Health care workers as moral agents in safe abortion care, Lusaka

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Abbreviation

ART – Antiretroviral

CAC – Comprehensive Abortion Care

HIV – Human Immunodeficiency Virus

ICPD – International Conference of Population and Development

MDG – Millennium Development Goals

MVA – Manual vacuum aspiration

NGO – Non-Governmental Organization

PAC – Post abortion care

REC – Regional Committees for Medical Research Ethics

SDG – Sustainable Development Goals

TOP – Termination of pregnancy

UN – United Nations

US – United States

UTH – University Teaching Hospital

WHO – Word Health Organization
Abstract

Introduction
Zambia legalized abortion on broad grounds in 1972. However, the access to safe abortion services is still limited and necessary requirements for performing abortion is strict. Combined with little knowledge about the abortion law in the public, many women still seek unsafe abortion methods outside health facilities. Health care workers are tasked with an important function in provision of safe abortion care to eligible girls and women, but little is known about how they handle this function. The aim of this study is to enhance our understanding of the role that health care workers play in access to safe abortion care to girls and women in Lusaka.

Methodology
Data were collected in Lusaka from January until May 2018 with a qualitative approach combining participant observation at the acute gynaecological ward with semi structured in-depth interviews. Data were analysed using manual thematic analysis and discussed within the framework of street-level bureaucracy and the concept of practical norms.

Findings
I found that many health care workers faced moral dilemmas when offering abortion services. They reported that their professional commitment and practises often were in conflict with personal beliefs on abortion. Despite the moral dilemmas health care workers dealt with when offering abortion service, the majority of informants in my study choose to offer or facilitate abortion, both officially and unofficially. Furthermore, health care workers in my study interpreted and implemented the law differently, which has resulted in a number of unwritten practises, both to facilitate and avoid safe abortion care.

Conclusion
Health care works are important “gatekeepers” for access to safe abortion care and their knowledge and their preparedness to offer this service has implication for the abortion service in practise.
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Introduction

Abortion has been performed throughout history with documentation dated 4000 years back (1) (2). Nevertheless, abortion is a delicate and debated issue globally, and laws restrict access to safe abortion services in most countries (2) (3). Pope Francis recently compared abortion with hiring a hitman (4) and currently we witness a move towards tightening women’s right to access safe abortion services in the United States (US) (5). Because it is associated with stigma, women need to justify their choice to have an abortion also in countries where abortion is legal (2) (3). This encourages clandestine unsafe abortion practises and every year millions of women turn to unsafe methods to terminate their unwanted pregnancies. The World Health Organization (WHO) estimates that twenty-five million unsafe abortion are performed globally each year and seven million women are hospitalized as a result of unsafe abortion procedures (6). Nearly all unsafe abortions occur in low income countries, and the problem is particularly large in Sub-Saharan Africa where the majority of abortions are unsafe (6). Health care workers play an important part in controlling access to safe abortion services (2) (7) and reducing or maintaining abortion related stigma (2). Using Zambia as an empirical example, I will in this thesis discuss the role of health care workers in abortion care and explore their challenges and experience working in a context where abortion is legal on broad grounds, but highly condemned and stigmatized as an offense against Christian values.

Background

Reproductive health refers to all health dealing with the reproductive processes, function and system at all stages in life and includes access to information and services, such as family planning, pre and post-natal, delivery and abortion services (8). In 1994 on the International Conference on Population and Development (ICPD), countries agreed that population policies should aim at empowering couples and especially women to make decisions about their reproductive health. ICPD highlighted the link between sexual and reproductive health with population and development issues and recognizes safe abortion as an important factor in improving maternal and reproductive health. There has been a tremendous progress in reproductive health globally since 1994, with increased contraceptive rates, reduction in teenage pregnancy rates and maternal deaths (9).
Maternal health is defined as the health of a woman during pregnancy, childbirth and postpartum (10). WHO has acknowledged the importance of maternal health and included maternal health both in the millennium development goals (MDG) (11) and the sustainable development goals (SDG) (12) with the target to reduce maternal mortality. These global health policies have set maternal health on the agenda both on national and international level. Maternal health is also used as an indicator of development, of women’s status and of health system functioning in a country (13). Unfortunately, the maternal mortality rate remains high in many countries and most maternal deaths could have been prevented (14). Severe bleeding, infections, pre-eclampsia and eclampsia, complications from delivery and unsafe abortions are the five major causes of maternal deaths globally (14).

Abortion methods, trends and access

Abortion is a procedure to terminate a pregnancy and the legislation of abortion around the world ranges from total ban to unrestricted access on woman’s request (2). Abortion can be performed medically or surgically under various circumstances and gestational age of the pregnancy is one factor affecting access to legal abortion, which varies from country to country (2). According to Ganatra et, al (15) abortion can be classified as either safe, lesser safe and least safe. WHO (6) defines unsafe abortion as termination of an unintended pregnancy either by a person lacking necessary skills or in an environment lacking medical standards or both.

