Midwives and Post-abortion Care in Gabon: "Things have really changed"

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Abstract

Complications from spontaneous and induced abortion are a primary cause of death of women in sub-Saharan Africa. Le Réseau d'Afrique Centrale pour la Santé Reproductive des Femmes: Gabon, Cameroun, Guinée Équatoriale (the Middle African Network for Women's Reproductive Health, or GCG as it is commonly known) was founded in 2009 to identify and overcome obstacles to post-abortion care in Gabon. Research identified the main obstacle as lack of emergency skills and provisions among first-line health care providers. To fill the lacuna, GCG designed a program to train midwives in manual vacuum aspiration (MVA), misoprostol protocols, and the insertion of T-shaped copper IUDs. This article presents a nine-year retrospective (2009–2018) of the program. Qualitative and quantitative results confirm correlations between midwives' practice of MVA in health centers and spectacular decreases in treatment delays, with corresponding decreases in mortality from abortion complications. Our findings also demonstrate how these advances have been threatened by opposition to midwife practice in certain urban medical centers despite encouragement by the Gabon Ministry of Health to use the new protocols. Women's human right to the highest attainable standard of health, including access to safe abortion, is an assumption that GCG shares with the 40 African countries that have ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. The training program illustrates how a direct-action strategy can fully equip medical practitioners, especially those in peripheral sites with meager resources, to provide emergency post-abortion and abortion care even before governments legislate their human rights commitment.

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Introduction

More than half of pregnancy-related deaths of women globally occur in sub-Saharan Africa. Among those deaths, complications from unsafe abortion are one of the most common and easily preventable and treatable causes.[1] By "abortion," we refer to spontaneous, induced, or missed abortions, as well as a multitude of other conditions requiring the evacuation of uterine products, such as intrauterine fetal demise and molar pregnancy.

In Gabon, the legal prohibition of induced abortion has not deterred women from ending unwanted pregnancies. The risk of criminal sanctions has, however, obliged them to do so without medical assistance until complications arise. The fact that incomplete induced abortion often presents the same symptoms and requires the same treatment as spontaneous or unviable pregnancies renders any woman with early pregnancy distress suspicious and thus susceptible to interrogation, reprimand, and mistreatment by medical personnel.

This article describes the strategy developed from 2009 to 2018 by a local network in Middle Africa for assuring quality emergency care for women with abortion complications. We begin by describing the socio-juridical context of our research site, Gabon, followed by an account of our field needs assessment, training process, quantitative and qualitative evaluation studies, and ongoing challenges. The quantitative studies that serve to demonstrate the statistical impact of training have already been published, albeit without discussion of the training process itself. We briefly summarize the experiments and the intervention modalities behind the reported results. Our qualitative interview study, published here for the first time, gives voice to midwives as emergency medical practitioners and inside witnesses within hospital wards. Whereas the quantitative studies verify our advances and setbacks in one hospital setting from 2009 to 2018, the qualitative study explains those dynamics through an analysis of interviews with 20 midwives and 12 doctors practicing in diverse rural and urban settings, all of whom participated in training over the same nine-year period. At the end of the article, we discuss our method in the context of the global movement for safe abortion. Rather than put forth a human rights discourse in the hope of persuading governments to provide adequate abortion provisions for women in line with their ratification of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (better known as the Maputo Protocol), we presume those rights and network directly with frontline emergency health care providers in dire need of enhanced clinical tools.

Background: High-risk abortions and inadequate treatment of complications

In 1969, contraceptives were outlawed in Gabon, and their sale was strictly prohibited (Law 64/69). Only in 2000 was the prohibition lifted and an explicit right to contraception decreed under a set of general measures for the health of women and children (Law 2000). Since that time, women have been allowed, if not encouraged, to delay childbearing. But 10 years later, modern methods still represented only 11.5% of contraceptive use, with women relying primarily on abortion to regulate their fertility.[2] For abortions, plants with abortive properties are the traditional method of choice. Adolescent girls learn to use such plants as a discrete, if risky, strategy to abort a pregnancy at no cost and in hiding from their parents.[3] Older women likewise rely on such methods to space or limit births.[4] The most commonly used methods are the insertion of a plant stem into the uterus or the ingestion of plant-based purging substances such as herbal teas and vaginal washes with lemon, ndolé, papaya root, grass, manioc leaves, papaya leaves, ginger, permanganate, bleach, salt, or quinine. In a GCG study of obstacles to post-abortion care, 60% of women interviewed about their own or a friend's self-induced abortion reported success without complication and 40% reported some sort of complication. The frequent success stories encourage others to try the same; meanwhile, common accounts of complications range from successful but traumatic resolution with the help of a traditional therapist, pharmacist, or doctor to lifelong disability to tragic death.[5]

