

# REVIEW ARTICLE

## Global policy change and women's access to safe abortion: The impact of the World Health Organization's guidance in Africa

Leila Hessini<sup>1</sup>, Eunice Brookman-Amisab<sup>2</sup> and Barbara B. Crane<sup>3</sup>

### ABSTRACT

Along with governments from around the world, African leaders agreed at the International Conference on Population and Development (ICPD) in 1994 to address unsafe abortion as a major public health problem. At the five-year review of the ICPD, they decided further that health systems should make safe abortion services accessible for legal indications. Based on this mandate, the World Health Organization (WHO) developed norms and standards for quality abortion services, *Safe Abortion: Technical and Policy Guidance for Health Systems*, released in 2003. While abortion-related maternal mortality and morbidity remains very high in many African countries, stakeholders are increasingly using WHO recommendations in conjunction with other global and regional policy frameworks, including the African Union Protocol on the Rights of Women in Africa, to spur new action to address this persistent problem. Efforts include: reforming national laws and policies; preparing service-delivery guidelines and regulations; strengthening training programs; and expanding community outreach programs. This paper reviews progress and lessons learned while drawing attention to the fragility of the progress made thus far and the key challenges that remain in ensuring access to safe abortion care for all African women. (*Afr J Reprod Health* 2006; 10[3]:14-27)

### RÉSUMÉ

**Modification de la politique mondiale et l'accès par la femme à l'avortement sans danger: L'impact du conseil de l'Organisation mondiale de la santé en Afrique.** Au cours de la Conférence Internationale sur la Population et le Développement (CIPD) en 1994, les leaders africains et les gouvernements partout dans le monde se sont mis d'accord pour s'occuper de l'avortement dangereux comme étant un problème majeur de la santé publique. Pendant la revue de cinq ans de la CIPD, ils ont décidé en plus que les systèmes de santé doivent rendre les services de l'avortement sans danger accessibles pour des indications légales. Se fondant sur ce mandat, l'organisation mondiale de la santé (OMS) a élaboré des normes et des standards permettant de rendre des services de l'avortement de qualité, *L'avortement sans danger: Les conseils technique et politique pour les systèmes de santé*, publié en 2003. Alors que la mortalité et la morbidité liées à l'avortement restent très élevées dans plusieurs pays d'Afrique, les dépositaires d'enjeu se servent de la OMS conjointement avec d'autres cadres de la politique régionale et mondiale y compris le protocole de l'Union Africaine sur les Droits de la Femme en Afrique pour encourager une nouvelle action pour s'occuper de ce problème continu. Les efforts comprennent: la réforme des lois et des politiques nationales; la préparation des conseils et des règlements concernant la prestation de service; le renforcement des programmes de formation; et l'élargissement des programmes de l'information au niveau de la communauté. Cet article passe en revue le progrès et les leçons apprises tout en tirant l'attention sur la fragilité du procès fait jusqu'ici et les défis clé qui ne sont pas encore atteints pour assurer l'accès au services du soin de l'avortement sans danger pour toutes les femmes africaines. (*Rev Afr Santé Reprod* 2006; 10[3]:14-27)

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**KEY WORDS:** *Abortion, postabortion care, maternal mortality, Africa, WHO, health policy*

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<sup>1</sup>Leila Hessini, Senior Policy Advisor, Ipas, P.O. Box 5027, Chapel Hill, NC 27514 USA. Tel: 919-967-7052. e-mail: [hessini@ipas.org](mailto:hessini@ipas.org). <sup>2</sup>Eunice Brookman-Amisab, Vice President for Africa, Ipas P.O. Box 1192, 00200 City Square, Nairobi, Kenya Tel: 254-20-577239, 577422, Fax: 254-20-576198 e-mail: [brookmanae@ipas.or.ke](mailto:brookmanae@ipas.or.ke). <sup>3</sup>Barbara B. Crane, Executive Vice President, Ipas, P.O. Box 5027, Chapel Hill, NC 27514 USA. Tel: 919-960-5566. E-mail: [craneb@ipas.org](mailto:craneb@ipas.org)

Correspondence: Leila Hessini, Senior Policy Advisor, Ipas, P.O. Box 5027, Chapel Hill, NC 27514 USA. Tel: 919-967-7052. E-mail: [hessini@ipas.org](mailto:hessini@ipas.org)