Unsafe abortion is associated with poor economy and social inequality and it is a major health burden in many low-income countries. Unsafe abortion often end as incomplete abortion, where post abortion care (PAC) and hospital admission is needed (6) (14). PAC includes treatment for complications from abortion, family planning counselling and services and was introduced to improve women’s reproductive health and break the circle with unwanted pregnancies (16). The introduction of PAC has had a tremendous impact on maternal health, especially in countries where abortion is illegal (2). Manual Vacuum Aspiration (MVA) is part of PAC and a common treatment for incomplete abortion up to gestational week fourteen of the pregnancy. MVA is a quick surgical procedure with few complications, where remaining products of conception are removed from the uterus using a syringe with vacuum (17).
Medical abortion is a safe and effective method to terminate a pregnancy and often preferred up to gestational week nine of the pregnancy (7) (17). WHO’s recommendation for medical abortion is to combine the drugs misoprostol and mifepristone. As mifepristone is not available in all countries, WHO has guidelines for the use of misoprostol alone to terminate a pregnancy (7). Misoprostol was put on the essential drug list for WHO in 2009 (18) and it is a drug available worldwide used to treat stomach ulcers, induce labour, induce abortion and to treat postpartum bleeding. Misoprostol can often be obtained at black markets or off label at pharmacies (7) (19).

Abortion is a culturally sensitive topic as women’s status is closely associated with childbearing (2). Access to safe abortion is therefore not only restricted by law, but in many cases also by religious norms, traditions and politics (20) (21). The US President Donald Trump expanded the Mexico City Policy also known as the global gag rule in 2017, and blocked funds to organization providing abortion services or information about abortion services (22). There is a reason to believe that this has negatively affected abortion access in many low-income countries and possibly made abortion more stigmatized (23). Due to the cultural and religious sensitivity of abortion, unsafe abortion is often underreported and/or misclassified as many women obtain abortion unofficially with or without trained providers. It is therefore a challenge to obtain accurate data on abortion (21) (24) (25) (26) (27). Moreover, as women often obtain abortion outside health institutions, but commonly seek health care for PAC to get treatment for complications, it is difficult for the health care workers to distinguish between induced and/or spontaneous abortion (28) (29) (30) (31) (32).

Countries with restrictive abortion law often defend their legislation by claiming abortion rates will rise with a more liberal law (21). However, reports and studies show that a less restrictive abortion law does not entail more abortions, it rather leads to the opposite. Europe is the continent with the most liberal abortions laws, and it also has the lowest abortion rates in the world (21) (24). Countries with strict abortion laws have both higher proportion of unsafe abortions and higher incidence of abortion related deaths compared to countries with more liberal abortion laws (6) (13) (33) (34) (35). This is also in agreement with findings in Nigeria by Lamina (36), who argues that most complications and deaths resulting from abortion could be reduced with more a liberal abortion law. However, the link between abortion law and unsafe abortion is not unidimensional as less restrictive abortion law alone is not sufficient to secure accessibility of safe abortion care (21). Knowledge of the framework
and increased access to the service is essential for better utilization of the service (2). Legislation is often not announced to the general public nor health care workers supposed to provide abortion services. When Colombia decriminalized abortion some years back, health care workers were not aware that safe abortion care was part of their duty, so girls and women met resistance when seeking the service in public institutions (35).

In countries with poor access to abortion service and/or a restrictive abortion law many women seek abortion unofficially. Abortion can be performed by health care workers, traditional healers, relatives or by the woman herself and many prefer to induce the abortion outside the health institution and present in the hospital with vaginal bleeding, in need of PAC (2) (31). Unsafe and traditional methods to terminate pregnancies by inserting dangerous objects in the cervix or using traditional medicines have been a major burden to maternal health (2) (6). Luckily there has been an increase in women accessing safer methods to terminate their unwanted pregnancies and authors link the availability of misoprostol to this change (2) (15) (21). However, many women still face complications from abortion due to poor drug quality, incorrect dosage or a combination of these (35) (37).

Complications and deaths from unsafe abortions is related to skills of the provider, the environment where the procedure is performed, and equipment being used. Hence health care workers have a crucial role in provision of safe abortion care (27). Health care workers are obliged to provide medical care to women suffering from abortion related complication, regardless of the abortion law in the respective countries (6).

WHO has acknowledged several barriers in access to safe abortion services, this includes restrictive abortion laws, poor access to health facilities, high costs, stigma and lack of trained providers (33).

**Abortion in Zambia**

Zambia has recently been categorized as a low-middle-income country, but health indicators are similar to low-income countries (38) (39). Among the population of 18 million almost half of it is under fifteen years (40). Adolescent pregnancy is a major social and health concern with a median age at first birth of nineteen years and where almost thirty percent of women aged fifteen to nineteen have a child or are pregnant with their first child (39). Zambia
has a high fertility rate with nearly five children per woman (40) and regardless of socioeconomic status, a national census revealed that most women had more children than they initially wanted (39). Maternal mortality rate in Zambia was estimated to be 224 deaths/100 000 live births in 2015 (41) and the Ministry of Health reports that up to fifty percent of all acute gynaecological admissions to hospitals in Zambia, were related to abortion complications, most of them a result of unsafe abortion methods (42).