In 2018, women interviewed for a study on contraceptive use in the north of Gabon made frequent reference to their use of the abortifacient medication misoprostol (often referred to by its brand name Cytotec).[6] Alongside traditional products, Cytotec has entered the popular vernacular of parlors, streets, and markets; it is available for little money from local merchants, accommodating pharmacists, and some physicians. Although far better than plant methods, misoprostol abortions do still need back-up medical help in cases of incomplete expulsions or complications due to poor-quality drugs, overdoses or underdoses, or pre-existing conditions.[7]

In Western Europe, abortion-related mortality and morbidity are described as "negligible" by the World Health Organization.[8] In contrast, complications from unsafe abortion in Middle Africa are among the main causes of pregnancy-related death. One in eighty-five women of reproductive age risks dying in her lifetime from pregnancy-related complications in Gabon.[9] Anecdotally, as soon as we speak of abortion, we hear accounts such as "A girl died in my village last week" and "Everyone in Gabon knows at least one woman who died from abortion complications."

The Middle Africa Network: Founding and networking

Le Réseau d'Afrique Centrale pour la Santé Reproductive des Femmes: Gabon, Cameroun, Guinée Équatoriale (the Middle Africa Network for Women's Reproductive Health, or GCG) was founded by two social science research activists, Aimée Patricia Ndembi Ndembi from Gabon and Gail Pheterson from France, the former just having completed a study on contraception in her country and the latter having developed a model for improving access to safe abortion in the Caribbean.[10] They invited Gabon-based midwife Justine Mekuí and South African-based physician and abortion expert Marijke Alblas to join them in adapting the Caribbean Initiative on Abortion and Contraception to the Middle Africa context. The Caribbean initiative had been conceived in 2001 to investigate abortion practice in a sub-region of the Caribbean with frequent travel between islands whose laws range from strict prohibition to elective first- and second-trimester abortion. Networking with health care providers and feminists, researchers found active abortion practices—both within and outside the law—among health professionals, who confidentially expressed the need for improved skills and provisions. Beginning on five small islands of the Northeast Caribbean and extending throughout the region, project directors organized regional and cross-regional workshops and conferences on manual vacuum aspiration (MVA), misoprostol protocols, and contraception. Those trainings mobilized a network of practitioners and feminists from 14 Caribbean countries who came together in Antigua in 2005 for educational sessions and to draft a declaration of health professionals, scientists, and advocates for the decriminalization of abortion in the Caribbean.[11] At present, the initiative is networking with the Solidarité Fanm Ayisyen (Solidarity of Haitian Feminists) to train Haitian physicians and nurses working in rural and urban zones.

The main goal of GCG is to prevent avoidable deaths and disability among women due to pregnancy-related complications. In line with the Caribbean initiative, we began our process in peripheral low-resource sites and went from there to the closest emergency medical centers. We launched the project in 2009 in Bitam, a small town in the north of Gabon near the southern border of Cameroon and the eastern border of Equatorial Guinea. National borders in this region are a colonial artifact separating one people, the Fang, who share a language, customs, and material needs.

After 10 days of visits to every health facility in the cross-border environs of Bitam, we brought together nearly all medical personnel on the Gabon side of the border—about 40 practitioners in total—along with leading midwives from nearby towns in Cameroon and Equatorial Guinea. Participants expounded on the main health risks of pregnancy, namely infection, hemorrhage, hypertension, and severe anemia, which are often compounded by conditions such as HIV, malaria, tuberculosis, and

diabetes. They enumerated the lacunas in material conditions, including light, water, electricity, sterile gloves, stethoscopes, telephones, transportation, incubators, oxygen, a blood bank, and contraceptives. In addition, they bemoaned the obstacles faced by women in accessing services (stemming from a lack of money and transportation), together with those that they, as service providers, faced in administering emergency care (due to inadequate equipment and skills). They expressed relief at the presence of an international team led by someone from their own community (midwife Mekuí was born in Bitam and speaks Fang) for the purpose of improving service delivery. We knew that although we could not resolve the infrastructural needs, we could improve the emergency care that was currently being offered.

