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FIGO INITIATIVE

Contribution of obstetrics and gynecology societies in East, Central, and Southern Africa to the prevention of unsafe abortion in the region

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ABSTRACT

Maternal mortality and morbidity rates are very high in Africa. A large proportion of these deaths is attributed to unsafe abortion. The International Federation of Gynecology and Obstetrics, in collaboration with its member societies in each participating country, their respective Ministries of Health, and various non-governmental agencies, has developed an initiative to prevent unsafe abortion and the morbidity and mortality attributed to it. Over the past 5 years, these teams undertook situational analyses, and developed and implemented plans of action. The progress achieved in this region is described in this article.

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1. Introduction

Although pregnancy termination is restricted by law in many countries in Eastern Africa, it is widely practiced and is almost always unsafe, according to the World Health Organization, which defines unsafe abortion as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" [1]. Worldwide, nearly 1 in 10 pregnancies ends in unsafe abortion. Almost all unsafe abortions take place in low-resource countries, and this is where 99% of abortion-related deaths occur, contributing to high maternal morbidity and mortality rates in these countries. Complications resulting from unsafe abortion contribute to 47 000 maternal deaths annually worldwide, comprising 13% of maternal mortality [1]. Yet, the majority of abortion-related deaths are preventable, as are the unintended pregnancies that result in abortion.

Better access to contraceptives, more comprehensive postabortion care, and increased availability of safe abortion services within the current legal framework represent critical steps toward achieving Millennium Development Goal 5—reducing maternal mortality by three-quarters by 2015. The appropriate treatment of incomplete abortion and of the other life-threatening complications of unsafe abortion is a reproductive right granted to all women [2]. In addition, postabortion care represents an opportunity to counsel and provide women with family planning methods to prevent future unwanted or mistimed pregnancies [3]. These 4 approaches—the prevention of unintended pregnancies; making abortion safer when unavoidable; providing good quality postabortion care; and providing postabortion contraception to reduce repeat abortion rates—have been defined as the 4 levels of prevention in the FIGO Working Group strategy for the prevention of unsafe abortion [4].

2. Commitments of the obstetrics and gynecology societies

The FIGO Initiative for the Prevention of Unsafe Abortion and its Consequences was launched in January 2007. The goal of the initiative was to reduce the number of unsafe abortions and their severity. Of the 44 countries involved in the FIGO initiative, the East, Central, and Southern Africa region is participating with 7 member societies: Ethiopia, Kenya, Mozambique, Tanzania, South Africa, Uganda, and Zambia. The intention of the FIGO initiative was to involve the national societies of obstetrics and gynecology in less developed countries in which rates of unsafe abortion or induced abortion are high in actions aimed at reducing this problem. FIGO obtained the societies' commitment to perform a situational analysis of unsafe abortion in their individual countries and to develop plans of actions based on their respective findings.

An analysis of some key indicators of reproductive health in these countries [5–9] reveals a large number of weaknesses that require immediate action (Table 1). These include a high maternal mortality ratio, with one-fifth to one-third of that mortality being associated with unsafe abortion.

The goal of this initiative is to contribute toward reducing the maternal mortality and morbidity associated with unsafe abortion and to decrease the burden of induced abortion for women. The national societies play the role of advocates and service providers. FIGO understands that these goals are shared by a number of other stakeholders and that a program aimed at reducing the number of induced abortions will only be successful if it is a nationwide program, not limited to the societies of obstetrics and gynecology. To achieve this objective, the societies

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Table 1
Some key reproductive health indicators in the seven priority countries of the East, Central, and Southern Africa region.

Indicators	Ethiopia [4,5]	Kenya [4,7]	Mozambique [4,8]	Tanzania [4,9]	Uganda [4,5]	Zambia [4,5]
Total fertility rate	5.4	4.6	5.9	5.4	6.7	6.2
Contraceptive prevalence rate, %	29	39 modern	16	34	30	34
Maternal mortality ratio (MMR)	680	488	550	454	600	591
Unmet family planning needs among married women, %	34	25	53	25	34	26
Proportion of MMR attributed to unsafe abortion, %	26.8	35	Unknown	16–19	20–30	30
Proportion of deliveries under skilled care, %	10	43	54.3	49	57	47

work in close collaboration with the Ministries of Health in developing national plans of action to be implemented in partnership with national and international organizations working in the field of reproductive health, thus strengthening the partnership between agencies, the Ministries of Health, and the national societies. Members of these societies have been playing a leadership role, contributing toward including some or all of the 4 levels of prevention of unsafe abortion in the plans of action in their respective countries.

