FIGO INITIATIVE

Contribution of obstetrics and gynecology societies in West and Central African countries to the prevention of unsafe abortion

Robert J.I. Leke *
Central Maternity Hospital Yaoundé, Yaoundé, Cameroon

A R T I C L E   I N F O

Keywords:
FIGO initiative
Long-acting reversible contraception (LARC)
Prevention
Strategies for prevention
Unsafe abortion
West and Central Africa

A B S T R A C T

Unsafe abortion is a major public health issue in low-resource countries. In the countries of West and Central Africa, abortion-related maternal mortality rates are extremely high, the prevalence of modern contraceptive use is very low, and the unmet need for family planning is also high. The International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion and its Consequences has contributed substantially toward increasing awareness of the problem of abortion, bringing abortion-related issues to the attention of the professional societies, individual gynecologists and obstetricians, Ministries of Health, healthcare providers, and to the community in general. The promotion of quality postabortion care including the use of manual vacuum aspiration, misoprostol, and postabortion contraception has greatly improved access to services; however, there is still a long way to go.

© 2014 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd.

1. Introduction

According to the World Health Organization (WHO), approximately 22 million unsafe abortions are performed each year, resulting in the deaths of 47 000 women and causing long-term health consequences in another 5 million women worldwide [1]. Unsafe abortion is a major public health issue in West and Central Africa, and constitutes a major cause of maternal death. Western Africa has one of the highest rates of unsafe abortion in the world, with 28 abortions per 1000 women aged 15–44 years [2].

Africa also has the highest abortion-related maternal mortality ratio, with 100 abortion-related deaths per 100 000 live births in 1990 and 80 deaths per 100 000 live births in 2008. These figures are 4-fold higher than in Asia and 8 times higher than in Latin America—two other world regions where abortion laws are highly restrictive [1]. The risk of death caused by an unsafe abortion is much greater in Africa than in any other region of the world, with 1 death for every 210 unsafe abortions compared with 1 for every 625 unsafe abortions in Asia and 1 for every 3300 in Latin America [1]. These data serve to explain the relevance of the International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion in this region.

The FIGO member societies from the 5 countries participating from the West and Central Africa region (Cameroon, Ivory Coast, Benin, Nigeria and Gabon) were invited to perform a situational analysis of unsafe abortion in their respective countries. The focal points from the analyses were as follows:

1. The abortion laws were found to be restrictive in all 5 countries.
2. In general, the availability of data on abortion was inadequate.
3. The prevalence of contraceptive use was low, particularly for modern contraceptive methods, the prevalence of which is below 20%.
4. In almost all cases of incomplete abortion, treatment was carried out by sharp curettage.
5. Postabortion guidelines were out-of-date and personnel lacked training.
6. The use of postabortion contraception was rare, particularly for long-acting reversible contraceptive (LARC) methods.

The situational analysis allowed each country to develop a plan of action with specific activities. The plans of action were prepared in collaboration with each country’s Ministry of Health and given their official approval.

All of the professional societies had received authorization from the government to function following registration at the appropriate governmental agency. Each society of obstetrics and gynecology is governed by statutes, with internal regulations and an executive board of directors. The societies are recognized by the governments as collaborators and partners in reproductive health-related activities. In some countries, such as Cameroon, the Director of Reproductive Health is an obstetrician and gynecologist. Furthermore, some of the countries, including Cameroon, have signed a Memorandum of Understanding with their respective Ministry of Health that defines the duties and responsibilities of the government in relation to the society and vice-
versa. This approach specifies and clarifies each party’s responsibilities and the society’s leadership role in reproductive health issues. This collaboration is not limited to the government alone, but also applies to other national and international partners working in the area of reproductive health.

Each participating society selected one of its members to supervise the different activities included in the plan of action and to ensure that the actions were being implemented. The task of the regional coordinator was to supervise the activities in the entire region through monitoring visits and regular communication to guarantee progress [3].