Our next stop was the medical center in Oyem, the provincial capital one hour from Bitam. There, we met Rosalie Ndoutoume, the only ob-gyn specialist for the entire northernmost province of Gabon, Woleu-Ntem, who quickly agreed to our conducting midwife trainings at her hospital. We proceeded to Libreville, the country's capital located nine hours away, where we met with the National Association of Midwives and ob-gyn specialists at the public hospitals, all of whom agreed to join our network. The standard medical practice both in Libreville and in Oyem for treating abortion complications was dilation and curettage under general anesthesia. Our new ob-gyn physician allies, also researchers, knew (in line with World Health Organization guidelines) that MVA under local anesthesia was a safer, faster, and less expensive method, thus their receptivity to our initiative.[12] They would become close collaborators in gathering hospital data for charting the impact of our work. In addition to their in-house support, they assisted us behind the scenes, such as by using their authority at the airport customs office to retrieve GCG materials sent from Europe or by passing on to us international donations of MVA equipment that they had in stock.

Upon hearing about our project, one of the new physician specialists in our network shared with us his recently completed study (from 2009) of comparative delays in emergency treatment at the largest public hospital in Libreville. The mean time between emergency room admission and treatment for women who died from post-partum hemorrhage or eclampsia was 1.2 hours, while it was 23.7 hours for women who died from abortion-related complications. He and his researcher colleagues concluded that discrimination against women who had induced an abortion increased their risk of dying.[13] This correlation between abortion stigma and poor medical treatment has been documented elsewhere in Africa and throughout the world.[14] But even with efforts to eradicate stigma, patient overloads in obstetrical emergency wards undermine optimal care by requiring a ranking of emergencies, however dubious the criteria. In addition to challenging the stigma of abortion, our goal was to increase the efficiency of emergency services such that all patients could receive timely quality care.

The trainings, 2010 to the present

Within 18 months of our August 2009 field trip, GCG had conducted clinical workshops in eight rural and urban sites in Gabon, Cameroon, and Equatorial Guinea on MVA, misoprostol protocols, and the insertion of T-shaped copper IUDs.[15] Hands-on clinical training was limited since we could not predict—and thus schedule—treatment for pregnancy-related complications. The Caribbean Initiative on Abortion and Contraception had given us a model for addressing training challenges in countries with restrictive abortion laws: we identified those practitioners best placed and most motivated to themselves become local trainers and, after on-site preliminary workshops, organized intensive trainings for these practitioners in a foreign country with legal abortion and high caseloads. We found a partner in Tunis, where abortion has long been legal, who agreed to help us conduct such intensive training in May 2011. Although we have been unable to replicate that workshop as of yet, we were able to reinforce the training at home through a series of workshops conducted by Marijke Alblas, our expert consultant. Within two years, GCG's local medical coordinator, Justine Mekuí, was herself

a regional trainer.

Since its launch in 2009, GCG has trained more than 500 hospital practitioners in Gabon, mostly midwives, in MVA. Although less than half of the trained midwives actually practice regularly, they all support and are familiar with the method, thus reinforcing acceptance of MVA as a tool for midwives, as well as physicians, to resolve abortion-related complications. An unanticipated factor in facilitating the spread of improved emergency care is the frequent transfer of midwives from one medical facility to another, both in rural and urban zones. They bring their materials with them to new settings, where they train midwife and physician colleagues.

