives, limited method choice, inadequate training of providers regarding the needs of abortion patients, and service organization issues (Cobb et al., 2001; Fetters and Jolayemi, 2002; Gebreselassie and Fetters, 2002).

3. Improving And Expanding Access To Contraceptive Services

Fred Hoogervorst / Panos Pictures

"All governments and relevant intergovernmental and non-governmental organizations are urged to…reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority…"

Contraception is a critical component in the health and well-being of women, their families and communities. Without access to contraception, most women's ability to participate fully and equally in life is severely curtailed by repeated childbearing and rearing. The ICPD POA recognised the importance of family planning for individual and social development and set goals for universal access to reproductive-health services including contraception.

Women who use effective contraception are much less likely to face an unintended pregnancy. Studies have shown that abortions will decline with better availability and proper use of contraceptives (see Figure 3, page 17). Where abortion rates are lowest (such as in Belgium and the Netherlands), contraceptive use is widespread. Conversely, where abortion rates are highest (such as in Vietnam and Cuba), access to contraception is very limited (Shears, 2002; AGI, 1999b). Put another way, women who do not use contraception are six times more likely to have an abortion than contraceptive users (Cohen, 1997).

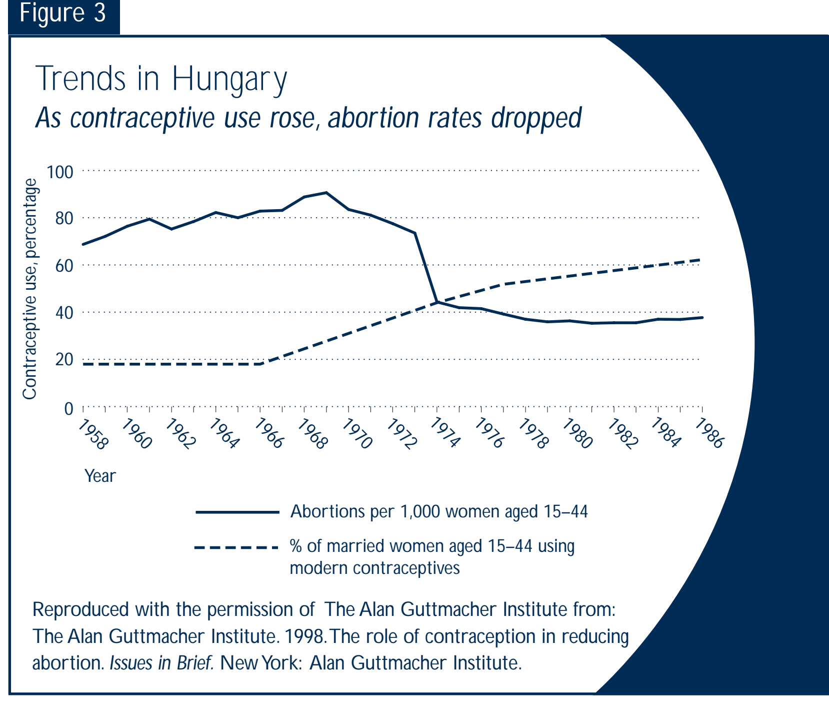
In Africa, where all pregnancy poses significant health risks, the potential benefits of broader access to contraception loom large. Overall, sexually active women in Africa have the world's highest risk of dying from reasons related to pregnancy (one in 15), which is 200 times greater than the risks faced by a women in the United States (Rosen and Conly, 1998).

Like women the world over, African women are increasingly eager to prevent or delay future pregnancies. At 5.7 children, desired family size is still larger in Africa than other developing countries of the world (3.3 children), but this is down from previous decades, and several countries have experienced more substantial declines, notably South Africa and Kenya (Rosen and Conly, 1998; Zlidar et al., 2003). A desire for fewer children also has an affect on the interaction between contraception and abortion, as people need access to one or both in order to meet lower fertility goals. A widespread desire for smaller families in any community or country may initially lead to an increase in the use of both contraception and abortion to regulate fertility. In such a situation, for the abortion rate to subsequently drop, contraceptives must be widely and consistently available for sustained use (Marston and Cleland, 2003).

National support and development of family-planning programs

Governmental support for family-planning programs has been steadily growing in Africa for the past 20 years. It received a significant boost at the African Population Conference in 1992 and was strengthened by the ICPD POA, which was signed by all African governments. In the last two decades, family-planning programs have been integrated into the maternal and child health services of most national health programs.

Figure 3



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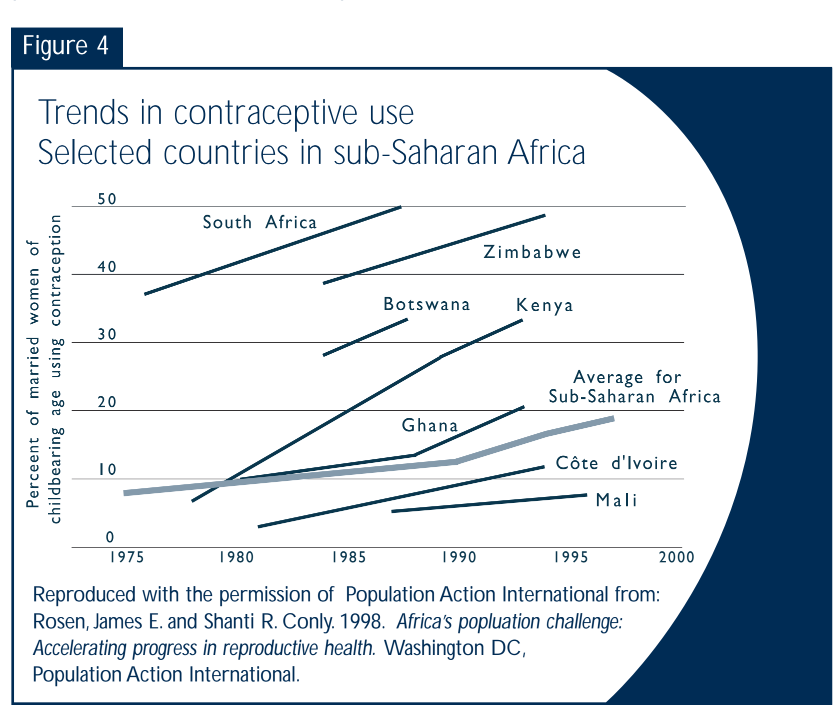
The Cairo conference also benefited greatly from the contribution of non-state agencies, and the POA reflects a strong belief in the importance role of private and non-governmental agencies in helping nations deliver quality reproductive-health care to their populations. **NGOs and other members of civil society** currently play a significant role in the delivery of family-planning services in many countries in Africa (Rosen and Conly, 1998).

