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**Midwives' role in management of elective abortion
and post-abortion care**

Zambian Country Report

Velepi Mtonga

Martha Ndhlovu

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CBoH	Central Board of Health
CPR	Contraceptive Prevalence Rate
FP	Family Planning
GRZ	Government of the Republic of Zambia

GNC	General Nursing Council
HIV	Human Immune Virus
HMIS	Health Management Information System
IEC	Information Education and Communication
KCH	Kitwe Central Hospital
MVA	Manual Vacuum Aspiration
MOH	Ministry of Health
NCH	Ndola Central Hospital
NGO	Non Governmental Organization
OJT	On The Job Training
Ob/Gy	Obstetrics and Gynaecology
PAC	Post Abortion Care
PHC	Primary Health Care
RH	Reproduction Health
SAP	Structural Adjustment Programme
SHO	Senior House Officer
STI	Sexually Transmitted Diseases
TOP	Termination of pregnancy
TBA	Traditional Birth Attendants
UTH	University Teaching Hospital
ZNA	Zambia Nurses Association

1 Country profile on health services

Zambia is a landlocked country with an area of 752,612 square km (2.5% area of Africa). The

preliminary estimate for the 2000 population of Zambia is 10,285,631; of the total 5,070,891 are males while 5,214,740 are females. The growth rate for Zambia between 1990 - 2000 was 2.9% as compared to 3.1% in 1980 - 1990. This shows that Zambia's average annual population growth rate declined by 6.4%. Copperbelt province has the highest population followed by Lusaka, Northern, and Southern and Eastern provinces. Northwestern has the lowest population followed by Western ⁽¹⁾.

Zambia is one of the poorest countries in the world with very high inflation rates and is implementing the Structural Adjustment Program (SAP) now called the Poverty Alleviation Program. The economic recovery program was introduced to turn around the protracted decline of the economy into a sustainable position and consequent improvement in living standards and quality of life for the people ⁽²⁾. For example almost 85% of Zambians earn less than US\$1 per day and the incidence of poverty has risen from 69% to 73% between 1996 and 1998 with majority of the poor living in the rural areas. Zambia also recorded an increase in deprivation for its households from 35.1% in 1996 to 38.4% in 1997 (UNDP 1998). Inequities exist along geographical and gender lines. For example women are more constrained in their access to health care than men for financial, educational and social reasons.

In 1991 the Zambian government embarked on a process of Health sector reforms with the aim of not only improving the accessibility of health services and reducing mortality and morbidity, but also improving quality of life for all Zambians. The reform process involved the establishment of Central Board of Health (CBoH) in 1996 which acts as a technical unit responsible for the delivery and implementation of health reforms and the development of the primary health care (PHC) program, which constitutes an important component of the health care delivery system. This has entrusted decentralization of the health services with responsibility of planning, implementing, monitoring and managing PHC program to District Health Boards.

The government through the ministry of health (MOH) is the main source of funding for the health sector contributing 57% with cooperating partners contributing 43% in the year 2000 and the community contributing through user fees and being actively involved in the decision making process through Neighborhood Health committees.

One of the major achievements of the 1990's reform has been the pooling of GRZ and donor funds to support the running costs of the district and their Hospital Management Boards (the district basket).

The reforms however have gone "off the rails" and need to be placed "back on track" as there seemed that more emphasis was placed on systems development rather than effecting early and much needed improvement in service delivery. (Sector wide approach to health a proposed Health sector supplied investment programme (2001-2005) Joint identification and formulation mission for Zambia. (Vol. 2 analysis of the health sector March 2000)

The paradigm shift from systems development to services delivery was subsequently recognized in the 1998 - 2000 National Strategic Plan but has proved difficult to deliver due to limited resources and rising demands for services provision with the impact of the HIV/AIDS pandemic.

1.1 The Impact of HIV/AIDS.

HIV prevalence remains high at almost 29% in urban areas and 14% in rural areas (MoH/CBoH, 1999). There are positive trends in the 15 - 19 year group where prevalence is dropping. This is attributable to behavior change, though there are concerns that such behavior change may not be sustained (UNICEF -1999a).

Zambia's burden of disease has significantly changed due to HIV/AIDS. The number of households experiencing chronic illness and death is increasing with a corresponding increase in the number of orphans estimated at 950,000 (CSO - 1998).

