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Introduction

Abortion is the termination of a pregnancy by the removal or expulsion of a fetus or embryo from the uterus, resulting in its death (Dutt and Matthews, 1998). According to World Health Organization, abortion is defined as an induced termination of pregnancy by use of medications or surgical interventions after implantation of the embryo and before the fetus is able to survive outside the maternal organism (before 22nd week of pregnancy). Induced abortion can either be therapeutic or elective. This discussion focuses on elective abortion.

The author of this work had a six weeks practical placement at a central hospital in Norway where she had a chance to nurse clients who went to seek abortion. This write-up gives an overview of induced abortion as a legal procedure before the 12th week of gestation, the abortion Act for both Zambia (author's home country) and Norway, and statement of the problem. The analysis highlights how accessible induced elective abortion is to the intended population; barriers to access and the consequences of lack of access to legal abortion. Accessibility is the extent to which a consumer or user can obtain a good or service at the time it is needed (Online Business Dictionary). In discussing the above, the following questions will be answered; is legalization of abortion necessary? Is legal elective abortion accessible in Zambia and Norway? What are the possible barriers to access and what are the consequences of lack of access? It will also look at the similarities, differences and challenges in Zambia and Norway as observed by the author having worked as a midwife for nine years. This will be followed by conclusion and then recommendations.

Overview of Induced Abortion

An abortion can occur spontaneously due to complications during pregnancy or can be induced. An abortion induced to preserve the health of the pregnant woman is termed a *therapeutic abortion*, while an abortion induced for any other reason such as is done at the woman's request is termed an *elective abortion*. The term *abortion* most commonly refers to the induced abortion of a human pregnancy, while spontaneous abortions are usually termed miscarriages. The method of termination of pregnancy largely depends on the gestational age of the pregnancy and the woman's choice (Dutt and Matthews,

1998). The procedures offered also vary from one hospital to another but two methods exist; medical and surgical methods.

During the first trimester, medical abortions can occur with the use of pharmaceutical drugs (Blanford, 2010). The drugs of choice in medical abortion are the combination of Mifepristone and Misoprostol which have the highest success rate compared with the use of Misoprostol alone. However Mifepristone is very expensive (ibid). Medical abortion using a combination of the above mentioned drugs have been on World Health Organization (WHO)'s complementary List of Essential Medicines since 2005, and has transformed both how abortion is provided and how it is experienced by women (WHO, 2005). Zambia does not use Mifepristone possibly because of its cost. The dosage for Mifepristone is 200 mg orally on the first day as a single dose while that of Misoprostol is 600-800 mcg vaginally in the next 48 hours for the medical termination of pregnancy up to 9 weeks. This combination has been developed in accordance with guidelines issued by the Royal College of Obstetricians and Gynecologists, United Kingdom (Blanford, 2010).

Following the administration of Misoprostol, the patient may need medication for abdominal cramps or gastrointestinal symptoms. Diclofenac combined with paracetamol or codein with paracetamol are the commonly used drugs for pain relief in Norway but in Zambia no pain treatment is given. The client is also given an antiemetic to prevent nausea and vomiting. Ideally, the patient should be given instructions on what to do if significant discomfort, excessive bleeding or other adverse reactions occur following the administration of Misoprostol and may be required to stay for 4-5 hours for monitoring of side effects. If the client chooses to have the abortion at home, she is advised to have someone with her. The bleeding will normally last 2-3 weeks following the abortion. She is also advised to go back for check of Human Chorionic Gonadotrophic hormone (HCG) on the 8th to 14th day following the abortion to ensure the success of the procedure. Normally, the levels of HCG will fall by this time.

The surgical or vacuum abortion is only available in fetuses that are less than 12 weeks old (Blanford, 2010). But the author has also seen it being used for pregnancies bigger than that depending on the woman's choice and available resources. WHO recommends vacuum aspiration of uterine contents for induction of abortion or treatment of complications at the first level referral hospital but currently the availability of this

equipment is limited (Rogo, 1993). Manual vacuum abortions consist of the removal of uterine contents by suction using a special syringe. Electric vacuum abortions use an electric pump to remove the fetus and placenta. In Zambia the manual vacuum aspiration syringe is used, while the electric vacuum apparatus is used in Norway. Surgical abortion in Norway is done under general anaesthesia as observed by the author while in Zambia; this procedure is done under cooperation.

Abortion Act (Zambia and Norway)

Abortion law is legislation pertaining to the provision of abortion. Abortion has been a controversial subject in many societies around the world because of the moral and ethical issues that surround it, though other considerations, such as a state's pro- or antinatalist policies, also dictate abortion law and regulation. It has been regularly banned and otherwise limited. However, abortion rates are similar in countries where the procedure is legal and in those where it is not (United Nations secretariat Data Bank).