Evaluation of the trainings and change in practice

Quantitative outcomes

Three of the Tunis trainees—two midwives and one ob-gyn specialist—worked as a team at the hospital site where the aforementioned study on comparative delays in emergency care was conducted. That study provided us with a before-training measure.[16] Within months of returning from Tunis, the team succeeded in making MVA the standard procedure for post-abortion care. Once the new protocol was in place, our GCG research associates again gathered data on delays in treatment and published the following results: whereas before the training 100% of emergency complications were treated with dilation and curettage by ob-gyn specialists accompanied by an anesthesiologist, after training two-thirds of complications were treated immediately upon arrival at the hospital with MVA and local anesthesia, half by midwives and the other half by the Tunis-qualified ob-gyn physician or his colleagues (who had been trained on the job). Before the Tunis training, the mean delay in the treatment of incomplete abortions was 18 hours (23.7 hours for those who died); after training, the mean delay decreased to 1.8 hours.[17] Charting mortalities up until 2013, rapid emergency care—half of which was provided by midwives—effectively lowered the percentage of pregnancy-related deaths due to abortion complications from 10% (2008-2010) to 2% (2011-2013).[18]

In 2013, this research hospital appointed a new administrator who prohibited midwives from practicing MVA. Investigators continued to chart delays in treatment and to correlate them with mortality statistics. From 2014 to 2016, delays in treatment increased, and death from abortion complications rose from 2% to 14.1% of all pregnancy-related deaths.[19] Without midwives practicing MVA, the ob-gyn specialists prioritized women with serious complications requiring an operating theater, general anesthesia, and lengthy interventions such as Caesarean sections or hysterectomies. Meanwhile, women with initially minor problems, notably incomplete abortions, were once again left waiting for hours in hospital corridors. Physicians used MVA for rapid out-patient procedures when they found the time. But the delays were far greater than when midwives, now idle at the side of women in crisis, had intervened immediately.

Qualitative analyses of improvements and setbacks

The team heard, anecdotally, that sentiments among medical personnel in the hospital corridors shifted from exasperation with women patients for having induced an abortion to exasperation with rigid medical administrators for prohibiting competent health professionals from exercising their life-saving skills. However, the Ministry of Health supported GCG in its training of midwives as emergency practitioners of MVA. Yolande Vierin, the ministry's national director of maternal and child health, called on GCG to "train all the midwives of Gabon." But hierarchies within medical establishments are sometimes more determinant of medical protocol than governmental stances, especially given the ministry's reticence to speak publicly about abortion. One rigid hospital administrator cannot prevent national trainings, on-site trainings in rural and urban settings, or midwives using their skills when they can, regardless of authorization. But arbitrary hierarchical obstacles can undermine the quality of care at a particular medical facility, with grave consequences for women.

Our qualitative study conducted among

practitioners in diverse rural and urban medical facilities gives an overview of midwives' experience. In 2017–2018, two of this paper's authors—GCG's medical coordinator (Mekuí) and its president (Ndembi Ndembi)—conducted semi-structured interviews with 20 midwives trained in MVA and unstructured interviews with 12 physicians (7 ob-gyn specialists and 5 general practitioners). This research had the support of the Centre National de la Recherche Scientifique et Technologique, where Ndembi Ndembi holds a research post. Half of the midwives and all of the physicians were interviewed on the job (where they could refer to caseload registers); the other half of midwives were interviewed in Lambaréné and Koulamoutou during the Annual Conference of the Gabon Midwife Association, where GCG conducts an annual day-long workshop. Public hospitals were the main work site of these interviewees, although practitioners also use their skills in private medical facilities since they often hold multiple posts inside and outside the public sphere.

Our interview guide for midwives focused on the nature of abortion emergencies and treatment outcomes with MVA; training and practice in diverse settings; doctors' attitudes toward midwives' enhanced authority; midwives' degree of satisfaction with the method; their feelings about abortion; and their opinions about the country's restrictive law. Our unstructured interviews with physicians focused on an opening inquiry of "How is it going with midwife MVA practice in the emergency ward?"

For an indicative sample of abortion emergencies, we asked 2 of the 20 midwives to detail the nature of the problems they treated with MVA at a particular site over a specified stretch of time. For one midwife at the Centre Hospitalier Universitaire de Libreville, between March 2015 and April 2018, 26 of 39 (67%) of the emergencies she treated with MVA were due to incomplete self-induced abortions, 6 (15%) were due to intrauterine embryonic demise, 4 (10%) were due to incomplete miscarriage, and 3 (8%) were due to an undeveloped embryo. All pregnancies were between 6 and 12 weeks. For another at the Centre Hospitalier Régional de Port-Gentil, between July 2018 and January 2019, 8 of 13 (61%) were due to incomplete induced abortions under 12 weeks' gestation, 3 (23%) were due to intrauterine embryonic demise under 13 weeks' gestation, 1 (8%) was due to partial infected expulsion of a multiple pregnancy at 14 weeks, and 1 (8%) was due to retention of the placenta after delivery. As to outcomes, neither those two midwives nor the others we interviewed had had any complications. Turning to our interviews, we will now present the issues that were discussed, as structured by the interview guide.