HIV/AIDS has also brought disruption and changes in social networks and support systems due to vastly increased burden of care on the health sector, communities and households. For example, women carry a much greater burden of care created by HIV/AIDS, as well as being more vulnerable for both physiological and social reasons.

1.2 Reproductive Health statistics

A review of secondary data from the Health Management Information Systems (HMIS) reveals that preventable health problems are still the predominant causes of morbidity and mortality.

Women and children are still the most commonly affected by diseases. While milestones have been achieved with interventions for childhood diseases in effectively reducing deaths and disability, the same cannot be said about women's health problems. Pregnancy and childbirth disorders are the second main reason for hospital admission amongst females over 15 years. Safe motherhood strategies and Interventions put in place by Government to improve women's health, have not yet borne fruit especially in the rural areas as manifested by the high maternal mortality rates, at 649/100,000 live births with some rural area rates being as high as 889/1,000,000. The five major causes of maternal mortality are Hemorrhage (34%), Sepsis (12%), Eclampsia (5%), Obstructed labor (8%) and unsafe Abortion (4%) (Nsemukila et al 1998). Other causes include Malaria (11%) and HIV/AIDS (10%).

Table 1 Reproductive health and abortion statistics

	1980s	1990s
Birth rate		
Fertility rate	6.5	6.1
Maternal mortality	200	649/100,000
CPR		26%
Age at first birth		18-19 years
Birth interval		32 months

Life expectancy at birth (in 2000) is 35 years for women and 37 years for men. Fertility rate declined to 6.1% in 1990 from 6.5 % in the 1980s. Fertility is lower in urban (5.1) population than in rural (6.9) population. 30% of women will have given birth at 18 years of age and 66% by 20 years. More than 31% of teenage girls begin child bearing at 15-19 years of age.

Many factors contribute to the low quality of women's reproductive health services in Zambia. The most significant of these are lack of appropriate infrastructure and referral system, inadequate supplies, equipment and drugs, lack of skilled staff, gaps in the content of service provided and in the implementation of policy that guide the services. The patient factors include maternal age at first pregnancy, lack of family planning and high parity, lack of knowledge of

risk factors and complications, poor access to health facilities and harmful practices. Over the next five years, 1.2 million Zambians will come of childbearing age. This is a major concern given the risk associated with pregnancies, unsafe abortions and sexually transmitted infections among teenagers. Contributing factors include lack of education and information, lack of negotiating skills, poverty, cultural practices and inaccessible or non-youth oriented health services ⁽³⁾.

Reproductive health services include: ante-natal care, contraceptive services, STD/HIV (preventive), adolescent health being provided at public health centers at primary level, cervical cancer screening and abortion services. Legal surgical and medical management of abortion being offered only at tertiary centers i.e. UTH in the gynae emergency ward and gynae in-patient wards and Ndola Central Hospital offers TOP on medical grounds only.

1-3. Magnitude of the problem of unsafe abortion

From the Zambia Demographic and Health Survey (1996), it was estimated that there are 115,000 abortions per year in Zambia and that 46,000 were induced ⁽⁵⁾.

There is certainly under reporting of contributions of abortion related maternal mortality and morbidity due the fact that not all Termination of Pregnancy (TOP) are performed in the hospital. Hospitals may be used only if complications arise. Also the stigma of abortion traditionally dictates the secrecy of the procedure. Hospital based studies of maternal mortality in 1983 by Mhango et al ⁽⁴⁾ indicated that abortion contributed 15%. In a multi-center hospital based study by Mati et al unsafe abortion contributed 30% ⁽⁶⁾ and in a nation wide retrospective case control study by Nsemukila et al (1998)⁽⁷⁾, abortion contributed 4%. Perhaps the design was not appropriate for abortion, given the clandestine nature but unsafe Abortion was still among the 5 major causes of maternal mortality.

i. ADOLESCENTS

Zambia Demographic Health Survey (1996) revealed that despite the adolescents' high risk of sexually transmitted diseases (STDs), unwanted pregnancies, and illegal abortions, they were often excluded from receiving reproductive health services. According to the situation analysis by Kaseba et al (1998)⁽¹⁴⁾ it was observed that limited access to quality family planning services in rural areas and among young women contributes to the high rate of unsafe abortion and abortion complications in Zambia. Health care providers interviewed in this assessment confirmed that the majority of post-abortion patients are young women, often in their early teens and in school, most are not counseled on the use of modern contraception.

