Unsafe abortions remain a major concern – and cause of maternal deaths – in Zambia despite the existence of the Termination of Pregnancy Act No. 26 of 1972 and several other policies and guidelines that are intended to prevent unwanted and unintended pregnancies. While these are all regarded favourably by the people who know about them, the fact is that very few Zambians are aware of them. Therefore, it is shocking – but not surprising – that the 2006 University Teaching Hospital facility based data showed that unsafe abortions accounted for 30 percent of all maternal deaths in Zambia.

Understanding the phenomena

Unsafe abortion is a procedure for terminating an unintended pregnancy either by a person lacking the necessary skills or in an environment lacking the minimal medical standards or both.¹

The 2009 Ministry of Health’s Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia² listed a number of consequences of unsafe abortions and reasons for the high number of unintended pregnancies, including:

- Incomplete abortions among women younger than 20 were estimated at 23 percent;
- 25 percent of maternal deaths due to induced abortions were in girls younger than 18;
- 50 percent of acute gynaecological admissions were the result of abortion complications, a big proportion being from unsafe abortion;
- In 1993, over 16,000 maternal hospital admissions nationally were due to abortions performed in the communities by non-professionals;
- Unsafe abortions account for 30 percent of all maternal mortality;
- Insufficient knowledge about women’s rights specifically those related to sexual and reproductive health;
- Stock-outs of reproductive products, such as family planning pills and condoms; and,
- There are often long distances to health care centres and a lack of youth-friendly services and a shortage of human resources.
Legal framework on abortion

Two pieces of legislation are important in understanding abortion provision in Zambia – namely the Termination of Pregnancy (TOP) Act, Chapter 304 of the Laws of Zambia and the Penal Code, Chapter 87 of the Laws of Zambia. However, the two have gaps and omissions that have, in some cases, encouraged women to risk unsafeabortions rather than seek safer options.

Until 1972, the laws relating to abortion were contained in the Penal Code. Section 151 of the Penal Code provides that any person who, with intent to procure the miscarriage of a woman or female child, unlawfully administers to her or causes her to take any poison or other noxious thing or uses any force of any kind or uses any other means whatsoever, commits a felony and is liable upon conviction to imprisonment for a term not exceeding seven years. The Penal Code further stipulates that any woman who administers any poison or noxious thing or uses any force of any kind or uses any other means or permits the same to be done commits a felony and is liable to imprisonment for fourteen years. The Act even extends liability to people who supply to, or procure for, any person anything whatever knowing that it is intended to be unlawfully used to procure the miscarriage of a woman or female child and the punishment is imprisonment for fourteen years. This criminalised abortion, forcing women to resort to unsafe and illegal termination of pregnancies.

Section 152 was amended in 2005 and now allows a pregnancy to be terminated in accordance with the Termination of Pregnancy Act when a female child is raped or defiled and becomes pregnant. This provision comes very close to that in Article 14 of the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa. Unfortunately, this provision does not include pregnancies arising from incestuous relations, which effectively leaves women in that situation with no choice but to resort to unsafe and illegal abortions. Furthermore, while the amendment appears progressive, it only refers to girl children, and excludes women who need abortions after being raped.

In addition to the Penal Code, Zambia has had legislation on abortion since 1972 known as the Termination of Pregnancy (TOP) Act modelled upon that in the United Kingdom. The TOP Act entitles a woman to seek a termination of pregnancy on health and socio-economic grounds, when her own life and health, or the health of other members of her family, may be put at risk by the pregnancy, or when the foetus may be expected to be damaged or diseased. Therefore, Zambia’s abortion law permits pregnancy termination on elective (socio-economic) and medical (health) grounds. The challenge with these provisions is that anything that is not deemed to be a socio-economic or health reason does not qualify as a justification for abortion. This does not give women full choice and control over their bodies.

Similarly, Zambia has several policies on the provision of reproductive health services that are designed to prevent unwanted and unintended pregnancies, such as the gender, population, education, reproductive health and national health policies. The most relevant are the national health policy, which addresses six key areas, including maternal and child health, family planning and HIV/AIDS/STDs, and the reproductive health policy, which raises issues related to adolescent sexual health, violence and the prevention of abortion.