Trends in contraceptive use

From a global perspective, Africa still has the lowest contraceptive use rates—an estimated 15% of married women are practicing contraception (with a range from 1 to 55%), compared to a global average of 57%. Relatedly, more married women in Africa (24%) report they would like to use contraception, making Africa the region with the highest rates of unmet need for contraception anywhere in the world (Zlidar et al., 2003) (see Figures 4 and 5).

Access to and use of contraception is generally increasing across sub-Saharan Africa with significant increases in the past decade in **Botswana, Cape Verde, Kenya, Mauritius, South Africa** and **Zimbabwe.** Oral and injectable contraceptives are the most widely used modern contraceptives, accounting for almost two-thirds

Figure 4



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Unmet need for contraception
Sub-Saharan African countries and selected regions

Percent of Married Women of Childbearing Age

0 10 20 30 40 50 60 70

Sub-Saharan Africa

Zimbabwe
Central African Republic
Niger
Nigeria
Cameroon
Namibia
Mali
Tanzania
Burundi
Sudan (northern)
Benin
Botswana
Eritrea
Uganda
Senegal
Zambia
Madagascar
Burkina Faso
Liberia
Ghana
Comoros
Kenya
Malawi
Rwanda
Togo
Côte d'Ivoire

Women with Unmet Need
Women Using Contraception

Developing World Regions

Sub-Saharan Africa
West Asia and North Africa
Latin America
Asia (excluding China)
All Developing Areas (excluding China)

0 10 20 30 40 50 60 70

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of all modern methods used. Condom availability has also increased. And while condoms only account for 4% of contraceptives use overall, they are used by significant numbers of contraceptive users in Ivory Coast (49%), Central African Republic (31%), Zambia (24%) and Ghana (22%) (Rosen and Conly, 1998).

The urban-rural divide also presents significant **challenges to the successful and equitable distribution of contraceptive services** in African countries. Fewer providers and unreliable supply chains in rural areas make the quality and consistency of services poor overall, whereas urban family-planning sites are generally better and busier. In most settings, rural women still have to travel an hour or more to obtain contraceptives (Rosen and Conly, 1998).

Emergency contraception

One new option that has become available in the past decade is **emergency contraception (EC)**, which offers women the chance to prevent pregnancy after an act of unprotected intercourse. EC can involve different regimens of some regular hormonal contraceptives, but has also become increasingly more available as a dedicated EC pill.

In Africa, dedicated EC products are now registered in over 20 countries, and some form of EC is available in many others (International Consortium for Emergency Contraception, 2003). To date, access to EC has been promoted through a limited number of public-sector clinics, and more commonly through non-governmental sites including directly through pharmacists. In general, EC use is still quite low, often hampered by irregular supplies and high prices, as well as limited knowledge and misconceptions among providers, the public and policymakers alike. However, interest across the continent is high and there are several and varied introductory approaches underway. A recently formed bilingual network of health professionals from across the continent called *ECafrique*, the African Forum on Emergency Contraception, plans to build upon those efforts and work toward broader dissemination and use of EC (ECafrique, 2003).

The U.S. Global Gag Rule Impact on Africa

In 2001, the United States issued a policy that is directly opposed to ICPD recommendations in the area of safe abortion care. The "Mexico City Policy" denies U.S. family-planning funds to any foreign NGOs that include abortion care, referral or counselling in their reproductive-health programs, even if they pay for those services with other funding. Under this policy, also known as the *Global Gag Rule* (GGR), NGOs that accept U.S. funding cannot inform their clients about abortion options— even if abortion is legal in their country— except in cases of rape or incest or to save the life of the woman. To date, there is no evidence that these exceptions are being implemented by U.S.-funded NGOs. Recent studies have found that cutbacks in funding and contraceptive donations for leading reproductive-health NGOs due to the GGR have significantly impeded access to a full range of reproductive-health services, including contraceptive services and supplies, youth reproductive-health programs, and HIV/AIDS prevention activities (Global Gag Rule Impact Project, 2003; Center for Reproductive Rights, 2003). Case studies have shown that Kenya, Ethiopia, Zambia, Uganda, and other countries receiving USAID funds are affected by the policy. The cruel irony of the GGR is that while its purported goal is to prevent abortions, its immediate effects are likely to be an increase in the number of unsafe abortions as women are unable to obtain contraceptive services to prevent unwanted pregnancies. Equally troubling is the GGR restriction on NGO advocacy, preventing U.S.-funded local NGOs from participating in ongoing democratic debates in their own countries on abortion laws and policies—helping to delay further the day when most African women will be able to access safe abortion care as a legal option.

Impact on other reproductive-health services

Within Africa, the commitments to family planning and reproductive health have grown in the past decade. However, these efforts are also dependent upon support from external donors, the biggest of which has been USAID. Restrictions imposed on USAID funding in 2001, while purporting to target only abortion services, have had a negative effect on the delivery of family planning and other reproductive-health services in several countries (see box, page 19).