Many more health facilities and hospitals have realised that there is need to have youth friendly corners where information can be given to youths on reproductive health and sexuality. A number of NGOs are working in collaboration with the CBoH to educate youths on their reproductive health and have assisted in the setting up of youth friendly corners in health centers.

ii. Demand for TOP

With a young active population and a reproduction health profile characterized by high fertility, low CPR and high perinatal and maternal mortality rates, access to contraception to prevent unwanted unplanned pregnancy and access to legal safe abortion is still remote. This has led to an environment promoting unsafe illegal abortions and increased abortion related mortality. In 1983 the MOH reported a total of only 1164 cases of illegally induced abortions. The same report, reports 14,940 and 16,977 cases of "unspecified abortions" in 1982 and 1983

The women often obtain TOP services from unskilled providers, often untrained community

members known to provide such services. Such abortion lead to high rates of infection, serious injuries, infertility and often death. This places a great burden on the hospital budgets, as they have to treat such cases with expensive antibiotics and increases the hospital stay of the patient.

However elective legal TOP is offered at the UTH and Table 2 shows the number done between 1996 and 2000.

TABLE 2. Elective TOP at UTH, 1996 – 2000

YEAR	Number of TOP
1996	1570
1997	1661
1998	840
1999	212
2000	138

1996 saw a marked increase in elective abortion due to the fact that the hospital had introduced private practice and elective abortion was provided at a low cost of ZK10, 000 (\$3) and the surgeon was paid a fee. With the withdrawal of private practice there was a sharp decline in elective TOP as seen in the above table. Other hospitals performed few TOPs but records were poorly kept. For example, in Ndola, 7 cases were recorded, in Livingstone District Hospital, 22 cases were recorded over 13 months and in Mongu, only 1 case was recorded for the previous year. In all these hospitals TOPs were performed under GA using sharp curettage (SC). However 10 - 20 TOPs were probably performed but not documented. (Kinoti et al - Monograph.Unpublished? year).

The demand for services is there and we have a challenge to prevent unwanted pregnancy and also to capture all women requiring TOPs so that they may be offered safe legal abortion.

1.4 Demand for PAC services

i. Post abortion care in Zambia

Post abortion care services were introduced in Zambia following the situation analysis by Kaseba et al (1998). Some of their key findings were:

- Capacity for emergency care is limited.
- Manual vacuum aspiration not widely used or available
- Infection control procedures vary widely, with most sites finding difficulties applying infection control principles
- PAC emergency care not linked to family planning counseling and other reproductive health services.
- Standards of care and protocols are not in place
- Supervision of hospitals minimal

- Support system for service delivery are weak

They noted that other elements of PAC service delivery that needed improvement were:

1. Service - delivery infrastructure e.g. referral systems and transport, counselling rooms, Gynaecology couches and lamps and adequate numbers of trained personnel
2. Logistics and distribution of expendable supplies for emergency treatment e.g. gloves, cotton wool, blood, disinfectants, etc, and family planning commodities
3. IEC materials and strategies, and
4. Information systems for monitoring and evaluation.

The CBoH with other stakeholders, through the PAC national task force which was formed in 1998 have put in place a strategy to source for the necessary equipment and training of staff to improve the delivery of comprehensive quality PAC services. So far these are bearing fruit. The three institutions that have been made into training centers are now training staff using on the job training (OJT) approach. Key staff who were identified (nurse/midwives and doctors) have been equipped with necessary knowledge and skills. These are now training other health providers within their hospitals and districts. The main aim of the CBoH is to scale up the services to at least 100 service sites. The Churches Medical Association of Zambia (CMAZ) has also been training staff in church mission hospitals in the provision of PAC services

2 Abortion laws and policies

Zambia has had one of the most ‘ liberal ‘ laws on abortion in Sub - Sahara Africa. The Termination of Pregnancy Act of 1972 permits abortion if continuation of pregnancy involves the risk to the life or injury to the physical or mental health of the mother, or if there is substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be severely handicapped. A legal abortion can also be obtained if continuation of pregnancy involves a risk of injury to the physical or mental health of any of her existing children ⁽⁸⁾.

