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Inaccessible sexual and reproductive health care continues to be a major obstacle to women’s health and a violation of their rights. Access to comprehensive abortion care—comprising induced abortion and post-abortion care, including contraceptive services—is fundamental to avert preventable maternal mortality and morbidity. In east Africa, abortion rates have not declined since 1990 and about 2·7 million abortions are estimated to occur annually in this region. The vast majority of these abortions are unsafe, making them a major cause of maternal mortality and morbidity. A workshop was organised in Kampala, Uganda, in March, 2016, to address the challenges of implementation and expansion of access to comprehensive abortion care in east Africa. Workshop participants included researchers from teaching institutions and health-care providers from Kenya, Uganda, and Sweden, members of the Uganda Ministry of Health, WHO, the International Federation of Gynecology and Obstetrics working group on the prevention of unsafe abortion, representatives of non-governmental organisations and aid organisations, and journalists. Although the workshop focused on Uganda and Kenya, delegates also presented research from Tanzania and Rwanda. Here we summarise key action points needed to speed up implementation and expand access to comprehensive abortion care in east Africa, as identified by the workshop delegates.

Kenya and Uganda have restrictive abortion laws dating from the time of British rule. In both countries the constitution and penal code are not harmonised, leaving room for ambiguous interpretation of the legal environment. Standards and guidelines on reduction of morbidity and mortality due to unsafe abortion were developed by the respective ministries of health in Kenya in 2012, and in Uganda in 2015. These standards and guidelines were an expansion of existing national policies and standards and the 2012 WHO Technical Guidance on Safe Abortion, supported by the constitutions. However, the standards and guidelines were withdrawn in Kenya in December, 2013, and in Uganda in January, 2016, because of disagreements between stakeholders regarding their content. Absence of clear standards and guidelines specific to comprehensive abortion care leaves vital questions on health-care access and provision—such as roles, eligibility, and responsibility—unanswered. At the time of the workshop, discussions between the Ugandan Ministry of Health and stakeholders were ongoing, including efforts to bring religious leaders who opposed the standards and guidelines to the table. Meanwhile, in Kenya, the withdrawal of the standards and guidelines was being petitioned in court by civil societies.

Delegates emphasised the urgent need for a consensus regarding the standards and guidelines among stakeholders in Kenya and Uganda. In addition, a common interpretation of the legal environment was considered crucial, and therefore the constitution and penal code would need to be harmonised in both countries. In east Africa, the shortage of health-care providers trained in comprehensive abortion care is severely restricting women’s access to care, and thus updated in-service comprehensive abortion-care training and quality pre-service training is imperative. Efforts to expand access to comprehensive abortion care through task sharing or shifting should also be prioritised, as they have been shown to be safe, effective, and highly acceptable to women. The harm reduction model, already in use within some settings in east Africa, was acknowledged as an important strategy to prevent unsafe abortions. The delegates also emphasised the opportunity for prevention of unintended pregnancies, which comprehensive abortion care entails. However, quality improvement of contraceptive services is needed to increase use of effective methods and ensure informed decision making. Quality comprehensive abortion care is also dependent on factors such as availability of misoprostol and effective contraceptives, known to be heavily affected by stock-outs in Kenya and Uganda within public facilities. Stock-outs at national dispensaries are unacceptable and should be addressed alongside the control of counterfeit misoprostol. Sensitisation and support for misoprostol and addressing of misconceptions at community, health-care, and decision-making levels were recognised as central to the implementation process.

Young women in particular struggle to access comprehensive abortion care, and delegates stressed that stigma and insufficient youth-friendly services across the east African region both need to be addressed. Abortion stigma continues to restrict comprehensive
abortion-care access and impair the quality of existing services, highlighting the need for stigma reduction measures such as values clarification. Comprehensive abortion-care providers were described as sometimes perpetuating stigma but also as targets of stigma and police harassment. Local human rights organisations providing legal support—and increasing awareness of the right to health—therefore play an important role in the move towards universal comprehensive abortion-care access. For implementation to be successful, faith-based organisations, civil society organisations, and the media should be engaged. Advocates for change need to come together, creating alliances and networks, and campaigning for the right to safe, high-quality sexual and reproductive care. Finally, comprehensive abortion care should be advocated as an indivisible component of women’s sexual and reproductive health care and rights, and a crucial strategy in reduction of gender inequality and social inequity.

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