GUTTMACHER INSTITUTE

In Brief

2009 Series, No.3

Unsafe Abortion in Zambia

In Zambia, because safe, legal abortion is inaccessible to many women, an unknown number of women each year resort to illegal abortions, many of which are performed under unsanitary and unsafe conditions. The death toll from these procedures is likely high, and almost all such deaths could be avoided if access to safe abortion were improved and unintended pregnancies were prevented.

Zambia's abortion law permits pregnancy termination on health and socioeconomic grounds (see box, page 2).[1] However few women who need an abortion can meet requirements that it be performed by a physician, in a hospital and with the consent of three registered medical practitioners, one of whom must be a specialist with expertise relating to the case. (In emergency situations, consent from only one physician is needed.) That there are fewer than two physicians for every 10,000 people in Zambia is just one of the hurdles women face when seeking a legal abortion.[2] Others include the cost of the procedure and the strong social and religious sanctions against abortion. Women who cannot overcome the considerable logistical, financial or social obstacles to obtaining a legal procedure may resort to illegal abortion, risking their well-being and seven years' imprisonment.[3]

Experts in Zambia have suggested increasing access to safe abortion by reducing the number of doctors' signatures required and allowing midlevel providers to perform abortions.[4] However, inaction by policymakers, persistent stigmatization of abortion, lack of awareness of abortion laws and a shortage of health care personnel and resources continue to act as barriers to safe services.

Determining the scope of unsafe abortions and the unintended pregnancies that precede them is an important step toward achieving effective policies to reduce maternal deaths and improve the reproductive health of Zambian women.

The Level of Abortion

In Eastern Africa as a whole, an estimated 14% of all pregnancies end in abortion; in 2003, there were an estimated 2.3 million induced abortions in the region (Table 1, page 2).[5] That translates to 39 abortions per 1,000 women of reproductive age, or about 20 abortions per 100 live births. The majority of these abortions were illegal and were likely performed under unsafe conditions. As a result, for every 100,000 live births occurring in Eastern Africa, an average of 160 women die from causes related to unsafe abortion—more than in any other region of the world.[6]

No national data on abortion are available for Zambia, but hospital records offer some clues to the incidence of safe and unsafe abortion. According to data from five major hospitals across Zambia, a total of 616 women obtained safe induced abortions between 2003 and 2008 (Figure 1, page 3).[7] In contrast, the number of women admitted to the hospitals with abortion-related complications (including complications from spontaneous abortion) increased from about 5,600 in 2003 to more than 10,000 in 2008—and totaled 52,791 over the six years. In other words, about 85 times as many women were treated for abortion complications as underwent safe, legal abortion in these five key hospitals. At least half of reported complications were attributable to unsafe abortion. Increasing access to safe abortion would likely decrease the rate of complications and mortality attributable to abortion, a trend that has been noted in South Africa.[8]

Health Care Providers' Attitudes About Abortion

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.[9] Yet a recent study found that many health care providers (including doctors) were not aware of the requirements for legal abortion.[10] When the law was explained, many thought that requiring three doctors' consent was unacceptable because of the shortage of doctors in most parts of the country; some expressed interest in being trained to provide legal abortions.

Some health care providers are uncomfortable with the issue of abortion or hold judgmental attitudes toward abortion patients.[10–12] Interviews with providers revealed that those with negative and discriminatory attitudes about women trying to terminate their pregnancies gave those women lower quality care.[11] Providers' negative attitudes toward abortion and other types of sexual and reproductive health care may affect adolescents disproportionately. In 2001, 94% of

Termination of Pregnancy Act of 1972

In Zambia, abortions are allowed under the following circumstances: "(a) continuation of the pregnancy would involve risk to the life of the pregnant woman; risk of injury to the physical or mental health of the pregnant woman; or risk of injury to the physical or mental health of any existing children of the pregnant woman; greater than if the pregnancy were terminated; or (b)…there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be severely handicapped. In determining whether the continuance of a pregnancy would involve such risk[s]…account may be taken of the pregnant woman's actual or reasonably foreseeable environment or of her age."

Source: reference 1.

nurse-midwives in public and private health facilities in two districts felt that abortion should not be an option for adolescents with unintended pregnancies.[12]

Characteristics of Women Having Abortions

Information on women who obtain abortions in Zambia generally comes from health care facilities. Women who induce abortion themselves or go to a lay provider and do not seek postabortion care at a hospital are therefore not included. A 1993–1994 study of four facilities found that the average patient seeking care for abortion complications was aged 24–26 and the mother of two children.[13] Another study showed that women presenting at University Teaching Hospital in 1990 with complications from unsafe abortion generally were 15–19 years old (60%), had some secondary education (55%), were unmarried (60%), had had no previous pregnancies (63%) and were students who wanted to continue their education (81%).[14] That study found that compared with women obtaining illegal abortions, women seeking legal procedures were older (55% were aged 20–29) and a higher proportion were mothers (71% had children).

