

Facts on Abortion and Unintended Pregnancy in Africa

INCIDENCE OF ABORTION

- The annual number of induced abortions in Africa rose between 1995 and 2003, from 5.0 million to 5.6 million. In 2003, most of the abortions occurred in Eastern Africa (2.3 million), Western Africa (1.5 million) and Northern Africa (1.0 million).
- Despite the increase in the number of abortions, the annual abortion rate declined between 1995 and 2003—from 33 to 29 abortions per 1,000 women aged 15–44. The decline in the rate was a result of the increase in the number of women of childbearing age.
- Of the 5.6 million abortions carried out in 2003, only 100,000 were performed under safe conditions.* Most safe abortions occurred in South Africa, Tunisia and Cape Verde, countries where the procedure is legally permitted on broad grounds.
- The estimated abortion rate in 2003 was 39 per 1,000 women aged 15–44 in Eastern Africa and 26–28 per 1,000 in Middle and Western Africa; all of the procedures in these subregions were unsafe. The rate was 22 per 1,000 in Northern Africa (all unsafe except for a small number in Tunisia), and 24 per 1,000 in Southern Africa—roughly five safe and 18 unsafe abortions per 1,000.†

*In this report, abortions are categorized as safe or unsafe using standard World Health Organization (WHO) definitions. WHO defines unsafe abortion as a procedure meant to terminate an unintended pregnancy that is performed by individuals without the necessary skills, in an environment that does not conform to the minimum medical standards or both.

†The sum of the safe and unsafe abortion rates differs from the total rate because of rounding.

LEGAL STATUS OF ABORTION

- An estimated 92% of women of childbearing age in Africa live in countries with restrictive abortion laws (countries falling into the first four categories in the table, page 2).¹ Even where there are narrow grounds for abortion, it is likely that few women in these countries are able to navigate the processes required to obtain a safe, legal procedure.
- Abortion is not permitted for any reason in 14 African countries.
- In nine countries, abortion is generally allowed only to save the life of the woman, although two of these countries also allow it in cases of rape and one in cases of incest. Seventeen other countries permit abortion to preserve a woman's physical health (as well as to save her life); eight of these countries also permit abortion if the woman has been raped, seven do so on the grounds of incest and eight in cases of fetal impairment.
- Abortion is permitted to preserve a woman's mental health (as well as to save her life and preserve her physical health) in nine countries, all but three of which also allow the procedure on the grounds of rape, incest or fetal impairment.
- Zambia permits abortion on socioeconomic grounds, and Cape Verde, South Africa and Tunisia allow pregnancy termination without restriction as to reason, but with gestational limits.

- In 2005, Ethiopia expanded its abortion law—which had previously allowed the procedure only to save the life of a woman or protect her physical health—to also allow abortion in cases of rape, incest or fetal impairment. It also added one broader social reason: A woman can legally terminate a pregnancy if she lacks the capacity to bring up the child, owing to her status as a minor or to a physical or mental infirmity.
- Between 1997 and 2009, Benin, Chad, Guinea, Mali, Niger, Swaziland and Togo all slightly expanded the grounds on which abortion is legal.

PROVIDERS OF CLANDESTINE ABORTIONS

- Surveys of knowledgeable health professionals suggest that in Uganda, 23% of women seeking abortions go to traditional practitioners, many of whom employ unsafe techniques, and 56% go to doctors or nurses, who generally provide safer services. Some women try to self-induce using highly dangerous methods (15%), while others purchase abortion-inducing drugs from pharmacists or other vendors (7%).
- However, urban women in Uganda are much more likely than rural women to use the services of doctors (42% vs. 16%). Studies in Burkina Faso and Côte d'Ivoire show similar results.
- In Nigeria, dependence on trained health professionals to perform abortions is common. A 2002 national household-based survey found that almost six in 10

Legality of Abortion

Countries in Africa can be classified into six categories, according to the reasons for which abortion is legally permitted

Reason	Countries
Prohibited altogether, or no explicit legal exception to save the life of a woman	Angola, Central African Republic, Congo (Brazzaville), Democratic Republic of the Congo, Egypt, Gabon, Guinea-Bissau, Lesotho, Madagascar, Mauritania, Mauritius, São Tomé and Príncipe, Senegal, Somalia
To save the life of a woman	Côte d'Ivoire, Kenya, Libya (e), Malawi (f), Mali (a,b), Nigeria, Sudan (a), Tanzania, Uganda
To preserve physical health (and to save a woman's life)*	Benin (a,b,c), Burkina Faso (a,b,c), Burundi, Cameroon (a), Chad (c), Comoros, Djibouti, Equatorial Guinea (e,f), Eritrea (a,b), Ethiopia (a,b,c,d), Guinea (a,b,c), Morocco (f), Mozambique, Niger (c), Rwanda, Togo (a,b,c), Zimbabwe (a,b,c)
To preserve mental health (and all of the above reasons)	Algeria, Botswana (a,b,c), Gambia, Ghana (a,b,c), Liberia (a,b,c), Namibia (a,b,c), Seychelles (a,b,c), Sierra Leone, Swaziland (a,b,c)
Socioeconomic grounds (and all of the above reasons)	Zambia (c)
Without restriction as to reason	Cape Verde, South Africa, Tunisia