Below is the summary of the abortion legislation:

Termination of pregnancy before viability i.e. the cut off point is 28 weeks.

Liberal law in Africa as it allows TOP for health and social economic reasons.

Requires signatures of 3 physicians one of whom must be specialist in the branch of medicine related to the patient’s reason for seeking abortion.

The operations should be performed in hospitals legally defined as: Any institution run by government or any other institution approved in writing by the permanent secretary of ministry of health (MOH).

Consent should be given by the one seeking abortion.

The ground on which TOP is permitted has to be clearly stated.

Penal code stipulates a penalty of Zk 200.00 for illegal abortion seekers and providers.

Notifiable within 24 hours of emergency TOP and 7 days of elective TOP to the Permanent Secretary of the MoH using a special form.

Medical Practitioners are not obliged to perform TOPS

The law is both oblique and explicit. Oblique in that it is subject to administrative professional discretion and explicit in that it confers users to seek the services when the need arises. Although the Act is said to be liberal compared to others in the Sub-Saharan region, it is restrictive in that the conditions in the law render hospital abortion services inaccessible to the majority of women who live far from the hospital and one can hardly find even a single physician present in the remote areas of Zambia.

2.1 Provider profile

Reproductive health services are provided by medical doctors, midwives, nurses and traditional birth attendants (TBAs). TBAs provided and still provide advice during antenatal and postnatal period. They also conduct deliveries especially in the rural areas. The MOH invested in the training of TBAs in a quest to provide a safe and clean delivery in rural areas where there is poor access to proper reproductive services. The same investment has not been in abortion services. There is need to give adequate information to TBAs on where one can procure safe legal abortions.

The training of midwives in Zambia started way back in February 1971 for Enrolled Midwives and July 1971 for Registered Midwives and takes one year. Since then Zambia has trained 4811 enrolled midwives and 4497 registered midwives.

After completion of general nurse training, the nurses are deployed in non-delivery areas, which includes gynae wards where abortion patients are cared. These are expected to offer both pre and post abortion counseling and emergency resuscitation for patients presenting with complications of abortion. They do not offer MVA. Midwives largely provide uncomplicated antenatal, delivery and post-natal care including contraceptive services. Midwives work independently but refer at risk patients to medical doctors.

Clinical officers receive a 2-year training but their curriculum does not allow them to cover sufficient experience in gynae and obs and are not allowed to provide abortion services.

The medical school in Zambia was opened in 1967 and the first medical students graduated in 1974. About 841 Zambian doctors have so far graduated from the University of Zambia (UNZA) school of medicine. The under graduate program is seven years. Thereafter they rise through the ranks of junior resident medical officers, senior house officers and after another year of postgraduate they become registrars. The four year Master of Medicine programme (Mmed) started in 1986 and twelve (12) candidates have so far graduated in the department of Obstetrics and Gynaecology. This confers specialist status. All the levels of medical doctors provide various degrees of reproductive health care including management of patients with complications of abortion with the specialist (if available) dealing with the more complicated cases.

The specialists are concentrated at the only teaching hospital, The University Teaching Hospital (UTH). The other hospitals are largely run by SHOs / GMOs who can provide complicated and surgical treatment for obs and gynae patients. During the 7year training for their first degree, the 7th year students have to perform five (5) MVAs for abortion complications and also have didactic lectures on the TOP Act. As interns they perform all evacuations after a brief induction. After internship those that remain at UTH, Ndola and Kitwe Central hospitals continue to provide evacuations using MVA and those posted to the district hospitals use sharp curettage under General Anesthesia, as they lack the MVA kits.

For postgraduate students in obs and gynae i.e. interested Registrars undergo unstructured

training in provision of elective TOP. Acquiring this skill is optional, but acquiring MVA skills for care of abortion complications is mandatory.

2.2 Knowledge, Attitudes and perception of abortion

Despite the law being ‘ liberal ‘ there is no evidence that the issue of abortion has even been debated publicly. Macwangi (1993) rightly refers to abortion as a **SILENT** problem .The Zambian society is generally not very open to sexual matters, worse still issues related to abortion. In recent years, due to the issue of HIV/AIDS, people are slowly opening up to sexual issues. Now on radios and television programs more and more people are talking about sexuality. But this is still being done with a lot of caution. In schools sex education is not compulsory. Children learn about sex during biology lessons and HIV/AIDS clubs.