When the initiative began, the legal framework for providing safe abortion services was restrictive in Kenya, Mozambique, Tanzania, and Uganda and more liberal in Ethiopia, South Africa, and Zambia. Since that time, several societies in the region have made significant progress in the prevention of unsafe abortion at all 4 levels, with the objective of improving the poor reproductive health indicators shown in Table 1.

A summary of the main objectives laid out in their respective plans of action is listed in Table 2.

3. Progress achieved over the past 5 years

The progress made in implementing the plans of action in each of the countries in the region is described according to the 4 levels of prevention proposed by FIGO [4].

3.1. Primary prevention

All of the countries in the region were involved at this level of prevention, which refers to the prevention of unintended pregnancy.

The Ethiopian Society of Obstetrics and Gynecology (ESOG) decided to concentrate its efforts in hard-to-reach regions: Affar, Benishangul-Gumuz, Gambela, and part of the Oromia region. Focusing on improving access to quality family planning, a facility needs assessment was performed in these emerging and hard-to-reach areas, with a fixed target of reaching 25% of the healthcare units providing contraception annually. This involved the adoption of information, education, and communication (IEC) materials from the national programs. Other interventions implemented in this area included training 244 healthcare providers in the use of manual vacuum aspiration (MVA) and the care of the equipment, and in the use of misoprostol, followed by supportive supervision and logistic assistance. At the latest evaluation, 20%–30% of healthcare facilities were providing medical abortion, with up to 41% of legal terminations of pregnancy being performed by medical abortion in these regions. ESOG also raised awareness in communities regarding emergency contraception through the use of electronic and print media by publishing 6 newspaper messages in 6 months and placing 2 posters in 200 administrative units, thus increasing awareness of emergency contraception in the population.

The Obstetrics and Gynecology Association of Mozambique (AMOG) advocated with the Minister of Social Affairs and Gender for abortion prevention and the strengthening of postabortion family planning, with a greater focus on the continued availability of long-term methods and emergency contraception. They also included sex education for youths, primarily girls, both in and out of schools, in their plan of action.

These efforts had the fundamental support of the UNFPA, which supplied contraceptive commodities to all major healthcare facilities in Mozambique. In addition, 16 healthcare providers from Maputo, Sofala, Nampula, C. Delgado, Tete, and Gaza were trained in conditions associated with a high risk of maternal mortality and severe morbidity, cases in which long-term or permanent contraceptive methods were mandatory. Following these training courses, in 2012 alone 242 intrauterine devices (IUDs) were inserted post partum and 94 were inserted post abortion in Nampula, Pemba, Tete, and Gaza, according to the society's report [10].

The Zambian Association of Obstetrics and Gynecology (ZAGO) is involved in providing postpartum contraception services with permanent or long-acting methods to up to 50% of women at a high risk of maternal mortality or severe morbidity delivering in 4 selected maternity hospitals in 4 different provinces. Job aids on high-risk conditions were developed and distributed. In addition, 40 physicians received training in bilateral tubal ligation and another 40 providers in the insertion of intrauterine contraceptive devices and subdermal implants (Jadelle; Bayer Healthcare, Berlin, Germany). The percentage of women accepting long-acting reversible contraceptives (LARCs) increased from 2% in 2011 to 8.8% in 2012 [11] according to data presented at the regional workshop in 2013 [11].

The focus of the Obstetrics and Gynecology Society of Uganda (AOGU) was on reducing unwanted pregnancies by increasing contraceptive use. To achieve this, the society established a goal of providing 500 000 women with contraceptives by training 50 village health technicians at district level and enabling these technicians to mobilize communities and increase reproductive health service uptake by conducting contraceptive outreach camps in various villages. This activity is ongoing and by the end of 2012 they had achieved 30% of their target and, in general, progress is being made toward achieving this ambitious goal by 2014 [12].

Table 2
Objectives included in the countries' plans of action.