Why and How Zambian Women Obtain Abortions

Women's reasons for terminating a pregnancy vary widely, but small-scale studies of patients seeking postabortion care reveal certain patterns. Adolescents' primary motivations 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 having a baby.[3] 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.[15]

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.[3,9,15] Women in several studies reported that they, or people they knew, had attempted to self-induce abortion by ingesting the antimalarial 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 abortion. A recent study of unsafe abortion in Zambia found that one form of medication abortion, misoprostol,* was widely available in pharmacies and prescribed by some doctors, but there were also reports of use without proper instruction.[10]

The same study noted that traditional healers may charge as little as ZK5,000 for an unsafe abortion, whereas a safe abortion typically costs ZK10,000–20,000 (plus ZK50,000 if the woman does not have a referral) at a public facility and even more at a private facility.[10]

Consequences of Unsafe Abortion

The most severe consequence of unsafe abortion is death. The maternal mortality ratio in Zambia stands at 591 deaths per 100,000 live births, as of 2007,[16] and a significant proportion of these deaths are likely due to unsafe abortion. Data from four districts in Western Province suggest that in 1994–1995, about 120 deaths occurred as a result of induced abortion for every 100,000 live births.[15] More than half of these deaths were among schoolgirls. Another study estimated that in 1993, 15% of all maternal deaths in Lusaka were due to unsafe abortion.[17]

For each woman who dies as a result of unsafe abortion, many more experience complications. In 2000–2008, some 66,579 women were admitted to five major Zambian hospitals for abortion-related complications, accounting for slightly more than one-third of all gynecologic admissions.[7] However, seeking postabortion care from Zambia's underresourced health care system is not a simple matter. As of 2004,

*The drugs misoprostol and mifepristone safely terminate pregnancy, but neither is currently registered in Zambia for this purpose.

Table 1

Abortion, Unplanned Births and Contraceptive Use

Zambian women experience high levels of unintended pregnancy.

Abortion	
Estimated no. of induced abortions in Eastern Africa	2,300,000
% of pregnancies ending in abortion in Eastern Africa	14
% of maternal deaths that are due to unsafe abortion in Eastern Africa	17
Maternal deaths per 100,000 live births in Zambia	591
Unplanned births	
Among women aged 15–49	
% of births that were unplanned	41.4
Unwanted	15.8
Mistimed	25.6
Contraceptive use and unmet need	
Among women aged 15–49	
% of currently married women using contraceptives	40.8
Any modern method	32.7
Any traditional method	8.1
% of currently married women with an unmet need for contraception	26.5
% of sexually active unmarried women using contraceptives	47.6
Any modern method	43.5
Any traditional method	4.0
% of unmarried women with an unmet need for contraception	4.4

Note: Data for Zambia are from 2007; regional data are from 2003.
Sources: **Regional abortion data**—reference 5. **Regional maternal mortality data**—reference 6. **All data for Zambia**—reference 16.

there were only 1.3 physicians, 17.4 nurses and 2.7 midwives for every 10,000 Zambians.[2] It is therefore likely that a large proportion of women experiencing complications are unable to obtain professional care. Of the women who were able to obtain treatment in the 2000–2008 study, six in 1,000 nonetheless died as a result of their abortion complications.[7]