Attitudes towards population growth rates and fertility among Zambian leaders have ranged until recently from pro-natalist to laissez-faire (ibid). The Termination of Pregnancy Act of 1972 was one of the population policy strategies put across to control the population growth rate in Zambia, although it was not a priority in the decade following independence because it was felt that the country was relatively large (752,614 square kilometres) in relation to its population size of 4.1 million in 1970 (Bureau of African Affairs, 2010). The overall objective of the Government's population policy was to improve the health and quality of life of all Zambians as well as slow the rate of population growth (United Nations Secretariat Data Bank).

Zambia's Termination of Pregnancy Act of 1972 which is thought to be one of the most liberal abortion laws in sub-Saharan Africa, allows abortions to be carried out on broad health as well as socioeconomic grounds (United Nations Secretariat Data Bank). The Act permits an abortion to be performed if three registered medical practitioners (one of whom must be a gynaecologist) are of the opinion that (a) continuation of the pregnancy would involve risk to the life or of injury to the physical or mental health of the pregnant woman, or of injury to the physical or mental health of any of her existing children, greater than if the pregnancy were terminated; or (b) that there is substantial

risk that if the child should be born, it would suffer from such physical or mental abnormalities as to be severely handicapped. In determining whether (a) above exists, account may be taken of the pregnant woman's actual or reasonably foreseeable environment or age. However, the Act does not provide for abortion for rape or incest as well as on request.

On the other hand, the legality of and public opinion towards abortion in Norway has changed dramatically in the last 100 years (WikiProject Norway, 2010). In Christian versus legislation era in 1687, abortion was punishable by death and by law but in 1842, it was no longer a capital offense. In 1902, new legislation allowed for abortion in cases where the mother's life was in danger or child had died in utero. The abortion issue became more important in 1915 when Katti A. Møller gave a speech in Kristiania calling for legalized abortion on demand (Norwegian Institute of Public Health, 2010).

In 1934 a committee led by Katti Møller's daughter, Tove Mohr started work on a new abortion law. The following year a campaign opposing the committee's work gathered 207, 000 signatures and debate continued through World War II and during Germany occupation. During early 1950s, 3000 legal abortions were performed against 7-10,000 illegal abortions (ibid) and by 1956 the prevalence of illegal abortions reached alarming levels. In 1960, a new law allowed abortion by application by woman's physician and only on basis of medical, eugenic, or criminal criteria and with consent from husband if woman was married. In 1969, the Norwegian Labour Party put abortion on demand on their platform for mainstream debate with the broader framework of feminism and the woman's campaign for abortion on demand was formed in 1974 (ibid). In 1978, the current law on abortion was passed providing for abortion on demand in the first 12 weeks and by application between 13 – 18th week under special circumstances requiring the authorization of a committee composed of two physicians. The policy permits abortion to be carried out for cases of rape or incest in addition to those found in the Zambia's Termination of Pregnancy Act.

Additional requirements include that, the application for an abortion must be submitted by the pregnant woman. If the woman is under 16 years of age, mentally retarded or is suffering from a severe mental illness, the application may be submitted by the parent or guardian. Abortion must be performed by a physician and if the duration of the

pregnancy exceeds 12 weeks, it must be performed in a hospital; otherwise, it can be performed in any approved institution including the home (Norwegian Institute of Public Health, 2010).

Statement of the Problem

Worldwide 42 million abortions are estimated to take place annually with 22 million of these occurring safely and 20 million unsafely (Shah and Ahman, 2009). While maternal mortality seldom results from safe abortions, unsafe abortions result in 70,000 deaths and 5 million disabilities per year (ibid). One of the main determinants of the availability of safe abortions is the legality of the procedure. Forty percent of the world's women are able to access therapeutic and elective abortions within gestational limits.

Abortion related deaths are a major cause of maternal mortality in Africa, and the treatment of abortion complications is severely taxing the scarce health resources of governments throughout the region (Coetaux, 1988). Yet the existing literature only hints at the magnitude and urgency of the problem and provides very little information on its nature or social epidemiology. For that reason, most information on abortion comes from hospital records of complications resulting from illegal abortions. Researchers attempting to study abortion through community based surveys discover that women are reluctant to talk about abortion (Bleak, 1987). Throughout sub-Saharan Africa, abortion is highly restrictive and because of the social stigma associated with it, the issues surrounding it are usually not discussed. Rights and laws are left to the doctors and lawyers and not to the women (Shah and Ahman, 2009).