Over the years, the in-country teams will revise their plans of action to define realistic objectives that can feasibly be accomplished within the established time frame.

Table 1 shows the objectives that were included as the major goals in the plans of action of the 5 participating countries from West and Central Africa. Each of the objectives was highlighted by at least one of the 44 countries participating in the FIGO initiative worldwide.

2. Progress and achievements in each country

The achievements represent the results of the work performed by the professional societies of obstetrics and gynecology in collaboration with their respective Ministries of Health and development partners. In most cases, the collaborating partners consisted of UNFPA, WHO, IPPF, Ipas, Gynuity Health Projects, the Concept Foundation, and Population Services International [4].

The progress made in implementing the objectives and activities determined in the plans of action can be measured according to previously determined prevention levels [5].

The data used to describe the achievements accomplished at the 4 levels of prevention are obtained from annual clinical and hospital reports, demographic health surveys, and from formal evaluations conducted in Benin, Gabon, and Cameroon. Key informants such as religious leaders, the heads of local communities, and nongovernmental organizations working in the field of reproductive health at the community level have also contributed information.

2.1. Progress in primary prevention

Most unsafe abortions result from unintended and unwanted pregnancies; therefore, primary prevention requires family planning programs that guarantee access to safe, effective, and affordable contraception. Based on the latest demographic health surveys, the 5 participating countries had plans to increase contraceptive prevalence and improve girls’ access to formal education [6]. Currently, however, the prevalence rates of the use of modern contraception remain extremely low, ranging from 7% in Benin to 14.2% in Cameroon [7]. This situation is reflected in all of the countries in the region, even those in which LARCs are available. Postpartum and postabortion use of intrauterine devices remains extremely low in all countries of the region.

Although postabortion contraception was included in the objectives of all 5 participating societies, only Nigeria established a goal to increase the prevalence rate of family planning in general in its plan of action. However, all of the societies are involved in training activities aimed at expanding the currently low rates of use of modern contraceptive methods.

In this region, LARCs are used as spacing methods; however, the prevalence rate of LARC use remains extremely low and a concentrated effort is required to increase acceptance of these methods. Nigeria has included the introduction of LARCs as a spacing method as a means of achieving its objective to increase contraceptive prevalence.

Promotion and implementation of sex education programs have not been included in the plans of action of any of the obstetrics and gynecology societies in West and Central Africa up to the present time, even though this strategy has been shown to be very important in preventing teenage pregnancy.

2.2. Progress in secondary prevention

Secondary prevention consists of providing access to safe abortion within the respective country’s legislation. Although abortion is illegal in all countries in the region, it is permitted in cases of rape and when there is a proven risk to the mother’s life [8]. Within this context, the initiative has contributed toward reducing the taboos surrounding abortion and has helped sensitize providers to use the opportunity to respond to women’s requests insofar as the law permits.

The introduction and increased use of the new techniques of manual vacuum aspiration (MVA) and misoprostol in abortion services, including the training of midlevel providers in its use, have significantly improved patient care. These measures have also served to bring the subject of abortion to the attention of providers, scientists, and the community in general to clarify values. Up to the present time, however, none of the societies in the region has included a goal of facilitating access to safe abortion within the limits of the current legislation in their plans of action.

Furthermore, none of the societies has specifically considered promoting changes in the country’s abortion laws and regulations in their plans of action.

2.3. Progress in tertiary prevention

Tertiary prevention consists of reducing morbidity and mortality rates after unsafe induced abortions. Strategies that contribute toward improving tertiary prevention include the use of MVA and misoprostol for the management of incomplete abortion, training personnel, and changing the attitudes and biases of providers regarding abortion. All countries participating in the initiative in the West and Central African region have adopted MVA and misoprostol for the treatment of incomplete abortion; however, compliance with the use of these techniques remains insufficient and tends to vary from country to country.