Training occurs both on the job and in national workshops. One midwife said, "When I first arrived [for a new position at an urban hospital], I didn't know how to do it. Then a colleague [midwife] taught me and then I participated in a training." And another explained, "I was trained by the gynecologist. I've been doing it now for two months. I'm in the province of Haut Ogooué [rural zone]. It has really changed things." And a physician said, "I train midwives, I need their help. I've got cases from the whole province night and day. I'm overwhelmed."

Although training occurs in both rural and urban settings, the situations are not comparable. For midwives in rural zones, MVA has been crucial in equipping them to treat women unable to travel the distance to find an ob-gyn specialist. For example, the Health Center of Kango is 100 kilometers from Libreville, and the road is so bad that it can take more than two hours to reach the capital, not to mention prohibitive transportation costs. Although there is a general practitioner on the premises in Kango, it is the midwife, more expert in pregnancy matters than the generalist, who handles abortion complications. In other rural towns, such as Mabanda and Ndindi, there is neither a doctor nor a midwife; the GCG-trained birth attendant performs MVA. In Oyem, the northern rural provincial center, the specialist declared, "Since midwives are doing MVA, I can sleep in peace. From time to time, I give a look, everything is going well, there hasn't ever been a problem. Midwives do it really well." Likewise, in Tchibanga, the southern provincial base, a physician urges midwives from surrounding rural sites to come to his hospital for training: "We [ob-gyn specialists] will accompany

them [midwives and nurses] for a time, we won't immediately give them the aspirators. Then, after sufficient practice, they can do it."

In contrast, in urban areas, cooperation between health professionals is not always so congenial. Midwives recounted their worst experiences: "I never had the occasion to use it [the MVA kit], the doctor confiscated the syringes." "The interns made war with us midwives over this affair of MVA. I was called into the office of my superior several times." "He [ob-gyn head of service] told me, 'You, the *sage* [literally "wise woman"], I hope the day that it goes badly you'll know how to open the belly.'" This last quotation reveals physicians' occasional sarcastic mockery of midwives, with an underlying assumption that post-abortion care is above their capacity. In fact, numerous studies demonstrate that the clinical outcomes of midwife MVA performance are equal to those of physicians.[20]

Sometimes, as demonstrated above, MVA practice depends on the authority of a particular, often transitory, hospital administrator. Midwives keep one another informed about the services available at their medical facility and refer patients accordingly: "I was trained by a [midwife] colleague, but I send the ladies to the CHUL [public hospital in Libreville] because I'm not allowed to do it in my establishment for the moment." Aside from the occasional interference of administrators or physicians, midwives sometimes hesitate to practice MVA until they feel fully confident. One admitted, "I was trained but I haven't yet practiced. It takes courage. I worry I'll make a mistake with the para-cervical block." Another said, "We midwives take more care than most doctors to ease women's pain and fear."

Overall, also in urban settings, midwives and doctors work together so emergency patients do not experience long delays before treatment. In Libreville and Port-Gentil, for example, where hospitals' patient load is immense, midwife-led emergency care frees obstetrical surgeons for major surgeries in the operating theater. One midwife noted, "I've been practicing MVA for the past six years. I've saved many lives. Sometimes the doctor is busy. MVA is really good." Another said, "Here it's me who handles incomplete abortions with MVA, it's so practical." And another said, "It's the gynecologists themselves who send me their patients."

As for general satisfaction with the method throughout the country, whether in rural or urban zones, midwives and doctors expressed relief and pride in treatment improvements through MVA. One rural doctor said, "When midwives are trained, their work is fantastic. They save lives." And a midwife noted, "I'm very satisfied with this practice. Things have really changed." The phrases "I/They save lives" and "Things have really changed" were repeated again and again in the interviews.

