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FIGO INITIATIVE

Increasing access to legal termination of pregnancy and postabortion contraception at the University Teaching Hospital, Lusaka, Zambia

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ABSTRACT

The Zambian Association of Gynecology and Obstetrics is one of the International Federation of Gynecology and Obstetrics (FIGO) member societies participating in the FIGO Initiative for the Prevention of Unsafe Abortion and its Consequences from the East, Central, and Southern Africa region. The activities included in this country's plan of action were to provide access to safe abortion within the full extent of the law to women receiving care at the University Teaching Hospital in Lusaka, and to increase the proportion of women leaving the hospital with a contraceptive method. Zambian law regarding abortion is liberal, but in general it was not applied until very recently. The proportion of legal terminations of pregnancy among patients receiving abortion care at the hospital increased from 3.2% in 2009 to 7.7% in 2011, while the percentage of women leaving the hospital with a contraceptive method increased from 25.3% to 69.4% over the same period.

1. Introduction

The Zambian Association of Gynecology and Obstetrics is one of the member societies participating in the International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion and its Consequences from the East, Central, and Southern Africa region. The main motivation to be part of the initiative was that unsafe abortion remains a challenge in Zambia despite a liberal abortion law dating back to 1972 [1] that permits pregnancy termination when there is a risk to the health of the pregnant woman or when there are claims based on socioeconomic grounds. However, most women and health professionals in Zambia appear to ignore the existence of this law. Safe legal pregnancy terminations were not practiced until recently; consequently, almost all abortions were clandestine and unsafe.

One tragic consequence of the lack of application of a more liberal abortion law is that the maternal mortality ratio in Zambia is estimated at 591 per 100 000 live births, with up to 30% of these deaths resulting from unsafe abortion, at least at the University Teaching Hospital in Lusaka in 2006 [2].

As a result of participating in the initiative, ZAGO was encouraged to promote some of the strategies proposed by FIGO aimed at reducing the incidence of unsafe abortion and its consequences. An effort has been made over the past 5 years to make safe legal abortion available and to increase the acceptance of postabortion contraception, with these initiatives beginning at the University Teaching Hospital, Lusaka.

Until 2007, legal termination of pregnancy was rarely performed at the University Teaching Hospital, as in most of the country. In addition, postabortion contraception was seldom provided and information on postabortion family planning was rarely given. Under the stimulus of the FIGO initiative and the objective of contributing toward reducing maternal mortality, staff began to inform patients of the benefits of preventing a further pregnancy and to provide these women with contraceptive methods. At the same time, the hospital staff was given information on the actual legislation governing the practice of abortion in Zambia and encouraged to provide safe, legal terminations of pregnancy as an alternative to combatting the many complications resulting from the practice of unsafe abortion.

A high number of women attend the Teaching Hospital as a result of incomplete abortion, either spontaneous or induced. Since 2009, legal termination of pregnancy is available at the hospital to women who request it and comply with the broad conditions established within the law. This information was made public. Therefore, women requesting an abortion within the law are provided with safe pregnancy termination care.

The present paper describes the progress made in the implementation of this process by evaluating the number of legal pregnancy terminations performed at the University Teaching Hospital in Lusaka annually between 2009 and 2011, and the proportion of women who leave the hospital using a contraceptive method of their choice.

2. Patients and methods

This was a retrospective, observational study of all women admitted to the emergency gynecology ward of the University Teaching Hospital

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in Lusaka seeking a legal termination or as a result of incomplete abortion between January 1, 2009, and December 31, 2011. Up until 2011, few legal pregnancy terminations were performed as medical abortions; however, these were recorded in the hospital statistics even though the women were not admitted to hospital. In 2012, Medabon (Sun Pharmaceutical Industries Ltd, Mumbai, India) was registered in Zambia and most doctors learned how to use it. Consequently, the number of legal medical pregnancy terminations performed on an outpatient basis increased considerably and with very few exceptions these procedures were not included in the hospital statistics. Therefore, the number of admissions for legal pregnancy terminations decreased at the Teaching Hospital, and the total number was no longer known, making it impossible to compare it with the statistics recorded in previous years. For this reason, 2012 data were not included in this evaluation.

All women admitted to hospital because of an incomplete abortion or those seeking a legal termination of pregnancy who underwent manual vacuum aspiration (MVA) or a medical abortion were included in the study. Curettage is not used to manage abortion at this hospital.