WHO (6) suggest three measures to prevent unwanted pregnancies and unsafe abortions, this includes sexual education, increased use of contraceptives, and facilitating for safe and legal abortion. In Zambia, there is an association between contraceptive use, wealth and education (39). Most women have knowledge about contraceptive methods but only thirty percent of women with multiple sex partners use condoms (39). Comprehensive sexual education was included in the school curriculum in 2014 (43), however considering the high adolescent pregnancy rates in Zambia there is a reason to believe that there is still a lack of sexual education awareness and/or access to contraception in Zambia.

The law on abortion

Abortion has been allowed on broad grounds in Zambia since 1972 with one the most liberal abortion laws in Sub-Saharan Africa. The framework does not indicate the limit in terms of gestational weeks to induce the abortion, but the guidelines for Comprehensive Abortion Care (42) implies medical and surgical methods up to gestational week twelve and surgical methods exclusively from week twelve and above. Zambia has signed the Maputo protocol and thereby committed to provide safe abortion within its legal framework (42). The legal framework on termination of pregnancy is defined by five principal acts of the parliament: The Republican Constitution, the Penal Code, Termination of Pregnancy Act, Health Professional Act and Gender Equity and Equality Act (42).

The law allows abortion to be performed in registered hospital and clinics if medical doctors perceive that the continuation of the pregnancy will put the woman’s life at risk or traumatisate her or her existing children physically or mentally. Furthermore, abortion is legal if the foetus has serious abnormalities or on socio-economic grounds, such as the woman’s age and her economic situation. Gender based violence has increased in Zambia, resulting in an amendment in the Penal Code in 2005, including pregnancies resulting from rape as a legal
ground for abortion if the girl is less than eighteen years. Nonetheless, to be allowed to abort, the requirement is that three doctors including one specialist signs the certificate of termination (Certificate a, see appendix 1) causing bureaucracy and delays in provision of the service. Nevertheless, in cases of emergency threatening the woman’s life, abortion can be executed with the signature and approval of only one doctor (Certificate b, see appendix 2) (42). Furthermore, if the doctor considers a risk of unsafe abortions and/or lack of other available doctors to certify for the procedure it is adequate to sign the emergency certificate. The penal code criminalizes unsafe and/or illegal abortions with imprisonment up to seven years for providers and up to fourteen years for women receiving the service (42).

Health care workers in Zambia can choose to be conscious objectors to abortion services due to personal beliefs, but their personal objections should not hinder women’s access to safe abortion care and health care workers are obliged to assist women in need of emergency care (42). Health care workers engaged in maternal health are offered training by an international non-governmental organization (NGO) IPAS in Comprehensive Abortion Care (CAC) which includes training in abortion care, post abortion care and family planning (44). Due to shortage of medical doctors’ mid-level providers (e.g. nurses, midwives and clinical officers) can now offer abortion under the supervision of a registered medical practitioner (42).

Christianity has a heavy influence on the Zambian society and politics (45) and this was highlighted when Zambia declared itself a Christian nation in 1991 (46). A study conducted in Zambia revealed that Christian believes affected health care workers’ decision about abortion provision (47). Another study from Zambia disclosed a connection between the declaration of Zambia as a Christian nation and health care workers’ role in providing safe and legal abortions. The abortion law in Zambia opens for interpretation both for abortion providers and non-providers and in connection with the limited knowledge about the abortion law it can restrict the access to safe abortion care (48). The 2016 government election included a referendum on a suggested change in the constitution stating that life begins at conception. This change in the constitution would have rendered abortion illegal in Zambia, but it did not gain sufficient support and was rejected (49). However, the suggested amendment was followed with debates about abortion that has led to further confusion on the legislation of abortion in Zambia (48).
Even though Zambia is among the countries with the most liberal abortion laws in Sub-Saharan Africa, the number of unsafe abortions remains high (25, 31, 50) (51, 52). A study from Zambia revealed that sixty-nine percent of respondents knew one or more women who had died from unsafe illegal abortions (20). The legislation on abortion is unknown to the general public, resulting in few women seeking safe abortion services (21) (50) (53) (54). Ministry of Health estimates that the majority of all abortion complications are connected to unsafe methods (42) often related to lack of access to safe abortion services. A study revealed that less than two percent of health facilities could fulfil the criteria for three signatures for a legal termination of pregnancy (55). Furthermore, long distances to health facilities and little knowledge on the abortion law also contributes to poor access to safe abortion services (39) (53). Cresswell et al., (50) found that only sixteen percent of women in reproductive age could identify the grounds of which abortion was legal, and concluded that poor knowledge and conservative attitudes were barriers in accessing safe abortion care. Moreover, most women asked found abortion to be immoral and disagreed that women should have access to safe abortion care (50).

Mifepristone was approved by Ministry of Health in Zambia in 2010 (56) and the combined use of misoprostol and mifepristone to induce abortions was registered in Zambia in 2012 (43). Few legal medical abortions were performed in Zambia until 2011 (25). Studies from Zambia has recently reported a reduction of women with severe complication resulting from unsafe abortion methods. This reduction can be related to the availability of misoprostol ((31) (54). Furthermore, different studies (54) (57) (58) report that drugs used for medical abortion are available in a variety of pharmacies in Zambia with the majority of pharmacist willing to sell misoprostol without a prescription. Moreover, one study disclosed that none of the pharmacist gave clients the correct drug dosage, demonstrating the role pharmacist have in providing medical abortions in Zambia (57). This is supported by studies (54) (52) revealing that several health facilities in central Zambia perform more PAC than termination of pregnancy. This can be related to women buying misoprostol off label and present in the hospital with bleeding and in need for PAC.