It is worth highlighting here that although these laws and policies are in place, not many Zambian women are aware of them. In some cases, women may know about the laws, but there are still challenges accessing the services for a number of reasons, some of which are highlighted later in this article.

The magnitude of the problem

Information on women who obtain abortions in Zambia generally comes from health care facilities. Women who induce abortions themselves or go to a lay provider and do not seek post abortion care at a hospital are therefore not included. A 1993–1994 study of four facilities found that an average patient seeking care for abortion was aged 24–26 and the mother of two children. Another study showed that women presenting at the University Teaching Hospital in 1990 with complications from unsafe abortions were generally 15–19 years old (60 percent), had some secondary education (55 percent), were unmarried (60 percent), had experienced no previous pregnancies (63 percent) and were students who wanted to continue their education (81 percent). The study found that – compared with women who obtained legal abortions – women who opted for illegal procedures were older (55 percent were aged 20–29) and a higher proportion of them were mothers (71 percent had children). Therefore, unsafe abortion affects women and girls from all sectors of society and this can be attributed to the non-availability of information on safe and legal abortion services.

The challenge of unsafe abortions arises from a combination of factors such as age of sexual debut for females; teenage pregnancies; premarital sexual practices; early marriages; sexual violence against women; fragmentation of the family; media influence; and unmet needs of family. Meanwhile, Zambian women and girls continue to face a challenge to access safe and legal abortions due to provider bias, limited information among women and girls about the Termination of Pregnancy Act, legal requirements, the limited number of sites that perform the procedure, and social and religious
sentiments against abortion – all of which lead an unknown number of women and girls to opt for unsafe and illegal abortions at the hands of untrained people in unsanitary and unsafe conditions.9

National data on abortion in Zambia, which includes hospital records, offers some clues as to the incidence of safe and unsafe abortions. According to data from five major hospitals across Zambia, a total of 616 women obtained safe induced abortions between 2003-2008.10 In contrast, the number of women admitted to hospitals with abortion-related complications (including complications from spontaneous abortion) increased from about 5600 in 2003 to more than 10,000 in 2008 – and totalled 52,791 over the six years. In other words, about 85 times as many women were treated for abortion complications as underwent safe, legal abortions in those five key hospitals. At least half of reported complications were attributable to unsafe abortions. Increasing access to safe abortion would likely decrease the rate of complications and mortality attributable to abortion – a trend that has been noted in other countries, for instance in South Africa.11

Why risk unsafe abortions?

Women’s reasons for terminating pregnancy vary widely, but small-scale studies of patients seeking post abortion care reveal certain patterns. Adolescents’ primary motivation include feeling ashamed because of the stigma attached to unwed motherhood, wanting to continue with school, having been abandoned by their partner, feeling too young to be a mother and being unable to afford to care for a baby. For instance, in a study of patients of all ages, participants wanted to avoid being expelled from school, avoid revealing a secret relationship, protect the health of their existing children and avoid revealing that they had violated cultural norms, such as postpartum sexual abstinence.12

Privacy, secrecy and economic concerns drive many women’s decisions about what type of provider and method to use – and thus determine the risks they face. Women in several studies reported that they, or people they knew, had attempted to self-induce abortions by ingesting the anti-malarial drug chloroquine, herbal remedies, gasoline or detergents. Others had gone to traditional healers, who had given them herbs or inserted cassava sticks or roots into their cervix. A small minority had received abortions from medical professionals, who had used IUDs or plastic cannulas to induce abortions. Meanwhile, a recent study on unsafe abortion in Zambia found that one form of medication for abortion, misoprostol, was widely available in pharmacies and prescribed by some doctors, but there were also reports of women using it without proper instruction.13