4. Improving Access to Safe, Legal Abortion Services

" ...in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible."

Peter Barker/Panos Pictures

Abortion laws in Africa include one of the most liberal in the world (South Africa) and many of the most restrictive, permitting abortion only to safe a woman's life. Restrictive does not mean illegal—in all countries in Africa, abortion is permitted to save the life of the pregnant woman, and in 21 countries in sub-Saharan Africa, it is permitted for additional reasons in varying configurations.[2] Some laws allow abortion to preserve the physical health of the woman; other countries add rape, incest or foetal impairment. Six countries include a mental health indication. Zambia allows abortion for broad social grounds, albeit with conditions that make it virtually inaccessible to most women. And finally, South Africa permits abortion without restriction up to 12 weeks gestation (AGI 1999b; Katzive, 2003).

Unfortunately, little of this variation in law translates into practice in sub-Saharan Africa. Few public hospitals provide induced abortion services for legal indications in their country. For example, in at least 12 countries in sub-Saharan Africa, the law would allow women to receive an abortion following rape or incest; in reality, very few women can find such needed care. Even in Zambia, abortions require the signatures of several doctors, but most clinics are lucky if they have even one doctor on staff.

Apart from South Africa and Tunisia, most abortions throughout Africa are still performed under clandestine and unsafe conditions, with tragic results. Many factors contribute to this discrepancy between policies and practice, including a lack of awareness about the legal indications among providers and the public, lack of reproductive-health services or trained providers, and the stigmatisation of anything related to abortion (WHO, 2003). A recent study found that even when services were available, they were unacceptable to many women because of their high cost and because women feared hospital staff and providers would violate confidentiality (Koster-Oyekan, 1998). In Ghana, where the law allows abortion to protect a woman's physical and mental health or because of foetal impairment, unsafe abortion continues to be a significant problem and contributor to maternal mortality (Lassey, 1995). Providers

and women are rarely aware of any legal provisions in their country's abortion law, and the stigma attached to abortion makes many providers unwilling to offer the service.

Providing *safe* abortion is one of the essential strategies for reducing the toll exacted by unsafe abortion. "Training and equipping" many cadres of health providers is an essential element in ensuring that women have access to safe, legal abortion services. But governments and health professionals must do more: they are obligated to ensure that women can actually find and use legal abortion services. Accepted ethical principles require medical facilities to make provisions for all legal services. Even when an individual provider is unwilling to offer the procedure, s/he must have a plan for referral to another provider or to a facility that will provide the care (WHO, 2003).

To help governments, international organizations and NGOs implement the abortion-related ICPD recommendations that will save women's lives, WHO has compiled and published international standards for safe abortion care at all levels of the health-care system (WHO, 2003). This landmark document is already in use in a number of countries that are working to implement ICPD recommendations on abortion and has been widely acclaimed by governments and NGOs alike. Given the widespread stigmatisation of abortion, it is highly significant that WHO has made available the most up-to-date, evidence-based information and recommendations about abortion practice to health systems worldwide.

While there have been striking improvements in linking women suffering from abortion complications to life-saving PAC, progress to ensure that women have access to abortion for all legal indications has been more scattered in Africa but is reflected in the following examples.

Revising policies or regulations

- **Nigeria:** The National Reproductive Health Strategic Framework and Plan 2002 to 2006 recommends both PAC and the provision of safe abortion to the extent of the law. The government has yet to implement the plan, but it has shown support for the plan's abortion-related elements.

- In **Ghana,** health advocates encouraged the Ministry of Health in late 2003 to revise its reproductive-health policy to include safe abortion for all legal indications. The Ministry of Health will work with technical experts to develop service standards and implement the policy throughout the country.

- In order to make safe abortion services available throughout **South Africa**, the 1996 Choice on Termination of Pregnancy Act (CTOP) recognized the scarcity of physicians at the primary health-care level and the importance of training providers who serve rural areas. As such, the national abortion programme undertook activities to train and support nurse-midwives throughout South Africa. A special abortion-training curriculum was developed, a series of national and provincial training programs were held and midwives then returned to their posts. A 1999 evaluation of this program found that midwives could offer—and were providing—high-quality abortion care in the absence of physicians (Dickson-Tetteh and Billings, 2002).

Moving toward safer and more cost-effective techniques to improve access, options and quality of abortion care

- In **Mozambique**, one of the poorest countries in Africa, contraceptive use is low,

unsafe abortion is common and health-care resources are strained. Faced with high maternal death rates and large expenditures to treat women presenting at public hospitals with abortion complications, the Ministry of Health came up with a unique solution in 1981. It authorized early abortions in the central hospital in Maputo as a way to reduce the recourse to unsafe abortion. A cost study showed that the savings were considerable, and as a result, safe abortion services were extended to other major hospitals in the country (Ipas and IHCAR, 2002).

- To implement the changes afforded by the CTOP Act in **South Africa**, the national action plan also recognises the importance of adopting the best and most appropriate abortion practices. As such, providers, especially midwives, have been trained in the use of MVA. In a progress review, the uptake of MVA has been seen to improve the quality and sustainability and decrease the cost of service delivery of abortion services (Braam, 2002). In South Africa, **medical methods of abortion** are also beginning to be used in abortion care. Medical methods of abortion refer to medicinal regimens (usually pills) which bring on abortion and are an important alternative to methods which involve the insertion of instruments into the uterus. Several drugs can be used for medical abortion, the most common being a combined regimen of mifepristone and misoprostol. However, mifepristone is registered only in South Africa and Tunisia, and misoprostol is largely unavailable in most of the region.