## Introduction

Women in sub-Saharan Africa face the highest risk of death and injury from abortion-related complications in the world, accounting for 60% of the nearly 20 million cases of unsafe abortion globally each year.<sup>1</sup> Tens of millions of women of reproductive age today in Africa will experience an unsafe abortion in their lifetimes. Globally, unsafe abortions claim the lives of at least 68,000 women each year; 43% of these women are African.<sup>2</sup> In addition to premature deaths, hundreds of thousands of African women who seek unsafe abortions each year experience severe complications: uterine perforation, chronic pelvic pain, haemorrhage and secondary infertility.<sup>3</sup> They also face trauma, stigmatisation and isolation from families and communities as a result of unwanted pregnancies and unsafe abortions. Recent national-level studies in Kenya, Uganda, and Nigeria document the high numbers of women presenting with complications from unsafe abortions in public health facilities, and are indicative of the region-wide burden of ill-health caused by unsafe abortion.<sup>4,5,6</sup> The consequences fall especially heavily on young women and girls; nearly 60% of women who have unsafe abortions are under the age of 25.<sup>7</sup> Taken together, the data on unnecessary deaths and illnesses from unsafe abortions point to a public health crisis, a social injustice and a violation of women's human rights and dignity.

This article examines the responses to unsafe abortion in Sub-Saharan Africa, with a special focus on how guidance for health systems released by the World Health Organization in 2003 has increased recognition of governments' obligations to provide safe services for legal indications and has contributed to greater efforts to make services available. The article addresses four central questions:

Have global and regional policies addressing unsafe abortion made any difference for women?

What progress is being made at the national level?

What challenges remain in advancing access to safe abortion in Africa?

What more is needed to improve the enabling environment?

In addition to reliance on secondary sources, the interpretations and conclusions of this article are based on the authors' own experiences and communications with a range of partners in the region as well as a set of qualitative interviews conducted with selected African stakeholders.<sup>8</sup> An appendix provides information on abortion laws in Africa.

## Global and regional policies – paving the way for national action

*"In recent decades, international understanding of the basic civil, social and economic rights with which all people are born has deepened and been progressively articulated in international covenants, treaties, and other instruments. Such agreements create a solid basis for real improvements in people's lives, as ratifying nations commit themselves to uphold the rights enumerated therein, including by adjusting laws and policies."*<sup>9</sup>

Modest efforts to address unsafe abortion have been underway in Africa for nearly two decades, with a primary focus on improving the capacity of public health systems to provide postabortion care (PAC) – a package of interventions that includes treatment of complications and provision of postabortion contraception and other reproductive health services.<sup>10</sup> PAC programs were initiated or expanded in a number of countries following global agreement at the International Conference on Population and Development (ICPD) to address the health consequences of unsafe abortion as a key component of comprehensive programs for reproductive health and rights. At the ICPD, governments agreed that: "In all cases, women should have access to quality services for the management of complications arising from abortion."<sup>11</sup> The ICPD Programme of Action (PoA) further states that postabortion counseling, education and family-planning services should be

an integral part of PAC services to avoid repeat abortions.

A year later at the Fourth World Conference on Women in Beijing, the Platform for Action called for governments to consider reviewing punitive abortion laws.<sup>12</sup> Most abortion laws in Africa are derived from the former laws of Belgium, England, France and Portugal and are quite restrictive.<sup>13</sup> Some countries in the region did expand legal indications for abortion between 1994 and 2003, allowing for abortions in cases of pregnancies resulting from rape or incest, foetal impairment or threats to women's health. These include Benin, Burkina Faso, Chad, Guinea and Mali.<sup>14</sup> Ethiopia legalized abortion for a range of indications in 2004.<sup>15</sup>

A major breakthrough was adoption of the Choice on Termination of Pregnancy (CTOP) Act in South Africa in 1996. South Africa's abortion law is considered a model as it recognizes: i) a women's right to have an abortion with no restrictions in the first trimester; ii) allows midlevel providers to perform early abortions; and iii) gives women, not husbands or guardians, the sole right to consent.<sup>16</sup> Until recently, several barriers – including the designation of who provides services and where services are provided – obstructed women's full access to services. The CTOP Act was amended in 2004 to remove these administrative and bureaucratic barriers.<sup>17</sup> The amendments allow for registered nurses, in addition to midwives, to perform abortions, while also decentralizing the approval process for the designated TOP sites from the National Department of Health to the provincial level and requiring all 24-hour maternity facilities to provide TOP services.<sup>18</sup>