Officially, GCG training in MVA is geared to post-abortion care, and the network speaks little about primary abortion provision. During our interviews, we nonetheless asked midwives to share their feelings about abortion and Gabon's restrictive law. Whereas feelings about abortion ranged from a sense of tragedy to moral judgment to resigned acceptance, opinions about the law were unambivalently in favor of decriminalization. Here's a sample of contrasting feelings: "My niece died after an abortion." "It's a bad thing, of course, as a Christian it's difficult." "I lost several patients, it's revolting." "I think one has to help adolescents." "Abortion isn't good but it's a fact, there's no family planning education." "No matter what, clandestine abortion is an everyday affair. What to do? We have to save lives!"

Regarding the law, opinions expressed in the interviews proved to be representative of a consensus at the yearly conference attended by hundreds of midwives—namely, unanimous denunciation of the juridical prohibition of abortion: "We should change the law, too much is too much, we're living an hypocrisy." "Things have to evolve." "The law is dangerous." "We should reconsider the law." "This law is obsolete." "Thank goodness the law is not respected!"

T-shaped copper IUD, misoprostol, and community education

Our primary focus in this article has been MVA. GCG's trainings, however, also include contracep-

tion sessions with hands-on workshops on how to insert copper IUDs, information on misoprostol protocols for primary and post-abortion care, and consciousness-raising sessions to lower abortion stigma. These trainings run parallel to GCG's community education efforts.

With regard to contraception, we focus on easy access, low cost, long-term effectiveness, minimal inconvenience and likelihood of complication, and ease of insertion and removal. The T-shaped copper IUD fits these criteria, and longitudinal studies conducted by GCG demonstrate women's satisfaction with the method.[21] With regard to misoprostol protocols, we rely on World Health Organization guidelines.[22] For consciousness-raising and stigma reduction, a sharing of experiences in discussion groups and pedagogic conferences on abortion realities in the world help normalize, and thus destigmatize, abortion.

Educational sessions in towns, villages, and high schools on sexuality, contraception, abortion and access to health care are meanwhile ongoing. Women and girls of four generations participate in village meetings. High school principals invite GCG coordinators and medical experts to talk to students. Midwives often co-facilitate meetings and serve as future resource persons. Our answers to the questions raised depend on the reality of quality contraception and post-abortion services in the community. Without those provisions and services, education in low-resource settings frequently turns into warnings and reprimands levied against sexually active women and girls rather than occasions for transmitting information and facilitating access to services.

Discussion: Political strategies and clinical methods

Worldwide, many groups focus on decriminalizing abortion as a necessary condition for women's access to safe services. This legal approach has experienced long-awaited successes, as well as excruciating setbacks. Others focus on mifepristone-misoprostol abortion through on-site or online grassroots provision of the drugs delivered with good information. That global mobilization testifies to the struggle to achieve safe, accessible abortion without professional support or government permission. Both the top-down legal approach to institutional services and the grassroots drug approach to home abortions are vital. There is room and need for multiple tactics in this thorny battle.

The strategy we have presented here is a cross between the institutional and grassroots approach. We are convinced that women need and deserve institutional services provided by well-qualified and well-equipped professionals, especially when faced with life-threatening pregnancy complications. While we advocate for the decriminalization of abortion, we know that services cannot await legal reform; we also know that a good law does not assure accessible services. Our experience tells us that joining forces with well-placed allies within the system is a faster and often more fruitful strategy for change than working with large governmental or nongovernmental organizations for whom grants and ministry approval must precede actions. We find the quiet, direct mobilization of on-site health providers more engaging and more sustainable. The midwives in our network are public health forerunners. They favor legal reform but do not await it to express collective solidarity as health professionals with women: "Thank goodness the law is not respected."