In the community mostly Non-Governmental Organizations (NGO) are working hand in hand with the government to educate and discuss sexual issues including contraception, abortions, STIs including HIV/AIDS. There is still a lot of IEC to be given to the community on the importance of seeking counsel on the issue of abortion, and the importance of preventing unwanted pregnancy. The church and other church organizations have also stepped up the education on reproductive goals. One such organization is the Youth for Christ which has introduced an Options Crisis Pregnancy Center in Ndola (1999), where they seek to assist the youths who have preferred to keep their pregnancies and those that are going through an emotional crisis after going through an abortion. They also teach chastity and abstinence to youths in schools and counseling in various areas that affect the youths.

i. POLICY MAKERS

Although many researchers have shown that unsafe abortion is a public health hazard policy makers have remained silent on the issue of providing accessible safe legal abortions preferring to deal with complications that arise from unsafe illegal abortions. To that effect the CBoH has introduced a comprehensive Post-Abortion Care programme to deal with this. They have also addressed the issue of prevention and management of abortion in the ‘Family Planning in Reproductive Health: Policy Framework, Strategies and Guidelines which stipulates that all health workers will address the problem of contraceptive failure or induced abortion in a sensitive and humane manner and will counsel women and inform them about the possibilities of legal abortion and its requirements according to the Termination of Pregnancy Act of 1972. But there exists a gap between policy and implementation.

ii. PATIENTS PERCEPTIONS

Knowledge about abortion and about where and how to obtain one outside of the formal medical sector is wide spread among Zambian women and adolescents.

Because of low availability of medical care services and the high costs, many women resort to self-induced abortions. The judgmental attitudes of both the community and the health providers has contributed to high rate of self-induced abortions. Most women and youths when faced with the issue of unwanted pregnancy would rather secretly find a way of terminating it before anyone notices it. But unfortunately most of them have ended up with complications. Below is the summary of how the clients induce abortions outside the hospitals.

Table 3 Ways used to induce abortions

Illegal Abortion provider	Method used
1. Private practitioner	IUD to induce abortion
	Plastic canular
2. traditional healer	Roots soaked in water into cervix
	Cassava sticks into cervix
	Oral herbs
3. Self	Drinking gasoline
	Chloroquine overdose
	Detergents

iii. HEALTH CARE PROVIDERS (Knowledge, Attitudes & Perceptions)

The abortion dilemma has been great amongst nurses and doctors who are the implementers of the abortion legislation ⁽¹⁰⁾. The legislation of abortion in many countries, allowing women the right to decide to terminate pregnancy, has introduced an unfamiliar situation to the medical professionals, especially nurses and doctors who are the implementers of the legislation.

DOCTORS

Abortion is a very sensitive issue, which has not been easily accepted among health personnel especially, nurses and doctors ⁽¹⁰⁾. According to population reports (1997:9)⁽¹⁵⁾. Deep differences in attitudes toward induced abortion exist among professionals around the world. Some health care providers hold judgmental or punitive attitudes towards women who have had abortions, and their attitudes can affect the care they give post abortion patients. Even in countries where abortion is legal, some providers who disapprove of abortion have difficulty separating their personal feelings about abortion from their professional commitment to provide medical care. Many doctors are not even aware that TOP is legal even for social reasons.

NURSES

The decision to participate in provision of elective abortion has been left to individual nurses depending on their own convictions. In a study done by Ndhlovu (1999)⁽¹⁰⁾ on nurse's experiences of abortion, she confirmed that the experiences most nurses go through during TOP are negative. The attitudes of nurses in her study were either judgmental or

conservative. She further states that nurses remain unfamiliar with the problems of the aborting woman due to her short stay in the ward. The study, which was done in Zambia and South Africa, confirmed that the participant's perception of abortion greatly influenced their attitudes towards the client. Nurses confessed that they were more sympathetic towards the woman with a spontaneous abortion than the one who had induced abortion. The study confirmed that the complexity of the abortion experience in nurses varied in the amount and type of stress it generates for them. The manner in which the nurses responded to the procedure was found to be a joint function of their psychological state and the reason for which abortion was done (p115).