The health system in Zambia

The health system in Zambia is divided into four level of provision consisting of; community level with health clinics and health centres, district level with first level hospitals, provincial
level with second level hospital and tertiary level with specialist care and third level hospitals (59). There is also a number of private health care providers, church organizations and international NGOs.

Health care in Zambia is affected by shortage of staff, lack of equipment and resources and poor infrastructure. Nevertheless, Zambia has committed to offer universal health coverage to its citizens and people can choose to pay for an additional health insurance to ensure faster and better health care (59).

PAC is provided in most hospitals and clinics with maternal health services. However, termination of pregnancy is limited to a few facilities (55). Governmental hospitals is the biggest abortion providers, with support from international NGOs like IPAS and Marie Stops. (60). Whilst IPAS aims at expanding women´s access to safe abortion and contraceptives by training local health care workers and inform women about abortion services (44), Marie stops provides both safe abortion and PAC to women approaching their clinics (61).

Rational

Several barriers exist that might prevent patients from seeking health care when it is needed such as little knowledge of the system and stigma both among people and in the health institutions. In a national census, thirty-four percent of women in Zambia listed rude health care workers as barriers in seeking health care (39). There might be several explanations for this, such as shortage of staff and lack of qualified health care workers (62). Studies have shown that health care workers are able to provide better abortion care when they are trained in sexual and reproductive health (54) (63) (64). A study from South Africa (64) concluded that trained health care workers were more likely to perceive abortion care as a human right and respondents reported that providing abortions likely reduced maternal mortality resulting from unsafe abortion practises.

Several studies conducted in Africa have found that health care workers offering abortion services often are stigmatized both from family and colleagues and experience conflicting expectation related to providing abortion service versus their professional duty to protect life (30, 47, 64). Health care workers’ perceptions about abortion is likely to influence both accessibility and quality of the service they provide.
Despite Zambia having a liberal abortion law, women still seek unsafe methods to terminate their pregnancies. Several studies on abortion have been conducted in Zambia, from investigating access to abortion care (25) (31) (52) (55), the knowledge about the abortion law (50) (48), health care workers attitudes on abortion (47), the financial burden of abortion (28) (29) (32), the stigma related to abortion (53) (65) and the introduction and availability of medical abortion in Zambia (54, 57) (58) However, there is limited knowledge on health care workers role in facilitation and provision of abortion care and this study therefore aims at exploring health care workers experiences and perception working with abortion.

Research objectives

Main objective

To enhance our understanding of the role health care workers` play in providing access to safe abortion care and their perception of their role and the space they have to shape their role according to their own values and preferences.

Specific objectives

1. Describe health care workers knowledge and interpretation on the abortion law.
2. Explore health care workers practises in facilitating access to safe abortion care
3. To understand health care workers role in the encounter with abortion seeking girls and women.
4. Investigate health care workers` perceptions of abortion and their challenges and experiences in providing abortion care.

Theoretical perspectives

Health care workers are central gatekeepers to abortion services. In order to analyse health care workers role in this field, I use the theory of street-level bureaucracy and the concept of practical norms.
Street-level Bureaucracy

The theory of street-level bureaucracy by Lipsky (66), describes how frontline workers develop strategies to deal with dilemmas when implementing policies and how they use their discretion to shape and implement these policies in practise. Health care workers (e.g. nurses and doctors) are policy implementers in regular and direct contact with the general population and their interpretation and implementation on laws and policies makes them street-level bureaucrats.

Street-level bureaucrats face dilemmas such as inadequate resources, growing demand for their services and conflicting expectations from both policymakers and clients. As street-level bureaucrats, health care workers have the power to apply discretion over the service being offered at their facilities, and structure how health care workers interact with patients, hence which benefits and/or sanction that can be received by the general population seeking their services (66).

Street-level bureaucracy is relevant to understand health care workers role in provision of abortion service in Lusaka and to understand health care workers moral dilemma when offering abortion care in a context where abortion is legal but stigmatized and condemned.

Practical norms and real governance

Practical norms is a concept developed by Herdt and Sardan (67) describing the gap between theory and practise in public institutions in Africa. The gap is described as a space where alternative norms are exercised to perform daily activities. Herdt and Sardan state that practical norms occur as a result of interpretation of rules and laws or from regulations emended by civil servants not complying with the official norms and how these are put into practise. Practical norms are often hidden and unwritten practises, which may vary from one location to another, and often described as the real every day practise of a profession.

Herdt and Sardan (67) recognize that a number of social issues in Africa are established because of corruption and problems in governance. The African context is diverse and complex, and the concept of practical norms could be used to understand the interaction
between civil servants and user on how practises are established both positively and negatively.