5. Taking Other Measures to Ensure Women's Health

UN/DPI photo

> *"In circumstances where abortion is not against the law, health systems should … take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health."*

In Africa, as elsewhere in the world, the legal status of abortion does not seem to have much effect on whether or not women will terminate unwanted pregnancies. However, it does have an effect on the safety of most abortion procedures. Removing legal restrictions on abortion can significantly improve women's chances of a healthy outcome and save lives. While the ICPD agreements do not specify what additional measures should be taken to ensure women's health, it is clear that a major missing element in the recommendations is a call for the removal of restrictive abortion laws. This section of the analysis is framed under this interpretation.

In Romania, following the end of the pro-natalist Ceausescu regime in 1989, the new government removed the law that had severely restricted access to abortion and contraception. Abortion-related deaths dropped dramatically (Hord et al., 1991) (see Figure 6). More recently, law changes in both Guyana and South Africa in the last decade also quickly resulted in fewer admissions for incomplete abortions in large public hospitals (AGI, 1999b).

To respond to the common and stated needs of women, and to reduce or eliminate the chance that women will become seriously injured or die as a result of their determination to end an unintended pregnancy, restrictive laws must be changed. For abortion to be safe and available to all women, it must be a legitimate and legal medical procedure. Once sanctioned by law, providers can receive proper training in modern methods and be held accountable for the quality of their services, services can be advertised, and women will have recourse if they are treated poorly or if complications do occur (Rahman et al., 1998).

In Africa, several types of efforts related to reforming abortion laws have been implemented in the past decade.

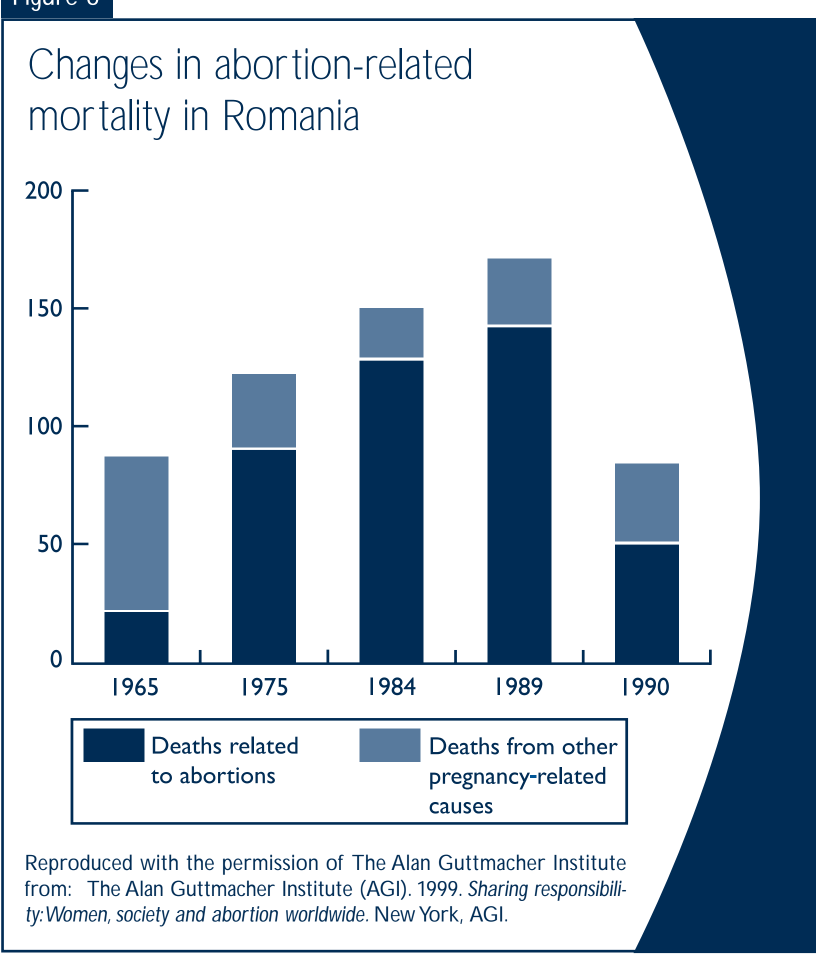
Reforming existing laws

In 2001, delegates from **Ethiopia, Kenya** and **Nigeria** undertook a study tour to South Africa to better understand the process and choices that culminated in the adoption of the 1996 CTOP Act. Since then, efforts have been underway in all three countries and others to

broaden the discussion of the negative consequences of restrictive laws and to promote movement toward law reforms. Activities have included public debates, advocacy and media efforts to make people aware of the health impact of unsafe abortion, and training strategies to enlist and mobilize a wider range of stakeholders in support of reform of abortion laws (Hord and Xaba, 2002).

Between 1996 and 2003, five countries in Africa (**Benin, Burkina Faso, Chad, Guinea** and **Mali)** passed comprehensive reproductive-health laws. The new laws expand legal abortion provisions from permitting abortion only to preserve the woman's life (or, in the case of Guinea, her health), to allowing abortions in the case of rape, incest or foetal impairment (Katzive, 2003). However, while adding indications can be seen as progress, there remains considerable disjunction between these new legal indications and the reasons most women in Africa and elsewhere seek abortion (see box, page 27).

Figure 6



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Adopting a Rights-Based Abortion Law in South Africa

Passed in December 1996, South Africa's CTOP Act is a remarkable and unique piece of legislation, from both South African and international perspectives. The CTOP Act mandates that all women have the right to reproductive decisionmaking and should have the services for safe pregnancy termination if they so choose. The CTOP Act allows for abortion upon request for the first 12 weeks of pregnancy, under certain circumstances until 20 weeks, and for very limited circumstances after that point. Within South Africa, a country that ended 46 years of apartheid rule in 1994, two years before the law change, the legal promise of equitable access to care for all women was significant. From the international viewpoint, South Africa's CTOP Act is important because it offers a strong rationale and support for abortion based upon international human rights principles such as the right to health, autonomy in reproductive decisionmaking, and freedom from discrimination (Braam, 2002; Center for Reproductive Law and Policy, 2000).