Most medical staff still feel that they are not obliged to give information as far as abortion is concerned.⁽¹⁴⁾ Price (1983:154) described one of the psychodynamic sources associated with emotional reactions of nurses as follows: "over-identification with the fetus and lack of identification with the aborting woman on a conscious/unconscious level". The study concluded that the participants' perception of abortion greatly influenced their attitudes towards the client.

Since the provision of quality PAC services started in January 2001, there has been a marked improvement of the attitudes towards both the patients seeking TOP and those patients presenting with complications of abortion. The providers are being taught to provide humanistic counseling and care for these patients. Most patients have appreciated these services. This has been demonstrated by the manner in which patients come back to the hospital for further inquiry or help.

3 The Nurses Act

Before the revision of the nurses Act, nurses and midwives were not allowed to operate on their own. They could not run nursing homes, due to legal barriers. The revised Nurses and Midwives Act of 1997 has expanded the scope of practice of the Nurse and Midwife. The nurse/midwife is now allowed to provide therapeutic, palliative and rehabilitative care and treatment of illnesses normally carried out in nursing and midwifery practice and in a nursing home⁽¹¹⁾. Some of the responsibilities a nurse is now able to carry out include:

- Assessing, diagnosing and providing the relevant therapeutic interventions;
- Carry out physical examinations
- Insert and remove intra -uterine devices
- Carry out resuscitation and intubation
- Carry out vacuum extraction
- Prescribe relevant drugs and other pharmaceutical preparations
- Provide counseling
- Provide such other information, care and procedures relevant to nursing and midwifery practice necessary to prevent disease, disability or any illness or to protect life⁽¹¹⁾.

This expanded scope includes performing MVA on post abortion patients but not for elective TOP patients as the TOP Act of 1972 does not permit any other health providers but medical practitioners to conduct TOPs.

3.1 Midwives role in abortion service

Generally midwives have been providing basic care during pregnancy, delivery and post partum period and all methods of contraception except bilateral tubal ligation in both urban and rural setting. They also provide information, education and communication (IEC) in reproductive health. Midwives are involved in youth corners and are involved in prevention of STIs including HIV/AIDS. Now counseling in reproductive health issues is being offered at every health center and hospitals mainly by trained midwives. Testing of blood is offered and treatment of various STIs provided. Also activities on prevention of mother to child transmission of HIV, including support of those mothers who are found to be HIV positive.

Following the approval and the signing of the new Act legal barriers have been removed to an expanded role for nurses in provision of certain primary medical care services. Nurses have now been given a greater role in the provision abortion services. They can now be trained to perform MVA for patients with incomplete abortion but not for elective abortion.

3.2 Midwifery curriculum

The General Nursing Council in collaboration with cooperating partners has revised the midwifery curriculum to strengthen the nursing and midwifery practice in line with the expanded scope of practice spelt out in the new Act. The new curriculum incorporates new trends in maternal and neonatal health, family planning, gender, infection prevention, health management information system and advocacy ⁽¹⁶⁾. Included in this curriculum is the component of pre and post abortion care counseling and provision of PAC family planning services. The content of PAC component included:

1. Review all types of abortion
2. Legal statutes regarding abortion
3. Elements of PAC
4. Principles of PAC
5. Emergency care
6. History
7. Pelvic examinations
8. Stabilization
9. Referral
10. Types of uterine evacuation didactically
11. PAC and STIs

12. Post abortion counseling and family planning
13. Recommended infection practices.

The current intakes of midwifery students at UTH are being used to try the implementation of the new curriculum. They have an opportunity to provide quality PAC services but not MVA.

4 Organization of abortion services

4.1 Elective TOP services

Improved management of incomplete abortion and increased capacity for procuring legal TOP was introduced in Zambia in a collaboration project between IPAS and department of Ob/Gy in 1988. The program introduced the manual vacuum aspiration (MVA) for evacuation of the uterus. This saw a reduced waiting time for evacuation and hospital stay for both elective and incomplete abortion. During this period the ratio of induced abortion to incomplete abortion improved from 1:25 to 1:5⁽¹²⁾. During the project period elective abortion remained constant at 55 and 59/month.