The same study noted that economic reasons also contributed to women opting for unsafe abortion methods, as most women cannot afford to pay for safe abortion services. It is ironic that despite the existence of a law that legalises abortion on socio-economic grounds, one of the reasons women decide to undergo unsafe abortions is for economic reasons related to the actual cost of the procedure. Traditional healers charge as little as 5000 Zambian kwacha (US$1) for an abortion, whereas a safe abortion typically costs between 10,000-20,000 Zambian Kwacha (US$2-4) plus 50,000 Zambian Kwacha (US$10) if the woman does not have a referral at a public facility and even more at a private facility. Women who cannot overcome the considerable logistical, financial and social obstacles to obtaining a legal procedure may resort to illegal abortion, risking their well-being and seven years’ imprisonment.14

No systems and mechanisms to match law and policy

Although abortion is legal (well, legal on condition) in Zambia, access to safe abortion services is severely limited as a result of provider biases, limited information among women about the TOP Act, legal requirements, the limited number of sites that perform the procedure, and social and religious sentiments against abortion.15 According to the International Conference on Population and Development (ICPD),16 reproductive health care in the context of primary health care includes, at a minimum, safe abortion services, where legal, and the management of abortion-related complications. Since safe abortion is permissible in Zambia (again on condition), increasing access to safe abortion by reducing the number of doctors’ signatures required and allowing mid-level providers to perform abortions would be both feasible and useful. To deliver on this, there is need for Zambia to have an effective and adequate healthcare delivery system, with sufficient personnel and resources to supply safe and timely services. This is not the case in the country, where many health centres have been equipped to provide all maternal and neonatal services except TOPs. One wonders why TOPs is not prioritised in centres where other systems and resources appear to be in place. Yet, to deliver quality abortion services the health care system should have adequate and trained staff, adequate and accessible health units, affordable services, clear guidelines, a range of abortion methods, appropriate equipment, pharmaceuticals and supplies, information, education and communication materials for the public, and be efficiently run.

In addition, the attitude of the personnel is critical. The Ministry of Health guidelines stipulate that health workers treat women who have undergone induced abortion in a sensitive and humane manner and inform women about the possibility of legal abortion.17 Yet, a recent study found that many health care providers, including doctors, were not aware of the requirements for legal abortion.18 When the law was explained, many thought that requiring the consent of three doctors was unacceptable given the shortage of doctors in most parts of the country. Meanwhile, some expressed interest in being trained to provide legal abortions.
Providers with negative and discriminatory attitudes towards women trying to terminate their pregnancies gave those women lower quality care. Providers’ negative attitudes towards abortion and other types of sexual and reproductive health care may also affect adolescents disproportionally.

The rural–urban divide is another dynamic that affects women’s access to abortion, despite the legal and policy framework that is available. In rural areas, most health centres have serious staff and equipment shortages and are unable to provide a basic package of primary healthcare services or provide 24 hours coverage. Some rural health centres are inadequately staffed with no nurse or midwife and services are delivered by untrained staff. This has serious implications for access to safe abortion, especially if the untrained personnel have negative attitudes towards abortion.

Even though the curriculum for midwives has been expanded in line with the Nurses and Midwives Act to enable them to provide essential reproductive health services, acquiring the skills needed to terminate a pregnancy is still optional for doctors at medical school. This is in line with the right of health care staff to conscientious objection. However, it also reflects the view that abortion is not a priority area and strengthens the belief that it is wrong, further stigmatising and discouraging women from seeking legal abortion.

Other major barriers to accessing safe abortion are administrative problems. Although the TOP Act permits pregnancy termination on health and socio-economic grounds, its implementation is hampered by stringent legal and administrative requirements and definitional issues. Whereas the World Health Organization defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease infirmity, the terms physical and mental health and reasonably foreseeable environment are not defined in the Act. It is thus unclear whether mental health includes psychological distress caused by rape or other sexual assault or detrimental socio-economic circumstances or diagnosis of fatal impairment, which leaves the current law subject to manipulation by those who may be opposed to abortion.

The requirement that three medical practitioners must authorize an abortion also creates serious legal barriers to women’s access to safe abortion. In rural areas where clinics are far away and may not even have three medical practitioners, this is a virtually impossible requirement to comply with. The requirement that one of the medical practitioners must be a specialist in the branch of medicine that the pregnant patient needs to be examined in – for example, mental or physical health – is another serious barrier. In particular, it is not clear how many mental health specialists are available in the country and where they are located, although mental health specialists are included in the minimum staffing requirements for primary health care delivery.
The law also restricts the cadre of workers allowed to perform abortions to registered medical practitioners – and gives medical practitioners the right to conscientious objection. It further restricts the kinds of facilities where abortion can be done to government run and approved hospitals.