| Table 1 |
|-----------------------------|------------|------------|-------------|-------------|
| Objectives established in the plans of action of the five participating countries from West and Central Africa. |
| | Nigeria | Cameroon | Benin | Gabon | Ivory Coast |
| Sex education | - | - | - | - | - |
| Family planning | X | - | - | - | - |
| Facilitating adoption | - | - | - | - | - |
| Access to safe legal abortion | - | - | - | - | - |
| Advocating for changes in legislation | - | - | - | - | - |
| MVA for incomplete abortion | X | X | X | X | X |
| Misoprostol for incomplete abortion | - | - | X | - | X |
| Postabortion contraception | X | X | X | X | X |
| Sensitizing politicians | X | X | X | X | X |
| Improving data on abortion | X | X | X | X | X |

Abbreviation: MVA, manual vacuum aspiration.
Most countries in the region scored well in terms of training personnel in the use of MVA and misoprostol. All countries have updated their training curricula and guidelines. All levels of healthcare personnel have been trained in the use of MVA, misoprostol, and LARCs, with a focus, however, on the training of midlevel providers.

The use of sharp curettage has been abandoned in both teaching hospitals in Benin in favor of MVA and misoprostol. In two teaching hospitals in Cameroon, the use of MVA is also nearing 100% [8]. Likewise, Gabon has made progress in the use of MVA; although use of this method is far below 50%, midlevel providers throughout Gabon have received training in its use, thus disseminating the method. The Ivory Coast has also introduced MVA into its healthcare practice; however, use of this technique suffered a major setback owing to political instability and a shortage of MVA kits.

Indeed, a major obstacle to the use of MVA in these countries is a lack of MVA kits [8], and a substantial effort is being made through the FIGO initiative to ensure that these kits are available in all 4 priority countries (Cameroon, Cote D’Ivoire, Benin, and Gabon).

Misoprostol has been introduced for the treatment of incomplete abortion in the Ivory Coast and in Benin. As a result, this drug is now being used in 1 in every 4 cases of incomplete abortion receiving care at the 3 most important hospitals in Benin. In addition, Benin has made progress by including misoprostol in its essential medicines list.

2.4. Progress in quaternary prevention

Quaternary prevention consists of preventing repeat induced abortion by providing contraceptive counselling, by giving the woman the opportunity to choose the method she prefers and providing her with her chosen method before she leaves the healthcare facility. These activities have now been implemented as a routine part of postabortion care in 3 of the 5 countries in the region (Benin, Gabon, and Cote D’Ivoire). The contraceptive method used by most of the patients immediately following an abortion is the pill—a short-term method that is less effective in preventing repeat abortions than LARCs. In fact, LARC methods are still rarely used following childbirth or an abortion. However, through the FIGO initiative, efforts are now being made to provide patients with LARC methods prior to their discharge from the healthcare facility. Over 25% of all patients treated for incomplete abortion at the 3 largest maternity hospitals in Benin receive a LARC method, while 10% of those seen at the largest maternity hospital in Gabon receive LARC and an additional 15% begin use of the 3-monthly injectable contraceptive.

3. Comments

The FIGO initiative has spotlighted the issue of abortion in the African region. This initiative is progressively changing the mentality, attitudes, and habits of providers and health administrators on the subject of abortion. Reproductive health services are now more aware of the need to provide comprehensive abortion care that includes MVA, misoprostol, counselling, and postabortion contraception. One of the accomplishments of the initiative is the increased collaboration between the societies of obstetrics and gynecology, the Ministries of Health, and their reproductive health partners. In addition, real progress has been achieved since the implementation of the FIGO initiative, although differences exist between countries.

The societies of obstetrics and gynecology participating in the initiative have identified barriers to the implementation of their plans of action. Such obstacles include insufficient financial resources to carry out the activities; lack of equipment in the healthcare facilities; constant shortages of contraceptive products in the countries; difficulties in including misoprostol in the list of essential medicines in various countries; and the persistence of restrictive abortion laws in the region.

Conflict of interest

The author has no conflicts of interest.

References