Practical norms mostly develop on the basis of the exercise of discretion but may also be a function of the commitment to prioritize and assist family members and of the expectation in a health institution to favour other staff and their kin. Therefore, this theory is relevant to understand how unwritten practises occur in abortion care and how they are maintained in the health institutions. Furthermore, as practical norms aim at understanding the gap between policies and action, the theory is suitable to explore the difference between what informants stated in the interviews and what actually happen in practise.
Methodology

Study setting

Material for this thesis was collected in Lusaka from January to May 2018. The fieldwork was primarily conducted at the University Teaching Hospital (UTH) in Lusaka, where I did three months of participant observation and interviewed health care workers, secondary I interviewed health care workers from lower level health facilities situated in different parts of Lusaka.

UTH is a tertiary and the largest hospital in Zambia with all major specialities. The maternity wing at UTH has the highest proportions of gynaecologist in the country and is divided into different sections with an acute ward, pre and postnatal ward, delivery, surgery and polyclinics. I was situated in the acute ward, where all women with gynaecology problems and pregnant women with gestation up to week 25 were referred. Patients admitted to the ward were observed there for 24 hours before discharged home or referred to other wards.

In the admission room, there were two consultation beds for women to be examined and two small desks with chairs where women sat back to back while doctors took their medical history. In the mornings there were two junior doctors present in the ward, consulting one patient each. Opposite the admission room was the “MVA” room, where most of the small procedures were performed including PAC. The triage table was placed in the middle of the ward, where most patients admitted came for vital signs (blood pressure, pulse, temperature and respiration rate). There was also one patient room for critical ill patients, three ordinary patients’ rooms and two consultation rooms.

Doctors in the maternity wing at UTH were divided into five different teams consisting of consultants, junior and senior doctors. There was one team on call each day of the week and they switched working weekends. Junior doctors were present in the ward 24/7, performing most of the daily routines in the ward including MVAs. Senior doctors did ward rounds in the morning and were called to the ward in cases of emergencies or if a woman was seeking abortion. Nurses followed their own rotation, shifting between days, evenings and nights.
In the lower level health facilities, I only conducted interviews and therefore I was only given a small orientation around their clinics and their routines concerning abortion. These health institutions were often the first encounter patients had with health care. The facilities were basic, but all of them offered both PAC and medical abortion. The size and facilities of these institutions varied from two newly built first level hospitals to two more worn out facilities. All of the four health institutions covered a large but unknown number of people. Mostly in these institutions, it was midlevel providers such as nurse, midwives and clinical officers offering medical abortion.

Women seeking abortion services are supposed to pass through a lower level health facility, who will refer the patient to UTH if they cannot assist the girl or woman. However, due to lack of knowledge about the legislation of abortion in Zambia and stigma, many women seek abortion unofficially. Those obtaining abortion at UTH need to sign a consent form (See appendix 3) and have either certificate a or certificate b signed by medical doctors. Women receiving MVA as part of PAC are required to sign the MVA form (See appendix 4).

**Study design**

This is a qualitative descriptive study, using participant observation and semi-structured interviews to get information directly from those experiencing the phenomena of interest (68). Qualitative method has been widely used in health research such as nursing, and it is recognized as flexible as the researcher can adjust the study design during the research when new and unexpected information emerges. Qualitative research is often suitable and a preferred method to understand the context of interest on areas where little research is done, as qualitative method explores people’s perceptions, experiences and attitudes to understand the diversity and complexity of a phenomena not possible to measure quantitatively (68). There is little research on health care workers’ role in safe abortion care in Lusaka. I choose qualitative method to explore this topic with an open and flexible approach to get an in-depth understanding of the working culture, social norms and traditions influencing health care workers role offering safe abortion care.

Triangulation is an important part of qualitative research where several research methods are combined to increase the trustworthiness of the study. By combining research methods weaknesses in one method will be balanced as strengths in another method (69). Therefore, to
overcome potential biases I conducted participant observation and semi-structured interviews to provide a range of perspectives and strengthen the validity of my findings (68).

Participant observation

Participant observation is a data collection method used increasingly in qualitative research, where the researcher talks, observes, actively participates and experiences the informants’ everyday life over time in their natural environment (68). Participant observation gives the researcher a deeper understanding of the dynamic in the context of interest, both from an “insider” and an “outsider” perspective (70). The blend of “outsider” and “insider” perspective is unique to each researcher and is affected by factors such as age, sex and education with both advantages and disadvantages. The “insider” perspective demonstrates to the researcher the process rather than the outcome and the researcher gets an exclusive perspective as informants often gain trust in them as they perceive the researcher as a member of their group, hence the researcher does not disturb unnaturally (70). The “outsider” perspective is important as one can see aspects invisible by “insiders” and the “outsider” can have conversations and ask questions the “insider” cannot ask (70). Informal talks with informants was a valuable source of information during the fieldwork, for instance a nurse shared with me during one of these talks how she had brought her niece in for an unofficial abortion to the hospital. In another conversation a nurse explained the unwritten practise of doctors charging for medical abortion even at UTH and that most of these cases were not documented.

Participant observation is a dynamic method that allows the researcher to get to know people rather than knowing about them (68). By observation you are able to see and participate in daily routines which informants might not feel worth commenting on in an interview (68). To do participant observation one needs to fit well enough into the environment to be trusted, accepted and ignored, so one can observe features of everyday life as if one were not around. However, when conducting participant observation, the researcher must keep in mind that he/she will affect the environment and hence shape the findings to some degree and that this impact can be minimized by a long duration of the fieldwork (71).