A further step in recognizing health system changes that are critical to women's reproductive health was taken at the five-year implementation review of the ICPD PoA in 1999. At that meeting, governments agreed that providers should be trained and equipped to provide abortion services where not against the law and that those services

should be accessible.<sup>19</sup> With this mandate, the World Health Organization gathered experts in 2000 to develop guidance for national health systems. Among the key recommendations were the following:

- Vacuum or electric aspiration, and medical abortion, are the preferred methods of abortion in the first 12 and 9 weeks of pregnancy.
- Safe abortion services should be available at all levels of the health system, including the primary health care level.
- Midlevel providers including nurses, midwives and clinical officers, should play a role in abortion counselling, service provision and referrals.
- Health systems should eliminate as many barriers as possible, such as required ultrasounds, waiting periods, and multiple signatures by committees.<sup>20</sup>

The guidance, based on the latest clinical evidence, was developed with great care and attention to the relevant ethical and policy considerations. It was finalized in time for the African regional conference on unsafe abortion in Addis Ababa, Ethiopia, in March 2003. One-hundred and twelve representatives of 15 African countries participated in the meeting, "Action to Reduce Maternal Mortality in Africa: A Regional Consultation on Unsafe Abortion," and issued a strong communiqué outlining concrete actions to reduce needless deaths and injuries from unsafe abortion.<sup>21</sup> Cosponsors included: the Ipas Africa Alliance for Women's Reproductive Health and Rights, the Centre for Gender and Development of the Economic Commission for Africa, the Commonwealth Regional Health Community Secretariat, the UNFPA Country Support Team for East and Central Africa, the Regional Prevention of Maternal Mortality Network, and the Amanitare Africa Partnership for Sexual and Reproductive Health and Rights.

Significantly, the WHO guidance was reinforced on July 11, 2003 when the African

Union adopted the Protocol on the Rights of Women in Africa, a supplement to the African Charter on Human and People's Rights. For the first time in international law, the Protocol explicitly sets forth the rights of women to safe elective abortion for a wide range of indications. Article 14 states that: "States parties shall take all appropriate measures to... protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus."<sup>22</sup> That protocol entered into force on November 25, 2005. As of October 2006 nineteen countries have ratified the protocol including Benin, Cape Verde, Comoros, Djibouti, Gambia, Lesotho, Libya, Malawi, Mali, Mauritania, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Seychelles, South Africa, Togo and Zambia. Three other countries - the Democratic Republic of Congo, Guinea and Uganda" have signed the protocol and are in the process of ratification.

The WHO Guidance has also been disseminated in a number of regional policy venues for health ministers and planners. Recommendations from these high-level policy meetings have called on member countries to implement abortion services to the full extent of the law and to review their abortion laws. For example, the West African Health Organization (WAHO)<sup>23</sup> and the Committee of Health Ministers of East, Central and Southern Africa (ECSA)<sup>24</sup> have incorporated access to safe abortion to the extent of the law as an element of their strategies and work plans.

As part of their commitment to promoting women's health, experts attending the Special Session of the Conference of African Union Ministers of Health September 21-22, 2006 in Maputo, Mozambique agreed that access to safe abortion care is an integral part of comprehensive sexual and reproductive health services.<sup>25</sup> At that meeting, Thoraya Obaid, reiterated UNFPA's

unequivocal support for the ICPD abortion-related commitments with a plea to African governments: "...where it is legal within the context of national legislation, abortion should be safe. Only three countries in the world have laws that prohibit abortion and they are not in the Africa region. Each country in this room has laws to regulate abortion and yet women are still dying. So, lead the way in saving women's lives by implementing what you committed yourselves to in Cairo."<sup>26</sup>