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. Notes: Some countries also allow abortion in cases of (a) rape, (b) incest, (c) fetal impairment or (d) other grounds. Some restrict abortion by requiring (e) parental or (f) spousal authorization. Countries that allow abortion on socioeconomic grounds or without restriction as to reason have gestational age limits (generally the first trimester); abortions may be permissible after the specified gestational age, but only on prescribed grounds.

nonpoor women having abortions had had a surgical pregnancy termination, compared with just three in 10 poor women.

- Conversely, poor women and those living in rural areas are more likely than urban and better-off women to turn to unsafe methods and untrained providers.

- Women in Cameroon, Ghana, Uganda and Zambia cite fear of legal consequences, social stigma, high cost and lack of access to trained health professionals as important factors preventing them from obtaining safe abortions.

HEALTH CONSEQUENCES OF UNSAFE ABORTION

- The World Health Organization estimates that in Africa, one in seven maternal deaths result from unsafe abortion.²

- About 1.7 million women in the region are hospitalized annually for treatment of complications of unsafe abortion.³

- The most common complications of unsafe abortion are incomplete abortion, infection and excessive blood loss. Less common but very serious complications include septic shock and trauma to reproductive and other organs.

- Recent studies have found that nearly three in 10 postabortion patients in Kenya experienced severe complications. In South Africa, the proportion of patients with severe complications declined considerably after the abortion law was liberalized in 1996.

- Because poor and rural women tend to depend on the least safe methods and on untrained providers, these

women are the ones most likely to experience severe health consequences.

- However, even abortions performed by doctors or nurses can have a high risk of complications when done under clandestine conditions. In Nigeria, where the majority of abortions are carried out in clinics and hospitals, the 2002 survey found that one in four women undergoing dilation and curettage (D&C) or manual vacuum aspiration (MVA)—both very safe techniques for terminating pregnancies, if correctly carried out—experienced complications.

- Experts estimate that in Uganda, 50% of all women having clandestine abortions experience health complications requiring treatment. Such complications are thought to be more common among poor women than better-off women (55% vs. 38%).

- In the Nigerian study, 25% of women having any type of induced abortion reported experiencing moderate or severe complications—however, only one-third of these women obtained treatment.

- In Uganda, an estimated 45% of all women who experience complications requiring treatment do not receive medical care at a facility, and the proportion is even higher among poorer women.⁴

- Many women with untreated complications suffer long-lasting health effects, such as anemia, chronic pain, chronic inflammation of the reproductive tract and infertility.

- Postabortion services are of very poor quality in Sub-Saharan Africa, largely because of low government spending on all health care. Common shortcomings include inadequate access to services, delays in treatment, shortages of trained health workers and medical supplies, use of inappropriate procedures, judgmental attitudes on the part of clinic and hospital staff, and high costs to the patient.

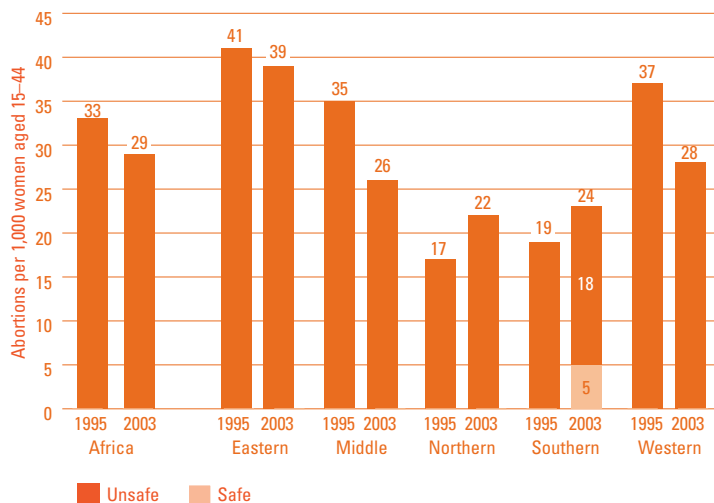
- These factors are likely to deter some women, particularly those who are poor or are young and unmarried, from obtaining needed treatment.

UNINTENDED PREGNANCY AND CONTRACEPTIVE USE

- The pregnancy rate in Africa declined from 262 per 1,000 women aged 15–44 in 1995 to 222 per 1,000 in 2008. The decline was almost entirely due to a drop in the rate of intended pregnancy.

Abortion Rates in Africa

Estimated abortion rates in 2003 were highest in Eastern Africa.