Prior to the CTOP Act, abortion was legally restricted with the usual consequences. A study released in 1994 showed that 34% of the 44,686 women presenting at hospitals with incomplete abortion were actually suffering as a result of unsafe abortions. The successful enactment of the CTOP Act was influenced by these data, and those responsible for implementation were mindful of the need to ensure access to services for all women, especially those

who are disadvantaged and/or live in areas remote from central health services. As such, the law recognizes the importance of delivering services at the primary health-care level, and the Department of Health has prioritised training for midwives, who are more geographically dispersed than physicians and can be key providers of abortion services.

Since 1997, much has been done to turn the promises of the CTOP Act into reality. Midwives and some physician providers from across the country have been trained, and CTOP services have been made more widely available. A follow-up study commissioned in 1999 found promising declines in abortion-related morbidity (Jewkes et al., 2002). At the same time, a variety of other reports show that barriers to equitable access still remain.

Despite the Act's focus on rural access, abortion services are still better established in urban areas and upper-level health facilities, limiting access for many women who live in rural areas. In the first five years of service, 40% of all abortions were performed in Gauteng, the province that includes Johannesburg and which represents 21% of the national population. In contrast, Limpopo Province, which represents 11% of the population, accounts for only 4% of the termination of pregnancies (TOPs), and even there only two (6.4%) of the TOP sites are health centres (Mitchell et al., 2004).

Training for midwives has been another key component of the TOP decentralisation strategy for South Africa, and a program for such began in 1997. While an evaluation of the training program found that a majority of the trained midwives were offering safe services, it also indicated that only a small percentage of eligible midwives had been trained. Midwives would also benefit from stronger monitoring and support systems so that their concerns and questions are answered in a timely fashion (Dickson-Tetteh and Billings, 2002).

Social awareness and attitudes, as well as professional attitudes about abortion, vary and have played a role in the availability of services. As in other parts of the world, abortion remains controversial in South Africa. Some women still refrain from seeking legal services and many do not even know of their rights to safe termination under the CTOP Act. Consequently there are still many unsafe abortions in South Africa. At the same time, some providers in South Africa refuse to perform abortions, which also limits access to care, while those providers who are offering services have borne criticism about their involvement. But recent provider reports suggest some positive shifts in this area: an increasing and more "open" demand for the services, and broader public discussion about the services in some communities. Still, some have suggested that the next phase of activity in South Africa include additional and widespread advocacy on behalf of women's health needs and their rights to reproductive decisions (Braam, 2002).

If South Africa can deliver on its promise of universal access to safe abortion services, and if it continues to honestly document the challenges it faces and its winning strategies, the lessons for other countries in Africa and elsewhere will be substantial.

Advocacy for better information about abortion provisions

- In **Kenya**, abortion is permitted only to save the life of the woman, and unsafe abortion is estimated to cause up to half of all maternal deaths each year (Onyango et al., 2003). In recent years, there has been considerable debate about abortion and possible legal reform including articles in the popular press, discussions among government officials and statements in support of reform. In an attempt to improve support for better abortion policies and capitalise on the development of a new constitution in Kenya, the

Federation of Women Lawyers (FIDA) in Kenya and the Kenya Medical Association spearheaded the formation of a coalition of partners called the Reproductive Health Advocacy Project (RHAP), which sought to raise public awareness about the problem of unsafe abortion in Kenya and foster dialogue about improving related reproductive-health policies including access to abortion.

- **Ethiopia** has a very restrictive abortion law and suffers extremely high rates of unsafe abortion and related mortality. A coalition of organisations drafted a suggested revision to the penal code that would liberalise access to safe abortion services. The Ethiopian Parliament then called upon each region of the country to conduct public discussions and submit their own recommendations for consideration during a formal review of the abortion provisions in the penal code. As of early 2004, the revised bill is before Parliament awaiting a vote.
- For **Ghana,** advocacy efforts in early 2004 were focused on implementing the existing, fairly liberal law and encouraging the Ministry of Health to develop and issue revised guidelines and voice support for safe legal abortion. Related activities include analysing how well Ghana's laws and policies are in line with international human rights commitments, training doctors and lawyers about what the current law permits, and increasing the visibility of abortion issues in the mass media.
- In **Nigeria,** reproductive law and policies are also under review. While abortion is legal only to save the life of the woman, many doctors perform abortions despite the possibility of harsh legal punishment. With high rates of unsafe abortion and related complications which consume significant health-sector resources, the Campaign Against Unwanted Pregnancy (CAUP) has joined forces with key associations including the International Federation of Women Lawyers (FIDA), the National Council of Women's Societies (NCWS), and the Society of Obstetricians and Gynaecologists of Nigeria (SOGON) and is advocating for liberalisation of the abortion law to make services safer. In 2003, CAUP

Why Women Choose Abortion

In every part of the world, women who have had an abortion give broadly similar reasons for their decision:

To stop childbearing

- I have already had as many children as I want
- I do not want any children
- My contraceptive method failed

To postpone childbearing

- My most recent child is still very young
- I want to delay having another child

Socioeconomic conditions

- I cannot afford a baby now
- I want to finish my education
- I need to work full-time to support [myself or] my children

Relationship problems

- I am having problems with my husband [or partner]
- I do not want to raise a child alone
- I want my child to grow up with a father
- I should be married before I have a child

Age

- I think I am too young to be a good mother
- My parents do not want me to have a child
- I do not want my parents to know I am pregnant
- I am too old to have another child

Health

- The pregnancy will affect my health
- I have a chronic illness
- The fetus may be deformed
- I am infected with HIV

Coercion

- I have been raped
- My father [or other male relative] made me pregnant
- My husband [or partner or parent] insists that I have an abortion

Source: Alan Guttmacher Institute. 1999b.

coordinated the drafting of a revised abortion law, which has not yet been put before the legislature for debate.