## **Progress in national policies and health systems**

Release of the WHO guidance and adoption of the African Union protocol had immediate significance for several countries. In Ethiopia these events, together with the 2003 regional conference in Addis Ababa, reinforced the process that was already underway to review legal indications for abortion as part of a broader reform of the national Penal Code. The reform process followed a participatory process that included mobilization of key stakeholders and public discussions organized in cities and towns across the country. The new law allows for abortion in cases of rape or incest; pregnancy endangering the woman's life and/or health; indications of foetal abnormalities; if the woman is physically disabled; and in cases of minors who are physically or psychologically unprepared to raise a child.<sup>27</sup> To ensure that the new law is implemented to its fullest extent, a working group was created to advise the Ministry in developing safe abortion guidelines.<sup>28</sup> The guidelines, finalized and issued formally by the Ministry of Health in July 2006 include: protocols for medication abortion; provisions to allow midlevel providers including nurses and midwives to provide abortion care; and measures to enhance the roles of community health workers, traditional birth attendants and community-based reproductive health agents (CBRHAs) in ensuring access to safe

abortion services, among other provisions.<sup>29</sup>

Leaders from Ghana who participated in the 2003 regional meeting returned home and intensified their dialogue on implementation of Ghana's 1985 abortion law and new measures to ensure women's access to comprehensive reproductive health care. As a result, Ghana's 2003 national reproductive health strategy was expanded to include the provision of induced abortion to the full extent of the law. Subsequently, a series of national-level workshops were organized to inform health professionals and other opinion leaders of the new law and the government's commitment to its implementation. A critical step was a request by the health ministry for assistance from international partners, including WHO and Ipas. They joined together in implementing a strategic assessment of the availability and quality of abortion-related care, with collaboration of representatives from the Ghana Medical Association, the African Women Lawyers' Association, and other local partners. The participatory assessment process, developed by WHO, has also been conducted in other countries, including Romania, Vietnam, and Mongolia, and allows teams of experts from international and local organizations to visit service-delivery sites and interview providers and women.<sup>30</sup> The government is currently implementing recommendations from the assessment in a model program that will be implemented in selected districts in three regions and then scaled up nationally. The recent decision of the Ghana Nurses and Midwives Council to approve provision of first trimester abortion care by nurses and midwives is also a major step forward.

Zimbabwe has also taken incremental steps to decrease barriers to abortion service provision. The requirement to obtain the approval of a second physician prior to termination of a pregnancy in cases of emergencies was removed in 2001.<sup>31</sup> Five years later, in April 2006, the Zimbabwean Ministry of Health and Child Welfare issued a national policy statement authorizing nurses and midwives to use manual vacuum

aspiration and other abortion techniques as long as they are adequately trained.<sup>32</sup>

Less visibly, stakeholders in a number of other countries have initiated or expanded efforts in training, research, and coalition-building for advocacy to address unsafe abortion. Respondents from several countries, in interviews conducted for this article, agreed that the ICPD framework and the WHO guidance have been instrumental in helping health systems move beyond the provision of PAC services to supporting Comprehensive Abortion Care (CAC) services to the full extent of the law. The WHO guidance has provided a critical framework and played a key role in legitimizing these new efforts. Dissemination has occurred through technical workshops in a number of countries, including in Ethiopia, Ghana, Kenya, Mozambique, Nigeria, South Africa and Uganda; in regional events; through the WHO website; and most recently, through a CDROM.<sup>33</sup> Zambia and Botswana are also taking steps to remove barriers to access. These include introducing new technologies, improving quality of care and service delivery, and training health professionals.

Technical resources are now available that can assist countries develop and adapt national service delivery standards and guidelines in conformity with the WHO guidance as well as training curricula in woman-centered comprehensive abortion care (CAC). According to the WHO guidance, abortion-related norms and standards should address "essential elements of good-quality abortion care's" including:

- Types of abortion services and where they can be provided;
- Essential equipment, supplies, medications, and facility capabilities;
- Referral mechanisms;
- Respect of women's informed decision-making, autonomy, confidentiality and privacy, with attention to the special needs of adolescents;
- Special provisions for women who have suffered rape.<sup>34</sup>

Consistent with these elements, new training curricula focus on the importance of tailoring each woman's care to her circumstances and needs, providing appropriate information and counselling, using the WHO-recommended technologies and appropriate clinical protocols, offering postabortion contraception, and referring women for other health services as needed.<sup>35</sup>