We understand that many abortion rights activists in the world are functioning in places where dying from pregnancy-related causes, other than unsafe abortion, is rare. That is not our situation. We are also aware that home abortions have been taboo in many places until the introduction of misoprostol. In Middle Africa, home abortions have long been the cultural norm, as have home therapies of many kinds; modern medical aid is traditionally more a last resort in case of emergency than a routine support for the healthy. Seeking help after an abortion, whether performed by oneself or a traditional practitioner, fits into the overall pattern of "aftercare," especially for pregnant women. In fact, post-abortion care is the norm for women everywhere if one includes spontaneous abortion, miscarriage, or other organic abortion events; those scenarios are

so common that women often take the precaution to reside near a medical facility during their pregnancy and often wait to announce their pregnancy until after the third month of gestation.

Access to misoprostol has been as revolutionary for women as was access to contraception. Home abortions in Middle Africa with misoprostol (even without mifepristone, the ideal partner drug) are safer than they have ever been; they do, however, still require back-up emergency care in case of complication. Repeated doses of misoprostol may, or may not, resolve incomplete or otherwise ill-turned home abortions. Like all clinical methods, efficacy depends on both physical and social realities. Women in our context do not rush to a medical facility when they see the first signs of complication. They wait, hoping their condition will improve so they can avoid parental scolding, public shaming, or legal sanction, not to mention costs beyond their means and frightful medical intervention. Only when their condition deteriorates badly do they decide to seek help, and then they must still find transportation money and await a bus, boat, or car. By the time they arrive at the hospital, they may have been bleeding for days. Treating a woman at this point with misoprostol does not make sense. The woman needs immediate treatment, not administration of a drug requiring medical surveillance at the hospital. Usually there are no beds available, and, regardless, women dread hospital admittance due to the social exposure and expense. MVA is the most secure and responsible medical response. It is a 10-minute procedure, whereas with misoprostol women must wait hours or days, and aspiration may still be necessary. So clinically, materially, socially, and financially, MVA is the preferable method for the rapid, safe, and effective resolution of post-abortion complications.

Within our context, focusing on follow-up treatment for the full range of induced and spontaneous abortions was realistic, critical, and legally irreproachable since attending to medical emergencies is a professional obligation under all legal regimes. Of course, we know that the tools and skills for post-abortion care are identical to those for inducing an abortion, and we trust midwives and doctors to use their new competence on women's behalf. We disregarded the colonial Napoleonic criminal code that prohibited abortion in Gabon, as in many former colonies of France, since it is irrational, unjust, and life-threatening.[23] We stand by the 40 African states, including Gabon, Cameroon, and Equatorial Guinea, that have signed and ratified the Maputo Protocol recognizing women's right to safe abortion. Like most signatory states, the three countries in our network had not yet legislated their commitment to justice for women when we designed our project. Rather than engage in a tug-of-war with governments, we prioritized strategies that make an immediate difference to women.

In 2019, GCG organized multiple public encounters with health authorities to announce its research findings and discuss obstacles to safe abortion services within the health establishment. As this article goes to press, we are pleased to learn that Gabon legislators have revised the Penal Code to allow abortion in the first trimester of pregnancy for minors in distress and for adults when there is grave fetal deformity, when the pregnancy is the result of rape or incest, and when the pregnant woman's health would be seriously jeopardized by continuation of the pregnancy.[24] We hope to participate in implementing and extending the reform and in facilitating access to primary abortion care as soon as possible.

Conclusion

Looking back at nine years of GCG activism, we see concrete improvements in women's access to post-abortion care. The network has clearly enhanced emergency services in numerous rural and urban sites. The work ahead remains vast, however, in Gabon and, even more so, across the borders. Our greatest success has been mobilizing, training, and legitimizing midwives. This ongoing process has the full support of rural physicians and health administrators. In urban medical facilities, certain physicians resist midwife authority, but most express satisfaction with the significant advantages of teamwork with their midwife colleagues.

Certainly, we hope that by implementing

women's right to the highest attainable standard of health, we will eventually undermine archaic colonial constraints. In Fang culture, there is a tradition of women disobeying the chief's orders to introduce a spirit called Évus. This spirit brings intelligence, knowledge, and determination into the community to "*rend toutes choses possible*" ("make all things possible").[25] GCG midwives ride their own wisdom as they work together to make sex and pregnancy possible for women without trauma, coercion, disability, or death. The crux of our struggle is neither legal nor clinical nor economic, but rather political. Subordination of women is the problem. Respect for women as patients, health care providers, and independent human beings is our essential drug and invaluable instrument for change.

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