Covert participant observation is a type of participant observation where the identity of the researcher and the nature of the research is concealed from those studied (71). I choose to
gain information through this method to get a wider perspective and get first-hand information on informal practices likely used by women obtaining abortion unofficially. I visited a number of pharmacies around Lusaka to check the availability of misoprostol, I contacted a traditional healer advertising for services with unwanted pregnancies, I read newspapers and magazines and I follow a number of pages on social media, where I have observed safe abortion being promoted. During my stay in Zambia, I had regular conversations about abortion both with friends, and random people I encountered such as taxi drivers and youths.

Due to the complex picture of abortion provision in Zambia, where religion plays a major role, I would argue that the best way to try and understand the context was to be present in the hospital and get access to information not possible to reach through other methods. Furthermore, by being in the ward, informants got to know me and gained trust in me, which was valuable as there was a lot of unwritten practices and hidden arrangements in the ward.

**Being a participant observer at UTH**

After getting all necessary approvals from the authorities, I introduced myself to the administration at the maternity wing at UTH to ask for permission to conduct participant observation at the hospital. After reading my research proposal, I was given a letter of introduction to the nurse in-charge of the acute gynaecological ward. I had already interviewed the in charge, so she knew about my research. The in charge appointed me to a nurse, who showed me around the ward and introduced me to her colleagues as a researcher on abortion. I followed this nurse’s shift the first weeks of the fieldwork.

I started participant observation in mid-February and carried on till first week of May. As a trained nurse, I gained access to the ward and I was in the ward on a daily basis, shifting between days, evening and weekends. It was challenging to be new in the ward. However, I was welcomed and soon became an "insider" and part of the daily life in the ward. At the same time as I was an “outsider” and tried to keep an analytic distance to the information I obtained through the observation. The benefit of being both an “insider” and an “outsider” is that informants have gained trust in you to reveal information naturally and you are able to recognize the information and interesting routines and as an “outsider” you can ask questions about things you observe which you do not understand (70) (71). Already the second week of
my fieldwork as I was collecting items from the storage room with one of the assisting staff, she told me to pay attention to women waiting for specific doctors for private arrangements in the ward.

At first, I tried to keep distance to the patients, and I was very conscious about getting approval from them to be part of counselling sessions and consultations. The first weeks, I had the consent forms and information sheet in my pocket, ready to ask for permission to observe their interactions. However, being an acute ward, things were in constant change and to come in the middle of a situation to ask for approval to observe their interaction felt unnatural and even unethical. Nonetheless, I kept on reminding health care workers of my role in the ward.

I preferred being in the ward evenings and weekends, as most of the interesting cases were admitted then. The disadvantage of being in the ward evenings and weekends were that less staff was available to tend for the patients and, I was expected to assist in the ward with all sorts of procedures. I found my role by the triage table, where all new patients came for vital signs (pulse, temperature, blood-pressure and respiration rate). Most of the patients had referral letters stating their problem. So, if there were cases of incomplete abortion or women seeking abortion, I could follow up the care provided to them. I observed few women sought abortion in the hospital, and many of those who did, came directly to the nurse or doctor without passing through the normal route of admission with a referral letter.

I participated in daily routines in the hospital: from transferring patients to other wards, colleting blood from the blood bank, assisting the nurse giving out medication and collecting items from storage room. Furthermore, I was asked to assist in all sorts of procedures from inserting cannulas to prepare patients for MVAs, sterilising equipment and PAC counselling. I tried to participate in different activities in the ward and interact with different health care profession to capture different aspect, views and routines of abortion services in the hospital.

English is the official language used in the hospital, but the majority of patients did not speak fluent English and health care workers often used local language among themselves. Due to previous work experience, both in Zambia and Malawi I knew some Nyanja, the most common local language in Lusaka which was a huge advantage in communicating with both
staff and patients. Although I am not fluent in Nyanja, I could follow conversations in the ward.

The formal interviews

Recruitment

I used purposive sampling (68) at UTH to identify my potential informants for the interviews, based on criteria of work experience, abortion training and professional background (nurses, midwives, clinical officer, doctor). I was interested in health care workers offering or facilitating abortion services, so the major recruitment were health care workers providing abortion services as part of their job.

Initially I planned to start the fieldwork with participant observation but due to delays in getting necessary approvals, I conducted eight interviews with health care workers at UTH before I started participant observation. A medical doctor specializing in obstetrics and gynaecology assisted me in recruiting informants for the interviews prior to the participant observation. He introduced me to nurses and doctors providing abortion in the ward. After I started the participant observation, I conducted interviews when I had potential informants interested to participate and if the workload in the ward allowed it, in total I carried out fourteen interviews at UTH. I was concerned that my presence in the ward would influence the informants in the interview situation. However, when analysing the data, I did not notice any difference between the interviews I conducted before and the ones I conducted during the participant observation.

At the lower level health institutions, the administration directed me to health care workers performing abortions and all together I conducted six interviews at four different health institutions situated in different parts of Lusaka; one in Matero, one in Mtendere, one at Levy Mwanawasa and three in Kanyama.