Many health centres have been equipped to provide all maternal and neonatal services but not TOPs. Few centres in Zambia perform elective abortion on social grounds. This is because specialists are not obliged to perform or allow TOP in their centers if it impinges on their religious or moral beliefs. Therefore the health centres have to refer clients seeking TOP to the tertiary centres which allow TOPs. Many clients by pass the health centre and have to pay by pass fee of ZK 25,000.00 after which they are referred to see a medical doctor who is pro - abortion for clerking and counseling to determine the indication for termination and contraceptive choice. A TOP form has to be signed according to the TOP Act and client's consent obtained. The client can have TOP services the same day or at the latest the next day. Termination of pregnancy below 12 weeks is performed surgically using MVA and those between 12 - 20 weeks medically using misoprostol. The surgical termination cost ZK 6000.00 and the medical ones depends on the number of misoprostol tablets used and each costs ZK 3500.00 in the department of Ob/Gyn UTH. The surgical terminations are ambulant day procedures and clients are discharged after 2hrs if all is well with a contraceptive method. A follow - up visit is scheduled at seven days thereafter visits are only if clients experience problems either with FP method or complication from TOP.

4.2 Record keeping and health statistics

All TOPs performed are recorded as per requirement of the TOP Act and includes hospital file number, name of client, age, marital status, occupation, gestation age, parity, date of termination, type of procedure and FP method given. The TOP forms bearing the indication, name of client, names and signatures of the three consenting medical practitioners are forwarded to the PS MoH. These records are confidential. Record keeping has improved although most medical abortions are not recorded unless MVA was performed.

5 Post - abortion care services

Recently in June 2001, three Central Hospitals (UTH, Kitwe and Ndola) have been set up as training centers for post abortion care (PAC) and use a structured PAC on the job training (OJT) module. Trainees include both Nurses and Doctors who undergo the same course except that the nurses have not yet been taught how to perform MVA. A pilot programme has been initiated in

Lusaka by CMAZ/ FHI in which nurse/midwife have been taught how to perform MVA. The nurses and midwives had started performing MVA but under the supervision of medical doctors trained in PAC. Since all the trained doctors left the nurses have stopped performing MVA. This is really a pity because this might have been a stepping stone to menstrual regulation.

The PAC services are offered within the emergency Gynae wards at the three centres using MVA for evacuation of uterus. For those using sharp curettage, counseling is done in the gynae ward and evacuation in theatre under GA. Patients are referred from health centres and after registering they present themselves to the gynae emergency wards. If patients pass the health centre they pay ZK 25,000.00 thereafter the services are free. The nurse/ midwife receives the patient, enters vital statistics in the admission book, does initial assessment and pre MVA counseling with the doctor, assists in the MVA procedure by providing verbacaine and continues with post MVA counseling.

Efforts to improve PAC in Zambia were started on a pilot basis by Ipas in 1989. MVA equipment was provided and doctors were trained in a number of sites. After the pilot project ended, equipment was not replaced and services were discontinued at every site except UTH and Ndola ⁽¹⁴⁾. With the introduction of the provision of quality PAC services the nurse/midwives are being trained in the provision of the services. Below is the summary of PAC services currently being provided since the year 2000:

Table 4 Summary of PAC services

FACILITY	ABORTION SERVICES PROVIDED
<p>University Teaching Hospital</p> <p>National referral and teaching hospital; district hospital for Lusaka. Department of Ob/Gy coordinates PAC services on behalf of CBoH</p>	<p>-TOP services using MVA provided</p> <p>-Sees more than 300 cases of incomplete abortion every month most of whom are self-induced.</p> <ul style="list-style-type: none"> • Training center for provision of PAC services • MVA services for emergency abortion complications • Pre and post abortion counseling and family planning services are now provided within the gynae ward mostly by nurse/midwives • Linkages to other RH services provided.
<p>Ndola Central Hospital</p> <p>Referral hospital, North – Western region. Teaching hospital</p>	<ul style="list-style-type: none"> • TOP services not provided as hospital policy • Training center for provision of quality PAC services • Sees more than 50 cases of incomplete abortion every month

	<p>induced outside the hospital.</p> <ul style="list-style-type: none"> • Provides pre and post family planning counseling within the gynae ward. • Linkages to other RH services available
<p>Kitwe Central Hospital</p> <p>Referral hospital, North – western region</p>	<p>- TOP services not provided as hospital policy</p> <ul style="list-style-type: none"> • Training center for quality PAC services • Sees an average of 55 post abortion patients induced outside the hospital. • Pre and post abortion family planning services including linkages to other RH services.