Beyond steps to provide care to the full extent of the law, discussions are active in Nigeria, Kenya, Uganda and other countries around the need for legislative reforms. Health ministries, women's rights advocates, and medical leaders are in dialogue with one another over the timing and strategies for initiating or pursuing such reforms.<sup>36</sup> In the meantime, governments in these and other African countries, including Malawi, Niger, Senegal, Tanzania, and Zimbabwe, are continuing efforts to improve postabortion care, with special emphasis on training more providers in the use of manual vacuum aspiration (MVA) and ensuring that women and young persons have access to quality services.<sup>37,38</sup>

Supporting this new momentum for change in policies and practices is a growing body of research on the magnitude of unsafe abortion, women's experiences, and the availability and quality of services.<sup>39</sup> Previously scattered efforts in abortion research in Africa were brought together for dissemination and discussion at a regional meeting in March 2006, "Linking Research to Action to Reduce Unsafe Abortion in Sub-Saharan Africa." Like the 2003 meeting, it was also held in Addis Ababa, and drew researchers and policymakers from across the region, as well as representatives of WHO and other international agencies and donors. Participants reached consensus on an agenda of research priorities for the region, endorsed the creation of a Consortium for Research on Unsafe Abortion in Africa, and issued a strong call to action to expand women's access to safe abortion as well as contraception and other components of comprehensive reproductive health care.<sup>40</sup>

## **Challenges in advancing access to safe abortion in Africa**

While progress is being made, introduction and scale-up of safe abortion services in many African countries faces numerous challenges. The grim realities facing all health and development efforts in the region are the stagnation, and, in many cases, deterioration, of health systems. Facilities are increasingly overwhelmed by HIV/AIDS and other infectious diseases and are coping with significant annual attrition in trained health workers. The shortage of contraceptives across the African continent is alarming. In 2005, 20-35% of all married women between the ages of 15-49 lacked access to effective methods thus contributing to high rates of unintended pregnancies.<sup>41</sup> Numerous obstacles to the provision of abortion services exist including: barriers to midlevel providers, negative provider attitudes, insufficient supplies of technologies, women's inability to access services, and lack of political will.

### **Barriers to midlevel providers**

*"Making safe, legal abortion services accessible to all eligible women is likely to require involving midlevel health professionals because trained medical doctors are not sufficiently available in many parts of the world."<sup>42</sup>*

Interview respondents expressed concern that the bulk of training that is done takes place in the public sector and among obstetrician-gynaecologists. Yet research studies in South Africa and Ghana show that midlevel providers are able to offer high quality services with the same efficacy as those provided by ob-gyns and underscore the importance of incorporating comprehensive abortion care, including post-abortion family planning, in midwives' training programs.<sup>43</sup> A multi-site study on misoprostol abortion in Mozambique is investigating the ability of midlevel providers to assess abortion completeness without high technology instruments such as ultrasound.<sup>44</sup>

## Provider knowledge and attitudes

*“Health professionals at all levels have ethical and legal obligations to respect women’s rights. Working together with the Ministries of Health and Justice, they can help to clarify the circumstances where abortion is not against the law. They should understand and apply their national law related to abortion, and contribute to the development of regulations, policies and protocols to ensure access to quality services to the extent permitted by law and respecting women’s rights to humane and confidential treatment.”<sup>45</sup>*

It is not sufficient for providers to only have skills in clinical protocols for abortion care. Health professionals may not be knowledgeable of national abortion laws and how to interpret them, and some are reluctant to provide or refer for services on religious grounds. The national strategic assessment of abortion in Ghana, for example, concluded that health workers often have negative attitudes toward those women in need of abortion services. This report recommended that values-clarification activities be undertaken by health providers and community workers.<sup>46</sup> While there is no simple answer to the challenge of addressing provider attitudes, experience with values clarification workshops suggests that these can help health workers consider diverse perspectives on abortion, understand the meaning of legal indications, and become motivated to provide abortion care.<sup>47</sup>

### *Reliable supplies of technologies*

“The preferred [early abortion] methods are manual or electric vacuum aspiration or medical methods using a combination of mifepristone followed by a prostaglandin ...dilatation and curettage should be used only where none of the above methods are available.”<sup>48</sup>