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 elective abortions between 2003 and 2008 (Likwa, 2009). In contrast, the number of women admitted to the hospitals with abortion-related complications increased from about 5,600 in 2003 to more than 10,000 in 2008. Increasing access to elective abortion would likely decrease the rate of complications and mortality attributable to abortion, a trend that has been noted in South Africa. In 1972, Zambia adopted a Termination of Pregnancy Act which is regarded to be liberal. However, in terms of its application, abortion services are not widely available, and where available, not easily accessible (Ministry of Health, 2000).

Analysis

Is legalization of abortion necessary and is elective abortion accessible in Zambia? The legalization of abortion is necessary to ensure safe abortion. However, it is not sufficient. Widespread evidence indicates that many women cannot access abortion services to which they are legally entitled. India and Zambia are commonly cited as examples of countries where legal reform has proven insufficient to guarantee access to safe abortion. In both countries the practice of unsafe abortion remains widespread and abortion-related maternal mortality remains high (Faculty of Law, 2008). Although the Zambian abortion 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 a single physician present in the remote areas of Zambia (Castle et al., 1990).

What then are the barriers to abortion access? According to the report on the findings of a preliminary investigation of women who sought treatment for abortion from the Gynecological Emergency Ward at the University Teaching Hospital (UTH) in Lusaka, by Castle et al. (1990), barriers to access included discriminatory access (poor women could not afford to pay for abortion services); lack of knowledge amongst poor women regarding abortion process; physician reluctance to schedule abortions; conscientious objection; community norms and attitudes as well as unnecessary delays. Does provider attitude hinder abortion access? Some health care providers are uncomfortable with the issue of abortion or hold judgmental attitudes toward abortion patients. Interviews with providers revealed that those with negative discriminatory attitudes about women trying to terminate their pregnancies gave those women lower quality care (Warenius et al. 2006). Providers' negative attitudes affect the accessibility of elective abortion to the intended population.

A community based study entitled "Why Resort to Illegal Abortion in Zambia?" by Koster-Oyekan (1998) in Western Province, revealed that geographic disparity in facility availability; economic barriers; and unnecessary provider restrictions were the barriers to abortion access. Other barriers include lack of provider training, lack of equipment; formal and informal procedural requirement; failure to respect confidentiality, stigma and discrimination, and misinformation regarding the legality of

abortion, since many health providers have never seen the Act as observed by the author when she went round one hospital in Zambia getting views from nurses. Some young women might not have accurate information about abortion services or may be afraid that these services would not guarantee them complete privacy (Agadjanian, 1998).

Could there be consequences of lack of access to elective abortion? Complicated procedural requirements and inadequate services limit the number of elective abortions performed in Zambia. Thus, despite the liberal nature of its abortion law, there are continuing obstacles to obtaining an elective abortion and therefore a continued reliance on illegal abortion. For example, UTH is the only government facility in Lusaka where an elective abortion can be obtained. The service is used by a wide spectrum of women, both the educated, and uneducated. Even so, their experience would be unacceptable to the women of Europe or America. There is no anaesthesia, the procedure is done on a day care basis, and there is no pain relief, and no follow-up. Unscrupulous practitioners aware of these practices offer terminations in private clinics and in their homes, where standards are unacceptably low, even dangerous, and prices high, but with some degree of confidentiality. Some women induce their own abortion and proceed to a hospital for emergency medical treatment. This may be successful or may result in major complications - organ failure, haemorrhage, infection, shock, chronic pelvic inflammatory disease, infertility or even death (United Nations Secretariat Data Bank).

Many studies have shown that illegal abortion is one of the major causes of the high rate of maternal mortality in the country- 591 per 100 000 births (Central Statistics Office, 2007) 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 per 100,000 live births occurred as a result of unsafe induced abortion (Koster-Oyekan, 1998). More than half of these deaths were among schoolgirls. 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. However, seeking post-abortion care from Zambia's under resourced health care system is not a simple matter (Likwa, 2009).

In Norway, elective abortion seems to be accessible. The total number of abortions in 2008 was estimated at 15,054 per 100,000 births (Johnston, 2010). In 2009, 15 774 terminations were carried out. This is higher than in the period 2000-2007, with

approximately 14 000 abortions per year. In the two studies done in Oslo in the period 2000-2003 where births and abortions were compared between ethnic Norwegian women, immigrants and refugees, the results show that the number of abortions is relatively higher among refugees and immigrant workers than among Norwegian women. This observation is similar to what the author observed during the placement period and could be due to lack of knowledge concerning family planning among this group since information on family planning is written in norsk and most of them do not know where to access family planning services. During the same study, it was also observed that 88% of Norwegian teenagers with unwanted pregnancies chose abortion as compared to 45% of Pakistan's pregnant teenagers though the number of teenagers seeking abortion has reduced. However, the number of abortions in the age group 20-24 is increasing (Norwegian Institute of Public Health, 2010).