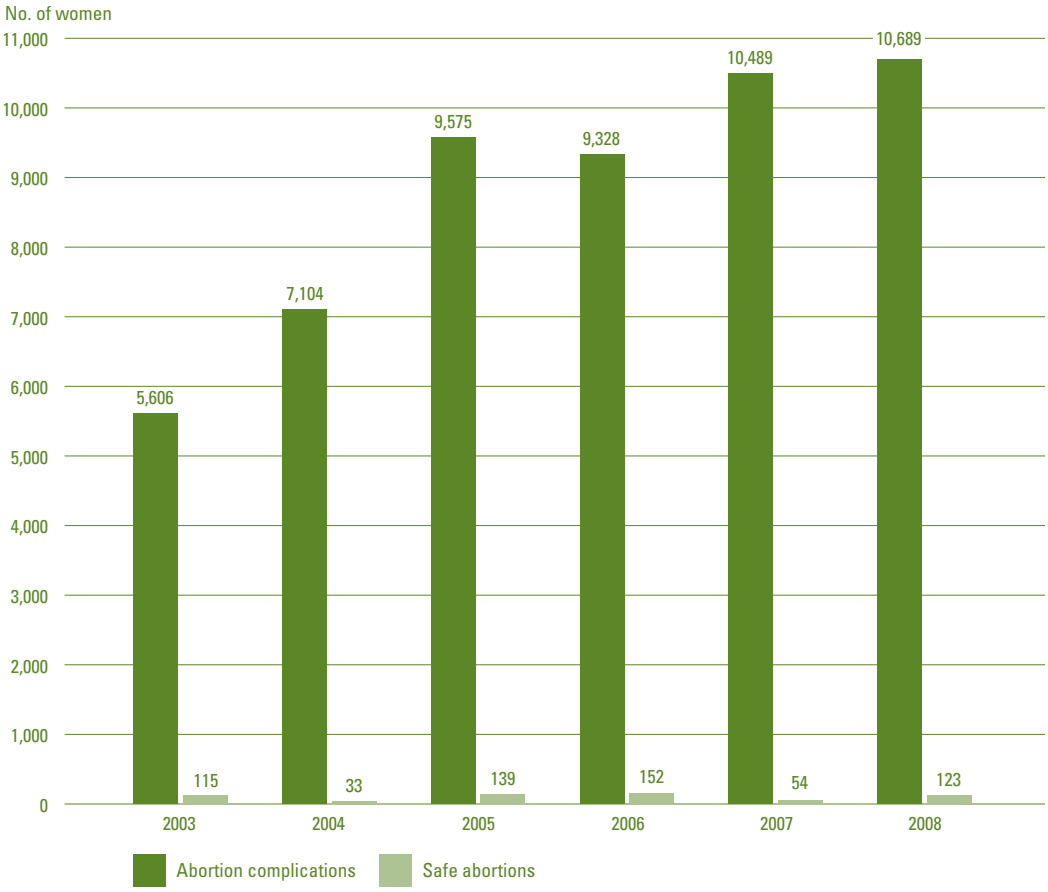
Unmet Need for Family Planning

In the vast majority of cases, women seek abortion because they are faced with an unintended pregnancy. In Zambia, 41% of births are unplanned, and the average women gives birth to about one child more than she wants, indicating that unintended pregnancy is very common.[16] Many women and couples are at risk for unintended pregnancy because they have an unmet need for contraception; that is, they want to delay or stop childbearing, but they are not practicing contraception. About one in four married women have an unmet need for contraception, and while this proportion decreases as education and economic status rise, nearly one in five women in the highest wealth quintile have an unmet need. However, progress is being made: Levels of contraceptive use increased between 2001–2002 and 2007 among both married women (from 34% to 41%) and sexually active unmarried women (from 33% to 48%). Yet, demand for family planning keeps growing, causing the level of unmet need to remain relatively static.[16,18]

Figure 1

Abortion Complications

In five major hopsitals, women treated for abortion complications far outnumber those who obtain safe abortions.



Source: reference 7.

Needed Evidence on Abortion

The following research objectives have great potential to support policy changes that would improve services for Zambian women and prevent maternal deaths:

• *Measure abortion and its consequences.* A nationally representative study estimating abortion incidence and the severity of related complications would be useful for increasing awareness of the health consequences of unsafe abortion. It would also serve as a baseline for measuring how effectively new medical guidelines (currently in development) increase access to safe abortion and decrease abortion-related complications and death.

• *Examine ways to offer medication abortion.* Medication abortion, an extremely safe and relatively low-cost form of early abortion, is not widely available in Zambian health facilities. Operations research on how to train providers and where to offer the procedure could result in safer abortion.

Going Beyond Research Evidence

Even with new evidence on the scope of unsafe abortion in Zambia and ways to make the procedure safer and more accessible, unsafe abortions will continue to pose a threat to the health of Zambian women unless steps are taken to prevent them.

• *Strengthen family planning service provision and demand.* Providing family planning services and information—including ensuring the availability of contraceptive supplies and training providers to help educate women and men about methods—could reduce the incidence of both unsafe abortion and abortion-related complications by preventing unintended pregnancy, especially among adolescents and people living in rural areas

• *Improve availability of and access to safe, comprehensive*

abortion care, including post-abortion care. To ensure that safe abortion is available to the extent allowed by law, Zambia should consider the World Health Organization's recommendations for safe provision, which include training providers about safe and aseptic abortion practice, ensuring the availability of needed equipment and supplies, and promoting the use of the safest methods for first-trimester abortions, including manual vacuum aspiration and medication abortion.[19] Progress in Zambia could be furthered by programs to reduce the stigma surrounding abortion and by including training in safe abortion services as a formal component of medical curricula.