Trained midwives or residents, in consultation with specialists in gynecology and obstetrics, admitted the women to hospital. Diagnosis of an incomplete abortion was made clinically and MVA was used to treat these women. For women who requested a legal termination of pregnancy, the nurse in charge of the ward, in consultation with the on-call registrar, decided whether or not the circumstances were in compliance with the law. If approved, MVA or a medical abortion was scheduled for the same day.

All women were counseled on the benefits of preventing a future unintended pregnancy that could result in another abortion. Information was provided on the different contraceptive methods, with particular emphasis on the higher efficacy of long-acting reversible contraceptive (LARC) methods.

Data were collected from the patients' case records and transcribed to a spreadsheet in the form of aggregated data for analysis. The primary outcomes were the type of abortion (legal termination of pregnancy or incomplete abortion) and provision of a contraceptive method prior to discharge from hospital. No attempt was made to separate cases of incomplete abortion into induced or spontaneous abortion—a difficult task when women use medical methods of inducing abortion.

The contraceptive methods offered were categorized into short-acting reversible contraceptives (SARC), which include the combined oral contraceptive pill and the condom; injectables (only depot medroxyprogesterone acetate [DMPA] was available); and LARC methods, which include the Copper T 380 intrauterine device (IUD), the levonorgestrel-releasing intrauterine system (LNG-IUS), and the Jadelle (Bayer Healthcare Pharmaceuticals, Berlin, Germany) subdermal implant.

The independent variables were calendar year (2009 — 2011) and age, dichotomized into younger than 20 years of age (defined here as adolescents) and 20 years or older (defined as adults).

Informed consent was not required since the study consisted of a review of patient records and identity remained confidential. The study protocol was approved by the internal review board of the University Teaching Hospital, Lusaka.

3. Results

Over the 3-year period between 2009 and 2011, each year over 5000 women were admitted with an incomplete abortion or to request a safe termination of pregnancy. Around 15% were adolescents and there was little variation in this percentage over time (Table 1).

There was a persistent rise in the proportion of legal pregnancy terminations at the hospital during the study period, increasing from 3.2% in 2009 to 7.7% in 2011 (Table 2). This increase was more pronounced in adolescents. In 2009, only 2.5% of all abortions in this age group consisted of safe legal pregnancy terminations; however, by 2011 this proportion had increased to over 15% (Table 2).

Table 1
Distribution of women admitted to hospital owing to induced abortion or seeking legal termination of pregnancy according to age and year.

Year	Age, y		Total
	<20 (Adolescents) No. (%)	≥20 (Adults) No. (%)	
2009	854 (15.0)	4835 (85.0)	5689
2010	801 (15.9)	4224 (84.0)	5025
2011	895 (16.6)	4494 (83.4)	5389

The total number of hospital admissions for abortion did not change over the study period, suggesting that legal pregnancy terminations simply replaced a proportion of clandestine abortions but did not increase the overall number of abortions that occurred in this population.

There was also a rapid increase in the number of women adopting contraceptive methods immediately after an incomplete abortion or legal termination of pregnancy. The proportion of women adopting a contraceptive method prior to discharge from hospital was greater following a legal pregnancy termination than after an incomplete abortion. The proportion of women leaving the hospital using a contraceptive method after undergoing a legal termination of pregnancy fluctuated between 80% and 90% during the study period compared with around 60% — 70% of women who attended for an incomplete abortion. Overall, the percentage of all abortion patients who left the hospital using a contraceptive method increased from 25% in 2009 to almost 70% in 2011 (Table 3).

SARC methods, namely oral contraceptives and male condoms, were the methods most often chosen by women who had undergone a legal termination of pregnancy—adopted by over 50% of women consulting over the 3 years of observation. They were also the most popular contraceptive options among women admitted owing to an incomplete abortion in 2009. In the following years, however, the percentage of women in this group who opted for an injectable contraceptive increased significantly, almost equaling the percentage of women consulting for an incomplete abortion who opted for a SARC method. In 2009, very few women opted for LARC methods, namely the copper IUD, the Jadelle implant, or the LNG-IUS, irrespective of whether they had had a legal termination of pregnancy or an incomplete abortion. However, by 2011 that percentage had doubled in the case of women who had undergone a legal termination of pregnancy and had tripled in the case of those who had had an incomplete abortion. Nevertheless, in 2011 only 7% of the women who underwent a legal termination of pregnancy and 1.7% of those with an incomplete abortion opted to use a LARC method immediately following abortion (Table 4).

Table 2
Number of safe legal terminations of pregnancy performed as a proportion of all abortions performed between 2009 and 2011.