Similarities and Differences

It is interesting to note that both countries are using the abortion act as a guide to the provision of abortion and both require a written consent from the pregnant woman before an abortion can be performed. Nevertheless, some differences exist and most of these are believed to stem from the differences in the socioeconomic aspect of the individual countries. During the counselling session, the author observed that majority of women chose medical abortion. This is also supported by what Rosoy (2010) said in her doctoral thesis where she mentioned that "clients are persuaded to choose a medical abortion because; in Norway medical abortion is the routine procedure for selective abortion". In Zambia the surgical abortion by manual vacuum aspiration is the treatment of choice. The author therefore, believes that the choice of treatment can be linked to the country's economy. Norwegian hospitals mostly use expensive drugs such as mifepristone for elective abortion since the economy of the country is good, while Zambia being a poor country uses surgical intervention which is more affordable as treatment of choice. Surgical abortion is done under anaesthesia in Norway and under cooperation in Zambia possibly because anaesthetic drugs are also costly.

The author also observed that the attitude of the health providers towards clients seeking abortion in Norway was positive compared to that in Zambia. This could have contributed to the high number of clients seeking abortion in this country. Both the

gynaecologist and the nurse received the client with respect and maintained confidentiality throughout the abortion process. In Zambia, most gynaecologists refuse to carry out abortion procedures on personal and religious grounds or simply persuade the clients to keep the pregnancy. This results in clients seeking abortion from private clinics or the so called 'wise women'. Unfortunately, the same clients go back to the hospital with severe complications for post-abortion care. The attitude of most Zambian nurses towards clients seeking abortion also leaves much to be desired. The clients are not accepted and are looked upon as anti-Christ when approached for abortion. Confidentiality is not maintained and this prevents the women especially young adults from seeking abortion services.

Challenges

- The number of clients seeking abortion in Norway is increasing, making the author to believe that family planning services are not fully utilized. This is supported by Johnson, (2010) in his statement; "If induced abortion is an important means of postponing childbirth in a population, it is to be expected that in young women the rate of conceived pregnancies is stable over time, but the induced abortion rate is increasing in the age group 20-24."
- More abortions are seen in immigrants and refugees in Norway.
- The Zambian Health Care System has continued to record an increasing number of unsafe abortions despite having a liberal abortion Act.
- Single drug versus combined drug therapy regime for medical abortions still remains a challenge for the Zambian Health Care System.
- Negative attitude of health providers towards clients seeking abortion in Zambia.

Conclusion

Despite the availability of family planning services, many young women and teenagers fail to prevent pregnancies. Abortion has been used as a method of terminating unwanted pregnancies and the abortion Act has been used in many countries as a guide to termination of pregnancy; however abortion has not been accessible to the majority of the population who needs it. Abortion behaviour is intimately linked to issues of women's roles and opportunities, and until the various dimensions of abortion behaviour and its socioeconomic context are understood, governments will not address

the problem effectively. From available statistics, the author was able to see that abortion is highly accessible in Norway but not in Zambia. This is also supported by the experience the author had in Norway. On average the gynaecology ward received a total of 8 clients per week seeking for abortion. In Zambia, despite having the most liberal abortion Act in the sub-Saharan Africa, abortion is not discussed openly and most clients present themselves with abortion complications for medical services. This calls for more sensitization on the abortion Act to both medical staff and the general public.

Recommendations

- The Norwegian Health Care System should emphasis on family planning as a method of preventing unwanted pregnancies to reduce the number of clients seeking abortion. This is because some clients that the author had contact with, has had more than one elective abortion for unwanted pregnancies. This can be done through the media, in schools and antenatal clinics. Information on family planning should also be available in English to cater for refugees and immigrants who are currently leading in abortion seeking. If possible family planning services should be free to all women aged 15-49 years so that even the under privileged can access them. Currently this service is only free to teenage girls.
- The Zambian Health Care System should improve access to abortion services by making it more affordable. The individual professional bodies (Medical Council and General Nursing Council of Zambia) should encourage legal abortion providers to act as medical professionals and practice confidentiality to assist women seeking abortion. Training of health care providers on safe abortion can also be done. This will improve accessibility and safeguard women from dangerous, illegal abortions.
- The department of Human Rights Commission in conjunction with Ministry of Health (Zambia) should sensitize the public on their rights and available services through the media. This will increase public awareness.
- Ministry of Health (Zambia) should encourage and support qualitative research on reproductive health care delivery for women who seek abortion. This will help in identifying reasons why women have continued to practice unsafe abortion when the law supports abortion.

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