REFERENCES

1. Termination of Pregnancy Act, Laws of Zambia, Ch. 304, 1972.

2. World Health Organization (WHO), *The World Health Report 2006: Working Together for Health,* Geneva: WHO, 2006.

3. Dahlback E et al., Unsafe induced abortions among adolescent girls in Lusaka, *Health Care Women International,* 2007, 28(7):654–676.

4. Ipas and Division of International Health, Department of Public Health Sciences, Karolinska Institutet, *Deciding Women's Lives Are Worth Saving: Expanding the Role of Midlevel Providers in Safe Abortion Care,* Chapel Hill, NC, USA: Ipas, 2002.

5. Sedgh G et al., Induced abortion: estimated rates and trends worldwide, *Lancet,* 2007, 370(9595):1338–1345.

6. WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003,* fifth ed., Geneva: WHO, 2007.

7. Likwa RN, Abortion statistics in Zambia: research in brief, Lusaka, Zambia: Department of Community Medicine, School of Medicine, University of Zambia, 2009.

8. Jewkes R et al., The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change, *British Journal of Obstetrics and Gynaecology,* 2005, 112(3):355–359.

9. Mtonga V and Ndhlovu M, Midwives' role in management of elective abortion and post-abortion care: Zambia country report, paper presented at the conference Expanding Access: Advancing the Roles of Midlevel Providers in Menstrual Regulation and Elective Abortion Care, Pilanesberg National Park, South Africa, Dec. 2–6, 2001.

10. Ministry of Health, Strategic assessment of policies, programs and research issues related to prevention of unsafe abortion in Zambia, unpublished report, Lusaka, Zambia: Ministry of Health, 2008.

11. Kaseba C et al., *The Situation of Postabortion Care in Zambia: An Assessment and Recommendations,* Research Triangle Park, NC, USA: Research Triangle Institute, 1998.

12. Warenius LU et al., Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia, *Reproductive Health Matters,* 2006, 14(27):119–128.

13. Kinoti SN, Gaffikin L and Benson J, How research can affect policy and programme advocacy: example from a three-country study on abortion complications in Sub-Saharan Africa, *East African Medical Journal,* 2004, 81(2):63–70.

14. Likwa RN and Whittaker M, Women presenting for abortion and complications of illegal abortions at the University Teaching Hospital, Lusaka, Zambia, *African Journal of Fertility, Sexuality and Reproductive Health,* 1996, 1(1):42–49.

15. Koster-Oyekan W, Why resort to illegal abortion in Zambia? findings of a community-based study in Western Province, *Social Science & Medicine,* 1998, 46(10):1303–1312.

16. Central Statistical Office et al., *Zambia Demographic and Health Survey 2007,* Lusaka, Zambia: Central Statistical Office; and Calverton, MD, USA: Macro International, 2009.

17. Syacumpi MM et al., *Country Analysis of Family Planning and HIV/AIDS: Zambia,* Washington, DC: Policy Project, 2003.

18. Westoff CF, New estimates of unmet need and the demand for family planning, *DHS Comparative Reports,* Calverton, MD, USA: Macro International, 2006, No. 14.

19. WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems,* Geneva: WHO, 2003.

CREDITS

This *In Brief* was written by Rosemary Ndonyo Likwa, University of Zambia, and Ann Biddlecom and Haley Ball, both of the Guttmacher Institute. The authors thank the following colleagues for their helpful comments and suggestions on early drafts: Akinrinola Bankole and Leila Darabi, Guttmacher Institute; Stephen Mupeta, University Teaching Hospital, Zambia; Amos Mwale, Youth Vision Zambia; and Duah Owusu-Sarfo, United Nations Population Fund.

Suggested citation: Likwa RN, Biddlecom AE and Ball H, Unsafe abortion in Zambia, *In Brief,* New York: Guttmacher Institute, 2009, No. 3.

Advancing sexual and reproductive health worldwide through research, policy analysis and public education

New York
125 Maiden Lane, New York, NY 10038
Tel: 212.248.1111
Fax: 212.248.1951
info@guttmacher.org

Washington D.C.
1301 Connecticut Avenue, N.W., Suite 700
Washington, DC 20036
Tel: 202.296.4012 Fax: 202.223.5756
policyinfo@guttmacher.org

www.guttmacher.org

November/2009