A number of stakeholders interviewed for this article observed that health-care providers with skills in abortion-related care often lacked the appropriate medical equipment and thus were unable to offer services. The importance of having preferred and less-costly methods available

cannot be over-emphasized. Manual vacuum aspiration (MVA) technology offers a major advantage in the management of abortion complications and provision of early abortion in all types of health care settings, including low-resource primary health care centres. This low-technology handheld instrument, comprised of an aspirator with a mounted cannula, obviates the need for abortion and PAC to be done in operating theatres by physicians. It allows for services to be provided safely on an outpatient basis in decentralized locations and by midlevel providers. MVA is registered or on commodity lists in many African countries, although procurement is still not reliable. Numerous studies have shown that switching from D&C to MVA significantly reduces facility costs.<sup>49,50</sup>

Medical abortion is just beginning to be introduced in some countries. It should be helpful that a combined regimen of mifepristone and misoprostol has been on the WHO Essential Medicines List since 2005.<sup>51</sup> However, mifepristone is still costly and generally not registered in most African countries. Exceptions are South Africa and Tunisia, whose governments have approved the use of mifepristone up to 8 and 9 weeks gestation.<sup>52</sup> Awareness of and interest in using misoprostol without mifepristone to induce abortion is increasing across the continent raising the potential for its use in safe abortion services. While misoprostol is not as effective as a combined regimen, respondents stated that it is increasingly being used in some settings by providers and women themselves for early elective abortions. Further exploration is needed of the potential role of medical abortion methods in the region and relevant service delivery issues.

## Ensuring that women know their options and can exercise them

Even if services are available in health facilities, many women do not have the power and resources to access and utilize the services. Groups

most likely to encounter barriers include adolescents, unmarried women, women living outside of urban centres, and women who are displaced or refugees. In a community-based study in Western Zambia, it was estimated that 1 in 100 schoolgirls dies from abortion-related complications each year.<sup>53</sup> Two-thirds of all abortion complications in a teaching hospital in Uganda were aged 15-19.<sup>54</sup>

As evidenced in Darfur and Chad, health facilities receiving humanitarian assistance often do not offer abortion care for victims of rape.<sup>55</sup> Further efforts must be taken to operationalise the United Nations High Commissioner for Refugees (UNHCR) standards with regards to safe abortion services. Moreover, as health centres are often inaccessible to huge sections of the African population, creative means of accessing rural, periurban and displaced populations must be developed. Respondents suggested using mobile clinics; increasing the training of midlevel providers, including those working in the private sector; and working with traditional healers. Another important approach is to increase the integration of abortion referral and counselling with other women's health interventions.

### **Political will and resources**

Mobilizing political will to implement supportive policy statements and commit adequate resources are the biggest immediate challenges. In this context, the lack of a concerted response and an unequivocal position by a number of international agencies and bilateral donors in support of intergovernmental commitments is troubling. The anti-choice position of the U.S. government accounts for hesitation by international organizations at all levels to play a more decisive role in addressing unsafe abortion.<sup>56</sup> As a result, international NGOs such as Ipas, the International Planned Parenthood Federation (IPPF) Africa regional office, and Planned Parenthood Federation of America International, are playing a critically important role in disseminating the

WHO guidance and other advocacy and technical assistance.

### **Improving the enabling environment: future directions**

As this article has demonstrated, the global mandate to address unsafe abortion, reinforced by the practical and evidence-based recommendations in the WHO guidance, has prepared the way for new actions both by governments and civil society actors as well. Still, the guidance is only a document, and its ultimate impact depends on whether additional steps are taken to create an enabling environment, described here with selected examples.

### **Building coalitions**

Implementing global policy recommendations requires collective action and networking across different sectors and disciplines. In some countries, multidisciplinary coalitions including grassroots organizations, medical professionals, women's groups and government officials have been created to strengthen abortion-related advocacy. Creating coalitions and networks has proven to be an effective way to mobilize action on abortion, as has been demonstrated in Ethiopia, Kenya, Nigeria and South Africa, among others. Lessons learned from successful experiences point to the need for:

- i. effective and sustained leadership, coordination and advocacy;
- ii. mobilization of a core group of various stakeholders dedicated to working on abortion over the long run;
- iii. expansion of efforts to include community groups and rural women;
- iv. increased efforts in the areas of community education, information and rights; and
- v. having the language and tools necessary to counter anti-abortion groups.

