

News from Overseas

Abortion as a public health problem in Zambia

Peter Sims

'Statistics are people without the tears'

Despite the world-wide controversy that continues to exist around abortion and the very strong feelings that the subject produces among health staff and others, it was a shock to find unsafe abortion a major cause of maternal death in the Zambia of 1995. It is difficult to obtain reliable statistics here, and the data which follow are crude and based on a series of estimates. The figures could well be 10 per cent out in either direction – there is no way of knowing. The question is: how many abortions are required in the Zambia of today? In those countries with a liberal policy on abortion, sufficient facilities to provide easy access to all women and adequate contraceptive services, still one in four or one in five pregnancies are deliberately aborted.

Zambia, with a population of some 9.2 million people, has a birth rate of 50 per 1000, and thus 450 000 births per annum. In Lusaka alone, there are 40 000 births a year. Of these, some 12 000 occur in hospital, 24 000 in the urban health clinics and the remainder in the woman's own home. Maternal mortality is estimated to be about 500 per 100 000 live births, and abortion is a major contributor to this figure (about 30 per cent). The poor and unlawful practice by nurses, clinical officers, doctors and traditional healers in the private sector, where standards are low, inspection is absent and the fear of reprisal protects the unscrupulous operator, is a major factor in the morbidity and mortality from abortion. If these figures reasonably reflect the true situation, then some 2300 women die in childbirth or of factors related to pregnancy every year, and some 700–1000 deaths are directly attributable to abortion; this despite the fact that Zambia has had an abortion act since 1972 modelled upon that in the United Kingdom. The law of the land entitles a woman to seek termination of pregnancy when her own life and health, or the health of other members of her family, may be put at risk by the pregnancy, or where the foetus may be expected to be

damaged or diseased. Yet the epidemic of illegal abortion continues. In effect, there could be 'abortion on demand' if the act was applied liberally. Although the country is Christian with some 40 per cent Roman Catholic, the religious pro-life lobby is not vociferous. Certainly, doctors who perform abortions are not the subject of attack or physical abuse. It is possible to obtain an abortion in the main teaching hospital (the University Teaching Hospital; UTH) in Lusaka, but only about 1000 are conducted annually, when a conservative estimate would argue that a service to the city should be providing 3000 terminations annually.

The women who seek termination at the UTH are surprisingly homogeneous and not particularly different from women obtaining an abortion elsewhere. The existing service is used by a wide spectrum of women, and not only the better educated, single woman with a good knowledge of English, and able to use the complex medical system. Even so, their experience would be unacceptable to the women of Northern Europe or North America. There is no anaesthesia, not even local infiltration of the cervix, the procedure is done on a day care basis, there is no pain relief or sedation, and no follow-up. Unscrupulous practitioners aware of these practices offer terminations in private clinics, where standards are unacceptably low, even dangerous, and prices high, but with some facade of confidentiality.

The majority of women faced with an unwanted pregnancy seek help from friends, go to traditional healers or the ubiquitous 'wise woman', or find and take the abortifacients of folklore or 'muti'. This may be successful or may result in major complications – organ failure, haemorrhage, infection, sepsis, shock, chronic pelvic inflammatory disease, infertility or

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death. Certainly, many of these deaths may be barely recorded, let alone certificated with a cause of death. The UTH sees some of the worst consequences with women admitted to the gynaecology wards with retained products and massive infections.

Zambia is a man's world, and contraception still neither widely accepted nor acceptable. HIV disease means that 25 per cent of women booking in their first pregnancy in Lusaka are positive. Condoms and oral contraceptives are available free of charge but in limited supply, in the urban clinics. This may mean a long wait to obtain a three-month supply. The condom may not be acceptable to the man, at least within marriage. The IUCD may be unacceptable both because the man can feel it during intercourse and because of increased prevalence of pelvic infection. Long-acting depot preparations are having a 'come-back' and are well tolerated, yet they are expensive and available only to the few. Sterilization is rarely requested, and is culturally unacceptable.

It is possible to buy condoms, often long past their shelf life, from street vendors, and the 'pill' is available over the counter at about 35p for a one-month supply, when for many families the total income for a month is less than £15. Again, there may be problems of oestrogen dosage, uniformity of supply and shelf life. With so much death and disease all around, amidst so much poverty, it is unsurprising that there is a fatalism around sexual behaviour and subsequent pregnancy. People are hungry, women often struggling to bring up children alone, and forced by circumstance to prostitute themselves for money to feed their children.

Abortion done in the public section of the Gynaecology Department may cost £1–£2. An abortion done in the fee-paying section of the University Hospital and by a consultant costs about £17. The

traditional healers may charge £5–£20 for an abortion, the private doctors £60 or more – a huge sum given the destitution of the community. The infant mortality rate is 107 per 1000 and worsening; these are the deaths of poor and unwanted children in the sprawling townships of Lusaka. The women want an abortion because they cannot feed the child, because they are unsupported, because they are ashamed, because it will otherwise mean the end of any chance for an education – the same reasons as anywhere in the world.

The rhetoric of Cairo and Beijing is expressed in the reality of women's lives. It is easy to scoff at the apparent irrelevance of such international junketings, but their message is the right one. Reproductive choice for all people based on an equal relationship between the parties concerned, an education for all and adult literacy rates over 90 per cent, sex education and fertility control as an integral part of that education, available, accessible, cheap services for family planning and pregnancy termination – we know all of this. We spent hard years learning this lesson in Europe and America. It seems we are destined to continue to repeat history and the mistakes of history.

It is easy to wring one's hands, tempting to accept the status quo as yet another insoluble problem of Africa. It is instead the time to get angry. This is a problem with a solution. Family planning and sex education can be improved immediately. Prostaglandin termination of pregnancy is safe and effective. The 'abortion racket', the black market in human misery, has to be closed down. The newer depot hormonal preparations can be used and are culturally acceptable. The accepted wisdom is that every African loves the child. The need is for every pregnancy in Africa to be wanted.

Accepted 12 December 1995