Notes: Subregions are defined according to the United Nations classification system. The sum of the unsafe and safe abortion rates may not equal the total rate because of rounding.

- The very high rate of unintended pregnancy in 1995—92 per 1,000 women—declined only slightly by 2008, to 86 per 1,000.

- The unintended pregnancy rate is much higher in Eastern Africa (118 per 1,000 women of childbearing age) and Middle Africa (94 per 1,000) than in the other three subregions—Northern, Southern and Western Africa—where the rate ranges between 56 and 83 per 1,000.

- About one-third of all unintended pregnancies in Africa end in abortion. This proportion is lower in Middle Africa (about one-quarter) and higher in Northern Africa (nearly half).

- On average, contraceptive use among married women aged 15–44 rose from 17% to 28%

between 1990 and 2003, an increase of 53%. However, even with this increase, current contraceptive use levels remain very low.

- The decline in the intended pregnancy rate between 1995 and 2008 (from 170 to 136) is partly explained by the increase in contraceptive use, but other factors have likely contributed as well, such as the rising age of marriage and the increase in HIV/AIDS.

- Many women in Africa who do not want a child in the next two years or who want no more children, are not using any method of contraception. An estimated 22% of women of childbearing age had an unmet need for contraceptives in 2002–2007, only a small decline from the mid-1990s level of 24%.*

- Levels of unmet need are even higher among young, unmarried, sexually active women. In most countries in the region,

*Women are considered to have an unmet need for contraceptives if they are married or are unmarried and sexually active, and they can become pregnant, do not want a child soon or at all, and are not using any method of contraception.

25–60% of unmarried, sexually active women aged 15–24 were not using any type of contraceptive method in 2002–2007.

- When sexually active women who say they do not want to become pregnant are asked why they are not using a contraceptive method, a common answer is that they have sex infrequently—suggesting a lack of understanding of their risk of unintended pregnancy.

- Another common response is that they are concerned about the real and perceived health risks associated with modern contraceptives, suggesting a need for services that provide adequate counseling about side effects and that facilitate switching methods.

- Approximately one in five African women with unmet need cite opposition to the use of contraceptives—either on their own part, or on the part of

family members, community leaders or institutions—as a reason for not using a method.

RECOMMENDATIONS

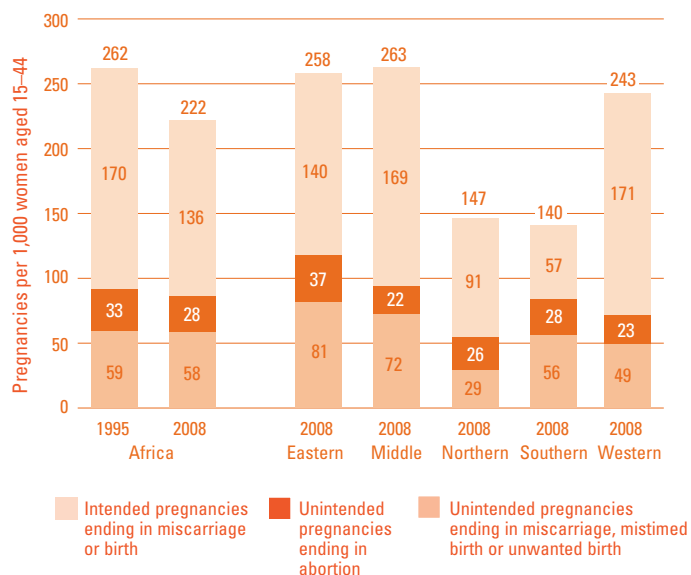
- Programs and policies that improve women’s and men’s knowledge of, access to and use of contraceptive methods should be established or strengthened, as contraceptive use is the surest way to prevent unintended pregnancy—and thus the need for abortion.

- To reduce the high levels of morbidity and mortality that result from unsafe abortion, provision of postabortion care should be improved and expanded.

- The grounds for legal abortion in the region should be broadened, and access should be implemented under the criteria permitted by existing laws, to reduce the number of clandestine and unsafe procedures.

Pregnancy Rates in Africa

The rate of intended pregnancy declined in Africa between 1995 and 2008, and it varied widely by subregion in 2008.



Note: Rates may not add up to totals because of rounding.

- Because rates of morbidity and mortality from unsafe abortion are disproportionately high among poor and rural women, access to family planning and postabortion care should be made more equitable.

Unless otherwise indicated, the information reported in this fact sheet is from Singh S et al., Abortion Worldwide: A Decade of Uneven Progress, New York: Guttmacher Institute, 2009.

REFERENCES

1. Appendix Table 1 applied to data from Population Division, United Nations Department of Economic and Social Affairs, World population prospects: the 2008 revision population database, 2009, <<http://esa.un.org/unpp>>, accessed May 18, 2009.
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