- Prompted by high maternal mortality and an increased recognition of women's rights to self-determination, abortion law reform has been the subject of debate in a number of other African countries, including **Namibia,** where a national study on unsafe abortion generated discussion in the media, and in **Mauritius**, **Mozambique** and **Uganda.**

6. The Challenges of Achieving Safe Abortion Care in Africa

Andy Johnstone / Panso Pictures

The ICPD's POA is anchored by a vision of development that requires attention to gender equity and specifically recognizes that women need universal access to reproductive-health care in order to participate fully in society. ICPD also represents a shift toward the involvement of a broader range of actors: namely those from civil society actors—private sector agencies and NGOs—working alongside governments and international donors to define local problems and shape strategies to meet those needs. The abortion-specific language in the ICPD POA, and its endorsement by governments in Africa, also serves as a very powerful tool for those interested in expanding safe abortion care.

At the same time, delivering safe abortion care to all the women who need it, when and where they need it, remains a challenging enterprise. In addition to the difficulties mentioned previously, all efforts—be they PAC programs or legal reform initiatives—face a common set of challenges in Africa.

- **Overcoming the limitations of poor health infrastructures.** While WHO estimates that US$35–40 per capita is the minimum needed for basic health services, many countries in Africa fall short of or only just reach this mark (United Nations Development Programme (UNDP), 2003). Moreover, health resource allocations are also inequitable, often not reaching poor or rural populations (AGI, 1999b). This gap is particularly important for abortion, where early access to care ensures better outcomes. Sustainable procurement and re-supply mechanisms are also vital to the equitable and timely provision of abortion care services, but are a constant challenge where health-care infrastructures are weak and supply chains erratic—common problems for virtually all abortion providers and many other health-care efforts in Africa (Corbett and Turner, 2003).

- **Securing resources for abortion care.** To date, much of the financial support for improvements in abortion care have come from external donors, including private foundations and bilateral and multilateral development assistance organizations. While USAID has been a lead supporter of PAC services, U.S. government funds have never been used to purchase the essential MVA supplies necessary for such care. Moreover, since 2001 and the reinstatement of the Mexico City Policy, no U.S. funding or contraceptive supplies can go to reproductive-health NGOs in developing countries that provide abortion-related information or services. Many of these NGOs are key family-planning providers in their countries and, as detailed earlier, have been seriously affected by these restrictions. Fortunately, several donors currently active in supporting abortion-related efforts in Africa, including the bilateral agencies from the U.K., Sweden, Finland and the Netherlands, do not impose such restrictions. Also, in contrast to the U.S., many of these donors are supportive of the full range of efforts to increase access to safe, legal abortion services. Nevertheless, large gaps in funding for abortion-related care remain.

- **Mobilising political will to support comprehensive reproductive health.** Considerable international attention and resources are being directed toward the anti-poverty agenda advanced in 2000 through the Millennium Development Goals (MDGs). Goal 5 of the MDGs seeks to improve maternal health and achieve a 75% reduction in maternal mortality in the next decade. Given unsafe abortion's large contribution to maternal mortality in Africa and the existence of effective interventions, safe abortion care programs could make an enormous contribution to that goal. However, the MDGs do not specifically acknowledge the problem of unsafe abortion, nor do they even mention or call for universal access to reproductive-health care as in the Cairo POA (United Nations, 2000; Sinding, 2002).

- **Addressing abortion in the context of the HIV/AIDS crisis.** Perhaps the greatest challenge for all other health and development interventions in Africa is HIV/AIDS. Africa accounts for 70% of all global HIV/AIDS cases with infection levels as high as one in five adults in Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe, and up to one in 20 adults in 19 more countries. New HIV infection is also disproportionately high among young women: in some countries they are six times more likely to be infected than men (UNDP, 2003). Understandably, expanded HIV/AIDS prevention and treatment programs are a critical priority for African countries and receive significant allocations of health budget funds. A United Nations Population Fund (UNFPA) review of international donor support for population activities between 1995 and 2000 found that the percentage of funds earmarked for STDs and HIV/AIDS activities grew from 9% to 32% in the same period (UNFPA, 2002). However, there are many social and service-delivery barriers to comprehensive reproductive-health care for women with HIV/AIDS. While they have the same rights to decide whether or not to bear children, the necessary services are not always available or properly provided for women with HIV/AIDS. Moreover, the health consequences of unsafe abortion may be exacerbated for women with HIV/AIDS, and there is little attention to this intersection (Ipas, 2003).

- **Meeting the special needs of young women.** Currently 44% of Africa's population is under 15 (UNDP, 2003). Regardless of their marital status and the stigma around premarital sex, many of these young people are sexually active. While many governments have acknowledged adolescent reproductive-health needs, service-delivery programs are often limited in their geographic range and scope, emphasising and offering information but not providing clinical services (Calvès, 2000). In general, too few adolescents have access to reproductive-health information and services, and in many settings are deliberately excluded from receiving contraceptives by reproductive-health programs focused on adult, married couples. Many young women are also reluctant to seek out reproductive-health services for fear of adult disapproval and lack of confidentiality (Radhakrishna et al., 2000). One result of this gap in health services is that women younger than 25 years old account for 60% of the unsafe abortions occurring in Africa each year. For young African women ages 15–19, the risk of unsafe abortion is higher than anywhere else in the world. The rates and risks of unsafe abortion among young people and the size of Africa's young population make it imperative that reproductive-health programs address their needs (Shah and Åhman, 2004).

7. The Way Forward

Martin Adler / Panos Pictures

While some positive changes have taken place in Africa in the decade since the Cairo conference in the field of reproductive health and rights, much remains to be done to ensure that women have access to the high-quality information and services they need to manage their own fertility. The ICPD spurred expansion of contraceptive programs and the creation of broader reproductive-health approaches, attention to unsafe abortion as a major public-health problem, and a number of efforts designed to expand women's ability to make their own child-bearing decisions. Yet it is clear from this modest analysis that NGOs and governments can and must continue to make changes in order to fully implement the ICPD recommendations from paragraphs 8.25 and 63iii.