## **Influencing how the general public understands and perceives abortion**

Destigmatising abortion and the women who choose to have abortions is essential to the development of an enabling environment. A 2003 study in South Africa documented efforts to promote discussion about sexual and reproductive rights through values clarification workshops with community leaders and health providers in Limpopo, a rural province in South Africa, and to identify community-based strategies for overcoming barriers to safe abortion care.<sup>57,58</sup> The experience of the Campaign against Unwanted Pregnancy (CAUP) in Nigeria also demonstrates a range of approaches to destigmatising the abortion issue and making it a legitimate subject of public debate. Founded in 1997, this campaign employs research, public education, media sensitization, and the training of various groups including women's organizations, policymakers and local NGOs.<sup>59</sup> In Kenya, Nigeria and Uganda, media workshops have been conducted to enhance print and electronic journalists' skills to more effectively report and highlight unsafe abortion within the context of reproductive rights.

## **Strengthening local-global links and regional sharing**

Some interview respondents stated that more support from WHO headquarters, regional and country offices was necessary in order to support national efforts to address unsafe abortion. Conversely, a stronger voice from national leaders in Africa in the governing bodies of WHO and other international organizations would strengthen the resolve of international secretariats to uphold longstanding international agreements on abortion.

Regional meetings help to break the isolation of national groups and serve as a forum for individuals and organizations to learn from their common interests, debate areas of divergence

and develop mutually-reinforcing strategies. Workshops have strengthened the knowledge base about abortion through strategic publications and dissemination of research studies across the continent. The accumulation of knowledge inherent in such exchanges is conducive to the process of preparing and presenting alternative perspectives on women's health and rights and ultimately bolsters national-level advocacy efforts. In addition, study tours have contributed to South-to-South exchanges, shared learning and development of common strategies.<sup>60</sup>

## **Expanding research**

Research can be a powerful advocacy tool if used, packaged and disseminated strategically. Local and widespread ownership of research processes and outcomes is important. This can be supported by ensuring the inclusion of a wide range of stakeholders in research design, publishing findings in national journals, translating research findings into local languages, and supporting non-print dissemination of findings. Research on women's experiences with unwanted sex, unwanted pregnancies and unsafe abortions deserves more attention. Respondents emphasized the need for more studies that compare maternal mortality rates in countries with restricted laws versus those that have liberalized legislation. Further documentation of the cost-savings of providing elective services versus emergency postabortion care was also recommended. Research on how best to deliver medical abortion is also a priority.<sup>61</sup>

## **Conclusion**

A multi-pronged strategy is necessary to combat the problem of unsafe abortion, entailing strengthened collaboration among policymakers, advocates, health professionals, and researchers. The World Health Organisation and other bodies of the UN system, and, increasingly important,

regional-level organizations that are closer to the daily realities faced by African women, also have key roles to play. As this paper has demonstrated, the guidance issued by the World Health Organization in 2003 has been a positive force for change in the region, and yet much more remains to be done.

Efforts must be expanded to change abortion-related laws and policies, strengthen the capacity of providers and health systems to provide postabortion care and elective services, and work to encourage an enabling environment that respects and supports women's decisions to terminate an unwanted or unhealthy pregnancy. Defining abortion services as an integral part of comprehensive, high-quality reproductive health care service delivery is an essential part of destigmatising the service and establishing safe abortion as a public health and human rights imperative, rather than a criminal activity. Advocacy and service delivery strategies must be developed to ensure that laws and policies, health system regulations, social values, norms and practices facilitate women's human rights to live, to be healthy and to take control over their lives.

Ultimately, comprehensive abortion care must be recognized as a routine service and a component of a minimum package of health care services at all levels of Africa's health systems.

### Acknowledgment

The authors gratefully acknowledge the generous support of the following donors for Ipas's regional work in Africa and, in particular, the preparation of this article: The John D. Rockefeller Foundation, the UK Department for International Development, the Swedish International Development Cooperation Agency (Sida), the Ministry for Foreign Affairs of Finland, and an anonymous donor. We are indebted to the late Nina Kavuma, a Ugandan women's activist, who conducted the qualitative interviews used in this paper. We thank each interviewee for their invaluable contributions to this article. Josephine Moyo also provided useful background information. We are grateful to others who reviewed previous versions of this article, including Charlotte Hord Smith and Katherine Turner. Cynthia Greenlee Donnell provided useful editorial assistance.