5.1 ROLE OF NURSES/MIDWIVES IN PAC

In the quest for safe motherhood, the health providers face the challenge of providing emergency care for the complications of unwanted pregnancy. Reduction in the need for induced abortion and prevention of unsafe abortion can be achieved through the provision of FP services and making these services accessible to the women in need. Accordingly, the health professionals are being trained in management, evacuation of removal of products of conception using MVA and post abortion counseling for FP. The implementation of the PAC package, which includes emergency care of abortion complications and post abortion contraception, counseling and initiating a contraceptive method of choice is one way of dealing with this challenge.

Table 5 PAC statistics Jan to December 2000

Institution	Adm.	Death	%death	MVA procedure	MVA as % of Adm.	MVA for adol.	5 of adol. Of total MVA
UTH	7550	5	0.07%	3622	48%	No record	
Ave/month	629	0	0.07%	302	48%		
NCH	3659	15	0.41%	487	13%	90	18%
Ave/month	305	1	0.41%	41	13%	11	28%

KCH	2505	13	0.52%	729	29%	189	26%
Ave/month	209	1	0.52%	61	29%	16	26%

Table 6 January – September 2001

UTH	6256	13	0.21%	2809	45%	595	21%
NCH	2505	5	0.20%	631	25%	119	19%
KCH	1698	9	0.53%	556	33%	No record	-

6 Complications and outcome

The complication rate has not been investigated, but since the introduction of PAC no women have reported back with bleeding or infection. The women who have had elective abortion have complained of moderate to severe pain during the procedure. Some are given analgesics such as Brufen, while the majority have had the procedure done under verbacaine. Due to the attitude of some providers towards TOP, very few providers take interest in the TOP clients.

There is need to conduct studies about complication rate in relation to provider especially when nurses begin to perform MVA although studies in Ghana have shown no difference in complication rates. Other studies include the effect of elective abortion on the adolescents.

The administrators in the hospitals where PAC has been initiated have testified that it has brought a lot of benefits to their institutions i.e.

- Reduced hospital stay

- Less complications
- Improved provider-client relationship
- Provision of FP services
- Cost saving

7 Incentives and Barriers

Laws and regulations

The Zambian law is restrictive in a lot of areas. The provision of abortion services depends on the attitudes and willingness of the health providers. Midwives will now begin to provide MVA for post abortion patients and resistance from physicians is unforeseeable due to huge workload. The resistance might come from the midwives, as performing MVA will add to their workload. A lot of teamwork will be required in this area. The nurses and midwives in Zambia owe a lot to the GNC and the Zambia Nurses Association (ZNA) for fighting tirelessly for the law to be changed in their favor.

8 Lessons learned

Zambia still has a lot of lessons to learn as far as the works around abortion is concerned. The most important is the change of attitude towards the women who request TOP. We believe this will come about when counseling skills will be instilled or taught to health providers. Some women have after all decided not to terminate their pregnancies after a good counseling session. Others have taken steps to ensure the prevention of the next unwanted pregnancy. The presence of a nurse/midwife during TOP or MVA has brought a lot of comfort and confidence in a lot of clients. One woman testified that there was a great difference between her first MVA and the second. She felt supported during the second MVA

Efforts are being made through PAC to ensure that every hospital and health center provides quality services. Youth friendly corners need to be strengthened to help the youths meet their reproductive goals. We believe prevention is better than cure. Sex education need to be strengthened in schools and for youths in the community.

9 Challenges

1. Lack of increase awareness about the 1972 TOP Act among women especially rural women, health care providers and communities.
2. Lack of contraception availability and access especially to rural women
3. Lack of trained human resource
4. Cultural constraints
5. Lobby Government to review the TOP Act to make it more accessible e.g. reduce number of doctors to sign, include other health care providers to perform TOP and include private hospitals to conduct TOP.
6. Poor transport and communication system.

10 Conclusion

Zambian midwives can participate in the provision of quality abortion services in many different ways even if the law is restrictive. They can offer counselling and family planning services. Now that the 1997 Nurses Act has been passed they can save lives of women who come in with complication of abortions by providing the full PAC package which includes performing MVA.

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