All informants were English speaking health care workers. I interviewed eleven nurses, three midwives, one clinical officer, one medical attendant and four medical doctors. Twelve of my informants were women: one medical attendant, three midwives and eight nurses. The average years of work experience were 10 year with an age range between 26-49 years. Eight
informants were men: one clinical officer, three nurses and four medical doctors. The average years of work experience were 8.8 years, with an age range between 25-47 years. Below is a summary of information about the informants:

<table>
<thead>
<tr>
<th>Informant</th>
<th>Sex</th>
<th>Profession</th>
<th>Age</th>
<th>Years in duty</th>
<th>IPAS training *</th>
<th>Institution</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Female</td>
<td>Nurse</td>
<td>38</td>
<td>20</td>
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<td>UTH</td>
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<tr>
<td>2</td>
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<td>25</td>
<td>3</td>
<td>OR</td>
<td>UTH</td>
</tr>
<tr>
<td>3</td>
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<td>Nurse</td>
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<td>13</td>
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<td>UTH</td>
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<tr>
<td>4</td>
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<td>36</td>
<td>3</td>
<td>OR</td>
<td>UTH</td>
</tr>
<tr>
<td>5</td>
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<td>Doctor</td>
<td>35</td>
<td>4</td>
<td>Yes</td>
<td>UTH</td>
</tr>
<tr>
<td>6</td>
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<td>Doctor</td>
<td>33</td>
<td>2</td>
<td>Yes</td>
<td>UTH</td>
</tr>
<tr>
<td>7</td>
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<td>34</td>
<td>4</td>
<td>Yes</td>
<td>UTH</td>
</tr>
<tr>
<td>8</td>
<td>Male</td>
<td>Doctor</td>
<td>37</td>
<td>5</td>
<td>Yes</td>
<td>UTH</td>
</tr>
<tr>
<td>9</td>
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</tr>
<tr>
<td>10</td>
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<td>11</td>
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<td>Medical attendant</td>
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<td>5</td>
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</tr>
<tr>
<td>12</td>
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</tr>
<tr>
<td>13</td>
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<td>9</td>
<td>OR</td>
<td>UTH</td>
</tr>
<tr>
<td>14</td>
<td>Female</td>
<td>Nurse</td>
<td>27</td>
<td>5</td>
<td>OR</td>
<td>UTH</td>
</tr>
<tr>
<td>15</td>
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<td>Nurse</td>
<td>43</td>
<td>15</td>
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</tr>
<tr>
<td>16</td>
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<tr>
<td>17</td>
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</tr>
<tr>
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<tr>
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<td>15</td>
<td>Yes</td>
<td>UTH</td>
</tr>
<tr>
<td>20</td>
<td>Female</td>
<td>Nurse</td>
<td>29</td>
<td>2</td>
<td>OR</td>
<td>UTH</td>
</tr>
</tbody>
</table>

- IPAS is an international NGO focusing on expanding women’s access to safe abortion and contraceptive use by training local staff in CAC, inform women about abortion services and advocate for safe and legal abortions (44).
- OR means that the informant had one day of orientation about abortion in the ward.
Semi-structured interviews

Interview is a commonly used method to gather data in qualitative research (68). Interviews could be organized in a number of ways and are suitable method to get rich and detailed information from the informants. As they are done privately, interview is a good approach for researching sensitive issues, such as abortion (68).

In my study, semi structured interviews were chosen due to the flexibility of the method, where I could modify the interview guide and choose to go deeper into questions if needed at the same time as it provides structure in the interview. Interview as a method for data collection is often criticized, because people might give the answer, they think the interviewer wants instead of presenting their own views and there is often a discrepancy between action and what people claim or say they do (68).

In the beginning of each interview I introduced myself as a nurse doing my master’s in international health to the informants that did not know me. I gave each informant time to read the information sheet for the study (see appendix 5) before deciding whether they wanted to participate or not. Those willing to participate signed the consent form (see appendix 6).

The interview guide (see appendix 7) was changed after the first interview as new interesting information emerged. The interview guide started with general questions about the informants’ background and work experience, before going deeper into the law regarding abortion in Zambia. Lastly the informants’ personal experiences from working with abortion were addressed. Most informants responded well to the questions and probing was only necessary in a few interviews. All interviews were conducted in private rooms at the informants’ workplace. The interviews were tape recorded and lasted between 30 to 120 minutes.

Ethical clearance

I applied for ethical clearance from REC in Norway autumn 2017, which was approved in January 2018 (see appendix 8). I sent an online application for ethical clearance in Zambia in November 2017, which was approved in February (see appendix 9). It took me almost four weeks to get all necessary approvals. Finally, by mid-February I had ethical clearance,
clearance from national health research authority, Ministry of Health provisional and district office and I could start my fieldwork (see appendix 10, 11 and 12).

**Ethical consideration**

Informed consent was obtained from all informant I interviewed. Each informant was given the information sheet which they read before signing the consent form. Only two informants were unsure about participating. However, I assured them that participation was voluntary and that they could withdraw from the study at any time. All interviews were completed, and nobody has withdrawn their participation.