However, the stringent rules have been relaxed. The Nurses and Midwives Act was revised in 1997 to expand the range of health care providers who can terminate pregnancies to include nurses and midwives. The Standards and Guidelines for reducing unsafe abortion mortality and morbidity in Zambia also provides that where trained and registered medical practitioners are unavailable, the Permanent Secretary in the Ministry of Health shall make provision for all trained and skilled health providers to administer drugs for termination of pregnancy in accordance with the TOP Act and Midwives and Nurses Act. The guidelines further provide that with appropriate training, health care providers who are not doctors (mid-level providers) can provide first trimester abortions as safely as doctors can and that all the providers performing termination of pregnancies must receive training in the performance of abortions and in the preparation, recognition and management of complications.

In line with the implementation guide for the place for termination of pregnancy, the guidelines provide that hospital means public health facility and or private clinic registered with the Medical Council of Zambia with adequate requirement to perform safe procedures (with trained personnel, equipment, supplies and with hygiene conditions). However, the guidelines further provide that a termination of pregnancy can be carried out in any other ‘place’ regardless of level of care, or health facility, if the termination was an emergency one necessary to save the life or prevent grave permanent injury to the physical or mental health of the pregnant woman. But despite all these more lenient guidelines, only a very limited number of women can access safe abortion services.

Is there any political will to address the challenges?

Abortion and post-abortion care do not appear to have been – or be – a government priority in Zambia. Following the ICPD in 1994, Zambia produced an Integrated Reproductive Health (IRH) package. Although the focus was on safe motherhood, the IRH plan of action did include the production of information, education and communication (IEC) materials on unsafe abortion. However, abortion services and post-abortion care were not among the services envisaged for the community, health post and health centre packages. Post-abortion care services were only incorporated into the district and provincial health packages. In the 2000-2005 IRH action plan, even though one of the specific objectives was the provision of quality reproductive health care services, the only activity in the work plan relating to safe abortion was the implementation of the Nurses and Midwives Act.

And even though the IRH plan of action indicated that IEC materials on unsafe abortions would be produced, this information is not available in either English or local languages. Therefore, only a few women and girls are aware of the dangers of unsafe abortion or the provisions of the TOP Act.

Conclusion

Much as unsafe abortion is a public health issue in Zambia, it is also a human rights issue, and can be better addressed by conducting a human rights needs assessment which would involve assessing the scope, causes, and consequences of unsafe abortion in particular communities and nationally. The assessment should identify laws, including the language of enacted laws and the decisions of the courts, and the policies of the government, health care facilities, and other influential agencies, which facilitate or obstruct the availability of, and access to, abortion services. The extent to which laws that would facilitate access are actually implemented or how they might be should be determined.

Laws and policies that limit women’s autonomy and choice regarding their health in general and abortions in particular should also be identified, along with laws that facilitate women’s empowerment, and laws that obstruct such empowerment. Only then can we begin to talk of Zambia creating a progressive environment that allows for women and girls to fully enjoy reproductive health, including abortion.
Endnotes

2. The Standard and Guidelines are directed at health providers, managers and policy makers involved in the provision of abortion related services, contain guidance on what, how and by whom, and in which facilities services can be provided and seek to ensure that women prevent unwanted pregnancies and those unwanted, unintended or risky pregnancies get appropriate services to prevent the occurrence of unsafe abortions and associated morbidity and mortality, Page xi.
3. The Penal Code, Chapter 87 of the Laws of Zambia
4. Section 152, Penal Code Act, Chapter 87 of the Laws of Zambia
5. Section 153, Chapter 87
10. Likwa RN, Abortion statistics in Zambia: research in brief, Lusaka, Zambia: Department of Community Medicine, School of Medicine, University of Zambia, 2009.
18. Ministry of Health, Strategic assessment of policies, programmes and research issues related to prevention of unsafe abortion in Zambia.