Year	Age, y				Total	
	<20 (Adolescents)		≥20 (Adults)			
	% LTP	No.	% LTP	No.	% LTP	No.
2009	2.5	854	3.4	4835	3.2	5689
2010	4.6	801	4.6	4224	4.6	5025
2011	15.4	895	6.2	4494	7.7	5389

Abbreviation: LTP, legal termination of pregnancy.

Table 3
Percentage of women adopting a contraceptive method prior to discharge from hospital following an induced abortion or a legal termination of pregnancy.

Reason for admission to hospital	% of women adopting a contraceptive method		
	2009	2010	2011
Incomplete abortion	23.5	49.1	67.4
Legal termination of pregnancy	82.9	85.3	92.5
All abortions	25.3	50.8	69.4

Table 4
Percentage distribution of contraceptive methods adopted by women prior to discharge from hospital following an incomplete abortion or a legal termination of pregnancy.

Contraceptive method	Year		
	2009, %	2010, %	2011, %
Short-acting reversible contraceptives (SARC)			
Incomplete abortion	14.3	21.6	34.7
Legal termination of pregnancy	52.5	52.8	57.5
Injectable			
Incomplete abortion	8.4	27.3	30.8
Legal termination of pregnancy	36.0	30.3	27.4
Long-acting reversible contraceptives (LARC)			
Incomplete abortion	0.6	0.2	1.7
Legal termination of pregnancy	3.9	2.2	7.0

Table 5
Percentage distribution of contraceptive methods adopted by adolescents and adults following an incomplete abortion or a legal termination of pregnancy.

Contraceptive method by age group, y	Year		
	2009, %	2010, %	2011, %
Short-acting reversible contraceptives (SARC)			
10 — 19	57.6	44.8	53.5
20 — 44	64.0	47.5	52.4
Injectable			
10 — 19	42.0	54.9	45.9
20 — 44	31.9	51.5	43.3
Long-acting reversible contraceptives (LARC)			
10 — 19	0.4	0.2	0.6
20 — 44	3.0	0.9	3.9

In 2009, adolescents were more likely than adults to opt for an injectable contraceptive and less likely to choose a SARC or LARC method. However, in 2011 there was little difference between adults and adolescents with regard to use of SARC methods or injectable contraceptives. On the other hand, the use of LARCs was 6-fold less among adolescents compared with adults (Table 5).

4. Discussion

The intervention implemented at this teaching hospital appears to have been successful. While the overall proportion of legal terminations of pregnancy (approximately 8% in 2011) is not very high, the trend toward an increase in the numbers and rates is promising. If half the abortions seen at the hospital were induced, this would mean that 15% of all cases of induced abortion attended at this teaching hospital consisted of safe legal abortions—a vast improvement from around zero 4 years earlier. It is also encouraging that the number of women undergoing a legal termination of pregnancy as a percentage of all abortions was much higher among adolescents, suggesting that this new generation of women is more aware of their rights.

It is regrettable that the statistics from 2012 could not be considered in the analysis because of the large number of legal terminations of pregnancy that were performed on an outpatient basis using Medabon and failed to be included in the hospital records. A solution to this problem is currently being sought to enable evaluation of the degree of acceptance of legal termination of pregnancy over time. On the one hand, the introduction of medical termination of pregnancy and the increased availability of these methods has allowed the practice of legal termination of pregnancy to be expanded; on the other hand, these procedures are not being appropriately registered.

The substantial proportion of women who left hospital having adopted a contraceptive method is very important considering that ovulation may occur within 10 days after an abortion, with over 80% of women ovulating in that cycle [3,4]. Several studies have shown that the proportion of repeat, unintended pregnancies and abortions is significantly less when contraceptive use is initiated immediately after the abortion rather than later [5,6].

Efforts to increase the use of LARC, particularly among adolescents, should be reinforced. The lower acceptance rate of LARC by adolescents in the present study may reflect the erroneous concept that IUDs and implants are inappropriate for young women who have yet to deliver their first child. A broad discussion with the hospital staff regarding the World Health Organization acceptability criteria may contribute toward changing this situation [7].

The relevance of introducing these strategies at the University Teaching Hospital in Lusaka relates to the role of this hospital as the principal teaching institute in the city—a place where future generations of health professionals including physicians, nurses, and specialists acquire the knowledge that they will later put into practice. In general, doctors tend to repeat the practices they witnessed at the hospital where they received their training and, in particular, what they themselves did during their clinical practice. In addition, the University Teaching Hospital is considered a model to be copied by doctors in Zambia. ZAGO is working to accelerate this process. The FIGO initiative is currently being expanded to the rest of the country and should be the subject of a detailed evaluation in the near future.

Conflict of interest

The authors have no conflicts of interest.

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