Objectives	South Africa	Ethiopia	Kenya	Mozambique	Tanzania	Uganda	Zambia
Sex education	(-)	(-)	x	x	x	(-)	(-)
Family planning	x	x	x	x	x	x	x
Facilitate adoption	(-)	(-)	(-)	(-)	(-)	(-)	(-)
Access to safe legal abortion	x	x	x	x	(-)	x	x
Advocacy for legal reform	x	x	x	x	(-)	x	x
MVA for incomplete abortion	x	x	x	x	x	x	x
Misoprostol for incomplete abortion	x	x	x	x	x	x	x
Postabortion contraception	x	x	x	x	x	x	x
Sensitize politicians	x	x	x	x	x	(-)	x
Improve data on abortion	(-)	x	(-)	(-)	(-)	(-)	(-)

Abbreviation: MVA, manual vacuum aspiration.

Another of the goals established by that society was to provide 25 000 women from Northern Uganda with LARCs or permanent contraceptive methods, focusing particularly on the postpartum period. Working in partnership with the Ministry of Health and the World Health Organization to achieve this goal, the society has held 5 in-service training workshops and contributed toward improving family planning commodity security by collaborating in procuring and distributing contraceptives.

The Association of Obstetrics and Gynecology of Tanzania (AGOTA) trained 36 healthcare providers in mini-laparotomy and introduced postpartum IUD insertion by training 4 providers at the Temeke Hospital, where at least 304 insertions were performed in the first year following training.

3.2. Secondary prevention

The aim of this level of prevention is to provide safe abortion when abortion is unpreventable. Several of the societies conducted activities aimed at addressing this goal. For example, one of the objectives outlined by ZAGO was to increase the number of safe legal abortions performed at the Lusaka University Teaching Hospital from 410 procedures in 2011 to 800 in 2013 and to over 1000 in 2014. To achieve this, all 20 residents at the Lusaka University Teaching Hospital were trained in surgical and medical procedures for the legal termination of pregnancy. In addition, the constant availability of MVA equipment, misoprostol, and mifepristone at the Teaching Hospital has been ensured; and information has been supplied to providers and clients of the hospital regarding Zambian legislation on abortion. With respect to this goal, 600 safe legal abortions were performed in 2013 either by medical abortion or MVA. As discussed by Macha et al. [13], it is difficult to ascertain the exact number of medical abortions performed because of the ineffective outpatient registration system.

Working in partnership with the Ethiopian Ministry of Health and other stakeholders, ESOG developed a comprehensive curriculum for abortion care for midlevel health providers to be used in both in-service and pre-service training courses in the country. To strengthen this curriculum, the society implemented medical abortion in 50% of public healthcare facilities by ensuring the availability of drugs for medical abortion. The goal of this initiative was to ensure that 50% of women who request a second trimester termination of pregnancy are given a medical abortion. About 150 healthcare providers have been trained in this curriculum, ensuring that more than 30% of healthcare facilities have at least one trained provider. To date, at least 230 of over 850 healthcare facilities provide medical abortions.

At the beginning of the initiative, legislation in Kenya was restrictive regarding the provision of comprehensive abortion care. Fortunately, a constitutional review was initiated in the country and the Kenya Obstetrical and Gynecological Society (KOGS) actively participated in the Kenyan constitutional review process, with a working group of 6 members who strategized, drafted, and reviewed relevant documents. The members prepared more than 30 statements for the Committee of Experts and Members of Parliament, participated in over 30 media debates, and published more than 20 articles in major national newspapers. Through the efforts of KOGS and other stakeholders, Kenyan legislation now permits abortion when, in the opinion of a trained healthcare professional, emergency treatment is required or the life or health of the mother is in danger, or in cases in which it is permitted under any other written law.

KOGS also established a protocol to deliver comprehensive abortion care for women in public hospitals within the full extent of the law. This was supported by training healthcare workers on comprehensive abortion care including the use of MVA and misoprostol for uterine evacuation. Several workshops were held to inform and sensitize healthcare professionals on the provision of safe abortion services to the fullest extent permitted by law. To support the trained healthcare workers, the society developed safe abortion standards and guidelines that have now been adapted by the Ministry of Health, and successfully advocated for the registration of misoprostol and mifepristone for all their reproductive health indications. The extent of the practical application of the standards and guidelines is still quite modest after decades of stigmatization of all forms of pregnancy termination in the country.