Appendix 1: Table of African Abortion Laws<sup>1</sup>

Grounds on which abortion is permitted (1)							
Region and Country	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
<b>Eastern Africa</b>							
Burundi	X	X	X(2)				
Comoros	X	X	X(2)				
Djibouti	X	X(3)					
Eritrea	X	X	X(2)				
Ethiopia	X	X	X	X	X	X	
Kenya	X(4)						
Madagascar	X(4)						
Malawi	X(4)						
Mauritius	X(4)						
Mozambique	X(5)	X	X(2)				

Rwanda	X	X	X(2)				
Seychelles	X	X	X	X	X		
Somalia	X(4)						
Uganda	X(4)						
Tanzania	X(4)						
Zambia	X	X	X	X(10)	X	X	
Zimbabwe	X	X		X	X		
<b>Middle Africa</b>							
Angola	X(4)						
Cameroon	X	X	X(2)	X			
Central African Republic	X(4)						
Chad	X(4)	X	X(2)				
Congo	X(4)						
Equatorial Guinea	X	X	X(2)				
Gabon	X(4)						
Sao Tome e Principe	X(4)						
Zaire	X(4)						
<b>Northern Africa</b>							
Algeria	X	X	X				
Egypt	X(6)						
Libya	X(4)						
Morocco	X	X	X(2)				
Sudan	X			X			
Tunisia	X	X	X	X	X	X	X
<b>Southern Africa</b>							
Botswana	X	X	X	X	X		
Lesotho	X(7)						
Namibia	X	X	X	X	X		
South Africa	X	X	X	X	X	X	X
Swaziland	X(7)						
<b>Western Africa</b>							
Benin	X(4)	X	X(2)				
Burkina Faso	X	X	X(2)	X	X		
Cape Verde	X	X	X	X	X	X	X
Cote d'Ivoire	X(4)						
Gambia	X(4)	X	X				
Ghana	X	X	X	X	X		
Guinea	X	X	X(2)				
Guinea-Bissau	X(4)						
Liberia	X	X	X	X	X		
Mali	X(4)						
Mauritania	X(4)						
Niger	X(4)						
Nigeria	X(8)						
Senegal	X(4)						
Sierra Leone	X(4)	X	X				
Togo	X	X(9)					

<sup>1</sup>This table was produced by Reed Boland, Research Associate, Department of Population and International Health, Harvard School of Public Health. It is based on data from the Annual Review of Population Laws. Harvard University, 2004.

### Appendix Note:

1. For purposes of this table, if an abortion is authorized on request, it is presumed that an abortion can be performed during the period when it is authorized on any of the grounds listed, even if the law does not specifically mention such grounds.
2. The abortion laws in these countries allow abortions to be performed to preserve the health of the woman, but do not differentiate between physical and mental health indications.
3. Djibouti's Penal Code allows abortions to be performed for therapeutic reasons. What those reasons are is unclear.
4. The abortion laws in these countries either specifically allow abortions to be performed only to save the life of the woman or are governed by general principles of criminal legislation which allow abortions to be performed for this reason on the grounds of necessity.
5. Abortions are also allowed in Mozambique in cases of contraceptive failure.
6. It is reported that abortions are also allowed to be performed in Egypt in case of threat to health and foetal defects.
7. There is no abortion statute in these countries; abortion is governed by Roman-Dutch common law. Under this law, general principles of criminal law permit abortions to be performed to save the life of the pregnant woman.
8. Nigeria has two abortion laws: one for the northern states and one for the southern states. Both laws specifically allow abortions to be performed to save the life of the woman. In addition, in the southern states, the holding of *R. v. Bourne* is applied, which allows abortions to be performed for physical and mental health reasons.

9. The exact status of the abortion law in Togo is unclear. The Penal Code contains no abortion provisions, and it has been reported that abortions are allowed to be performed to save the life of the woman and to preserve her health, as well as on other grounds.
10. Although Zambia's law does not specifically allow abortions to be performed in cases of rape or incest, it is presumed that this indication would be included under socioeconomic grounds.

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