In their exchanges at the 2003 regional consultation on unsafe abortion in Addis Ababa, participants discussed many of the issues raised in this review of progress and challenges related to abortion care in Africa since ICPD. The final communiqué from the conference is appropriate for this review, as it contains key recommendations for the future and represents the consensus of a diverse cross section of African Ministers of Health, health professionals, academics, women's organizations, youth groups, NGOs and others (see box below).

Communiqué from the "Action to Reduce Maternal Mortality in Africa" Regional Consultation on Unsafe Abortion

Addis Ababa, Ethiopia

Background and Preamble

We, the 112 participants of "Action to Reduce Maternal Mortality in Africa: A Regional Consultation on Unsafe Abortion," which took place March 5–7, 2003, in Addis Ababa, Ethiopia, represent a cross section of African Ministers of Health, parliamentarians, directors of health services, heads of reproductive-health units, heads of academic institutions, youth activists, national and regional women's groups, national networks engaged in promoting women's health, nongovernmental organisations, religious organisations, professional organisations such as obstetrician-gynaecologists and nurse-midwives, lawyers, sociologists and media practitioners.

During the three-day consultation, we reviewed numerous dimensions of the public-health challenge of unsafe abortion, including the sociocultural, legal and policy context in which it occurs. Recognising that abortion has always occurred and will continue to occur in all cultures, we focused on the need to make it safe in order to reduce related deaths and injuries of women. We examined laws, policies and international commitments influencing access to safe abortion in Africa; health-care providers' and public and private health systems' role in meeting women's needs for safe abortion; and strategies for creating an enabling environment that supports women's right to safe abortion and related services.

Based on our own experiences and on presentations and discussions during the consultation, we note with alarm that maternal mortality rates remain unacceptably high and that unsafe abortion accounts for an average of 12 percent of maternal deaths on the African continent. At the national level, experts estimate that unsafe abortion contributes in the range of 10–50 percent of maternal

deaths in African countries. Of the 68,000 deaths from complications of unsafe abortion worldwide, 30,000—or nearly half—are in sub-Saharan Africa. In addition to the shocking number of African women whose lives are lost each year, unsafe abortion causes thousands more women to suffer serious illnesses and injuries and renders many infertile. These deaths and injuries are preventable, since safe and effective technologies for contraception, pregnancy termination and postabortion care are available but underutilised. We also know that deaths and injuries from unsafe abortion disproportionately affect adolescents, poor and other marginalised groups of women, depriving Africa of a valuable human resource.

We recognise that, worldwide, restrictive abortion laws and lack of safe abortion services are the major factors contributing to the disproportionately high mortality of women from unsafe abortion. Most African countries operate under archaic laws related to abortion that were imposed by former colonial powers and have long since been changed in those countries. In most countries where abortion laws are liberalised, there are almost no deaths from unsafe abortions.

We note that legislation in most African countries legally permits abortion in limited circumstances—such as in cases of rape, incest or to save a woman's life—but that the majority of women and health-care providers remain uninformed of their legal rights and obligations. We further recognise that many of the root causes of unsafe abortion—including African women's lack of access to comprehensive reproductive-health information services to prevent unwanted pregnancy, and lack of decision-making power related to sex and reproduction—are the same as those underlying the HIV/AIDS pandemic.

We note also that all African countries have signed the Programme of Action of the International Conference on Population and Development, the Platform for Action of the Fourth World Conference on Women and other international agreements, compliance with which requires addressing the public-health problem of unsafe abortion, including by making safe abortion available to the full extent of local law.

We stress that unsafe abortion has significant economic implications, including the enormous costs to African health systems associated with managing its complications. Until women can make their own reproductive choices safely, poverty alleviation and economic development cannot be achieved. Policies of Northern governments and international financial institutions such as health-sector reform, debt restructuring and structural adjustment severely constrain health and social spending by African governments and require revisiting.

Commitments and Recommendations

Thus, we the participants commit ourselves to:

Formulate specific strategies to educate and engage all stakeholders in advocacy to reduce the incidence and impact of unsafe abortion

Work more effectively within existing legislation and health systems to ensure that high-quality, comprehensive reproductive-health care is universally available, with special attention to reaching and responding to the needs of especially vulnerable populations.

We the participants call on African governments to:

Include specific and increased funding for reproductive health and to address unsafe abortion in national and health system budgets

Advocate for specific attention to reproductive health and unsafe abortion in programs to achieve the Millennium Development Goals, notably with regard to objectives specified in Goal 5, "Improve Maternal Health"

Initiate reviews of existing, and in many cases outdated, laws criminalising abortion, in line with specific commitments under international agreements.

Additionally, we the participants call on multilateral and bilateral donor agencies, headquarters and regional country offices of international technical support agencies, and the global community to:

Direct more resources to preventing unsafe abortion and to making safe legal abortion available to the full extent of the law

Provide the necessary leadership in addressing issues of unsafe abortion especially in the dissemination and implementation of technical and policy guidance for safe abortion in Africa.

Finally, we the participants vehemently oppose the Global Gag Rule that was reinstituted in January 2001 by U.S. President George W. Bush and which clearly impedes efforts to reduce unsafe abortion. We call on African governments and the global community to be accountable to their citizens and other stakeholders by opposing it.

In conclusion, participants in the "*Action to Reduce Maternal Mortality in Africa*" consultation reaffirm our commitment to doing whatever is within our power at the national and regional levels to halt the needless deaths and injuries of African women and girls from unsafe abortion. We do this not only in the interest of the girls, women, families and communities affected by unsafe abortion today, but also for Africa's future.