3.3. Tertiary prevention

Working with the Ministry of Health and partners, ESOG advocated for the procurement and distribution of MVA kits to ensure that all healthcare centers and hospitals were supplied with kits and that 80% of women with an incomplete abortion or requesting a legal termination of pregnancy were treated with MVA. As a result, 500 MVA kits have been distributed and MVA has been continuously available in around 40% of healthcare units since 2009. About 80% of women requesting a legal abortion or needing care for an incomplete abortion were treated with MVA in some of these facilities [14].

ZAGO worked to ensure that 70 clinics in 4 provinces use the safer techniques of MVA or medical abortion, thus improving the quality of the postabortion care provided to women consulting because of an incomplete abortion. The society's intention is to increase the proportion of public healthcare facilities offering MVA and misoprostol for postabortion care services from the current 20% to 40% by December 2014 [11].

Together with the Ministry of Health, KOGS trained 178 healthcare providers in the use of MVA and medical abortion for postabortion care, and provided MVA and misoprostol to 6 selected country healthcare facilities for the treatment of incomplete abortion. Almost all the women presenting with an incomplete abortion at these 6 selected country healthcare facilities are now treated with MVA or misoprostol depending on gestational age. KOGS conducted randomized clinical trials comparing MVA with misoprostol to document the effectiveness of misoprostol for uterine evacuation and to dispel the myths surrounding this method [15]. The results of that study, which were disseminated in various forums, played an important advocacy role and were used to successfully register misoprostol for its various reproductive health indications in the country.

In collaboration with the Ministry of Health and partners such as UNFPA, AOGU conducted training courses on postabortion care and provided MVA kits to both private and public healthcare facilities. The objective of AOGU is to provide high-quality, safe postabortion care services with MVA and misoprostol to 60% of women who present with an incomplete abortion at any hospital. At least 25% of the women consulting for postabortion care in public healthcare services in urban areas since December 2011 were treated with either MVA or misoprostol in place of the traditional curettage [12].

AMOG successfully advocated for the inclusion of misoprostol as a treatment for spontaneous incomplete abortion and authorized pregnancy terminations. Twenty-eight nurses from 25 primary healthcare clinics and 1 regional hospital in 2 districts were trained in the medical treatment of incomplete abortion, which is currently offered in these 25 clinics. Later, the Ministry of Health agreed to expand the use of this method.

3.4. Quaternary prevention

Quaternary prevention consists of the prevention of repeat abortion through the use of postabortion contraception. In Kenya, the current objective is for 100% of patients in the 10 selected level 5 and 6 hospitals to receive postabortion family planning counseling and a contraceptive method of their choice, and for at least 30% of postabortion care patients attending these healthcare facilities to take home a method of their choice. The Kenyan Society, working in partnership with the Ministry of Health and Ipas, operated in western Kenya and trained over 50 providers in level 4 and 5 healthcare facilities in the use of MVA for the treatment of incomplete abortion. Fifty percent of uterine evacuations were performed

with medication in Ipas-sponsored sites. Over 90% of these clients received postabortion contraceptive counseling, with about 65% uptake, the most popular method being depot-medroxyprogesterone acetate (DMPA), which was accepted by close to 50% of these women. The trend in the acceptance of implants and IUDs is gradually rising [16].

AMOG trained 40 providers at 10 target hospitals on counseling and the provision of postabortion contraception, and these services have now been implemented in these 10 hospitals. Since December 2011, at least 20% of women receiving pregnancy termination services leave the targeted hospitals with a contraceptive method. This is a modest figure, but a step forward compared with the previous period when postabortion contraception was nonexistent [10].

ZAGO conducted a training-of-trainers (TOT) workshop on the insertion, removal, and management of IUDs and implants (Jadelle) for 22 professionals who went on to train a further 140 additional providers. Data are only available for the Lusaka University Te1aching Hospital, where postabortion contraception increased from 25% in 2009 to 60% in 2012, but not for the country as a whole.

4. Comments

Through this FIGO initiative, the national societies of obstetrics and gynecology developed a strategic partnership with their respective Ministry of Health, ensuring that the abortion prevention agenda remained in the forefront in the countries in this region. This highlights the commitment of the national societies to prevent the maternal mortality and morbidity resulting from unsafe abortion, setting the standard in service provision. To achieve these goals, FIGO member societies are working with other agencies in the country to build strong partnerships. This initiative has shown that the national societies of obstetrics and gynecology act both as advocates and as examples of best practice in the region.

Conflict of interest

The author has no conflicts of interest.

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