Cosponsors of the consultation were the Amanitare African Partnership for Sexual and Reproductive Health and Rights of Women and Girls, the Centre for Gender and Development of the Economic Commission of Africa, the Commonwealth Regional Health Community Secretariat, the Ipas Africa Alliance for Women's Reproductive Health and Rights, the Regional Prevention of Maternal Mortality Network and the UNFPA Country Support Team for East and Central Africa. Representatives of multilateral and bilateral donor and technical support agencies also attended the consultation. Neither cosponsorship nor representation at the consultation implies endorsement by these organizations of the contents of this communiqué. UNFPA does not support abortion services anywhere in the world.

In addition, the following actions should take priority as we move toward 2015, the endpoint of the ICPD POA.

Governments and others must take action to save the lives and preserve the health of Africa's young people by making comprehensive reproductive-health services broadly available to adolescents. Few adolescents have access to reproductive-health information and services, and as a result of unprotected sex, young African women undergo unsafe abortion. Adolescents are the future of Africa; safeguarding their health must be a priority.

Family-planning programs should take action to extend their services to women in the postabortion period. Helping women avoid unplanned pregnancy is key to bringing down the rates of unsafe abortion and related morbidity and mortality. With varying degrees of success, PAC programs seek to ensure that women in their care receive services. However, there is little evidence that this link is made from the other direction: few family-planning programs and service providers seek to make their services available to women seeking treatment for abortion complications.

Integrate safe motherhood programs with abortion, HIV/AIDS and other reproductive health issues for maximum effect and best use of scarce resources. These issues are inextricably linked to each other, and to the overwhelming poverty affecting much of Africa, and must be addressed in an integrated fashion in order to achieve the Millennium Development Goal of reducing maternal mortality by 75% by 2015.

Mobilise political will to address abortion-related needs. Governments have shown their support on paper, but must now demonstrate through action that they can and will

change the face of unsafe abortion in Africa. Laws in a number of countries permit abortion for a range of indications and all countries must provide life-saving treatment for miscarriage and abortion complications. As governments pledged in Dakar in 1999 in the regional ICPD+5 review, action must be taken now to ensure that "[access] to counselling and safe abortion, where legal, should be improved and treatment for abortion complications provided" (United Nations, 1999). Nations in Africa should also prioritise ratifying the Optional Protocol on the Rights of Women in Africa, which endorses women's human rights, including reproductive rights.

Reform restrictive abortion laws as the only real meaningful way to end deaths from unsafe abortion and underscore each woman's right to decide whether and when to have children. Even with perfect use, contraception is not 100% effective. Given low contraceptive use rates in Africa, unwanted pregnancies are inevitable for the foreseeable future. Until each African woman has the ability to make her own childbearing decisions and the full means to plan her pregnancies, women will continue to die from unsafe abortion.

8. Conclusion

Peter Barker/Panos Pictures

The grim persistence of unsafe abortion in Africa is undeniable. Well over half a million women have died from the complications of unsafe abortions in the past decade. Furthermore, in a clear violation of their rights to health and life, over 100 million women alive today will experience the risks and trauma of an unsafe abortion during their lives unless they are enabled to avoid unwanted pregnancies. This tragedy is a reflection of one of the most glaring health disparities between the world's poor and rich countries. Women in Africa are almost 200 times more likely to die from any pregnancy-related cause and 700 times more likely to die from unsafe abortion than their counterparts in developed countries (AGI, 1999b; Rosen and Conly, 1998).

ICPD's promise of equity and universal access to reproductive-health care and its specific recognition and commitments to reducing the impact of unsafe abortion offered important recommendations for changing this picture. Much has happened since 1994, notably in the area of PAC, but also in the arena of public awareness and discussion about the disconnection between women's lives and restrictive abortions laws, perhaps most significantly with the introduction the rights-based CTOP Act in South Africa. PAC, while an important lifesaving service, is secondary prevention and will never bring about the kind of decreases in death that primary prevention can do through safe accessible abortion. Providing safe abortion services is possibly the easiest technical approach to reducing maternal mortality, yet the stigma attached to it and concurrent lack of political will make it the cause of pregnancy-related death that is least frequently addressed.

In this light, it can be argued that even the ICPD recommendations were not strong enough as they do not call for the liberalisation of restrictive abortion laws, even when the evidence is clear that such a course can result in significant reductions in pregnancy-related mortality. However, ICPD remains the key international event where consensus was reached about the fundamental and critical importance of reproductive health to human development. While the more recent anti-poverty goals of the UN Millennium Development Goals loom larger now, many believe, and the evidence suggests, that their success, especially in the area of improvements in maternal health and significant reductions in maternal mortality, will depend upon improving reproductive-health services, including safe abortion.

The premature loss of women's lives and health and the impact on families and communities in Africa is unconscionable given that effective preventions and interventions exist and are being practiced elsewhere. Fulfilling the ICPD commitments to women's rights and health remains as critical as it was in 1994, and it is still the right thing to do. For African women, the many and varied approaches around the continent offer lessons and encouragement in this critically important endeavour. African lives **are** worth saving.

Footnotes

1 Midlevel providers refers to a range of non-physician clinicians—midwives, nurse practitioners, clinical officers, physician assistants and others—whose training and responsibilities differ among countries but who are trained to provide basic, clinical procedures related to reproductive health, including bimanual pelvic examination to determine pregnancy and positioning of the uterus, uterine sounding and transcervical procedures, and who can be trained to provide an early abortion (WHO, 2003).

2 While some countries prohibit all abortions, almost all criminal codes contain "defense of necessity" provisions. These allow people who have acted to save their own life or that of another to be excused from criminal penalty. Thus, a provider who performs an abortion to save the life of the woman could use " the defense of necessity" principle as an argument against prosecution. However, raising the principle does not guarantee success, which would be determined by subsequent legal proceedings. (Rahman et al., 1998)

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