At the lower level health facilities, I had to acquire permission from the administration to perform interviews at each health facility. The administration directed me to potential informants. In the health facilities I visited, only a few health care workers provided abortion, and as the administration had already approved my research, some informants might feel pressured to participate, which might affect the result. However, I ensured all informants that participation was voluntary prior to the interview and combined with the fact that most health care workers providing abortion have chosen to offer the service, I feel this was not an issue.

I need to consider the ethics doing covert participant observation as the people involved were unaware of my aim of contact and it violates the norm of informed consent (71). It was essential for me to acquire accurate information about these practices, which they most likely would not share if they knew my role as a researcher (71). Furthermore, I would claim that the individuals I encountered using this method was not personally affected as I only gather information about their practices.

The head of department had approved my participant observation at UTH, and I tried to remind the health care workers that I was doing research during my participant observation.

I faced ethical dilemmas on a daily basis during the fieldwork. I found it especially challenging to differentiate between being a nurse and a researcher, particularly in situations with critically ill patients. I had not obtained nurse authorization in Zambia, hence in practice I could not work as a nurse. However, as an authorized nurse in Norway, I am required to assist in medical situations when needed. As a researcher, I wanted to participate in the daily
life as an "insider", but on the other hand I tried not to interrupt as an "outsider” observer. Shortage of staff was a constant problem during the fieldwork at UTH. At first, I tried to only observe situations, but it felt wrong to be there and watch as the ward was hectic with critically ill patients. As when a 34 old lady had a septic abortion and died in the ward whilst I was present. It was obvious to me that the nurses on duty were not used to perform cardiopulmonary resuscitation, so I assisted in the resuscitation. In such situations, you forget that you are a researcher to try and save a life. Moreover, it felt more natural to be part of everyday life by helping with their duties. Split between these two roles was a constant ethical dilemma for me, and at times I felt as a double agent, trying to be part of their working team at the same time as I wanted to observe them for my research. Furthermore, as I was in my nurse uniform, it was expected of me to take part in their duties and already on my fourth day in the ward I was asked to assist the doctor when performing an MVA, as the nurses were busy with other patients. It would be unnatural for me to say, “No, I am here to observe, and I can’t take part in MVAs as I don’t have ethical clearance for that”. Initially, you want to observe what happens when you are not around, but this woman was bleeding profusely and needed to be evacuated.

Compensation

All the interviews were conducted during working hours, so I gave the informants a soft drink and biscuits for their participation. Only one informant asked for money for being interviewed, as she said nobody came to their hospital conducting interviews for free. I agreed with my local supervisor to give her 50 Kwacha for the interview (around 41 NOK).

Confidentiality

The informants’ names and identity are confidential for all others than the researcher. The consent forms were locked in a room during fieldwork. The audio files from the interviews is stored in a password protected computer and copy into USB stick, locked in a room.

Patient names in the findings chapter are fictional for confidentiality.
Data analysis

The data analysis was continuous process from the first interview and first day of participant observation. Throughout the process I asked myself: Which questions are more relevant? Which question can I get more detailed information from? Could I ask any other questions? During my first interview new information emerged, which ended up with some additional questions, which was followed throughout the rest of the interviews.

I transcribed the interviews myself and tried to transcribe after each interview to get a better understanding of the theme, the interview guide and also to have the chance of going back to the informant to ask questions if anything was unclear.

The first week of participant observation I tried to figure out routines and practises in the ward concerning abortion and when writing fieldnotes and reflecting on what I had observed in the hospital, I used my research questions as guidance. A lot of situations happened in the ward on a daily basis, so I needed to structure what was relevant for my study.

I wrote field notes after each day in the ward, which gave me time to reflect what I had observed and the chance to ask questions if I had observed something interesting or if there was anything which I did not understand.

I used manual thematic analysis, which is a flexible and one of the most common methods to analyse qualitative data. The core of thematic analysis is to find patterns and themes to describe the phenomena of interest (72). I used Attride-Stirling (73) thematic network as a starting point in my analysis, which consists of a three-stage analysis: breakdown of the text, exploration of the text and integration of the exploration. This was a continuous process, and I have changed my thematic network several times. The thematic analysis consists of global theme: Health care workers as moral agents in safe abortion care. Organizing themes: 1. Uncertainties about the law, 2. Different approaches in patient care, 3. Torn between professional commitments, social norms and Christian values, 4. Unofficial practises in safe abortion care and 5. Access to misoprostol beyond health care workers control. Under the organizing themes I have constructed 2-5 basic themes like: “Being a good Christian” and “The obligation to save lives” as illustrated in the figure below.
Step 1: Coding the material

The first part of the analysis is about reduction of data and coding the material by recognizing patterns in the dataset. Codes often emerged in relation to the research questions and are building blocks for the further analysis and theme design (72). I printed out all transcribed interviews and started reading through them one by one, noting keywords on the side. After reading all interviews I looked through the noted keywords and made an overview to find common characters. Thereafter, I re-read the interviews and started noting quotes and interesting answers on yellow post-it-notes and sorted them out into different groups. I used the research questions as a guide when coding the interviews, to decided what to included and not. After coding, I sorted the interesting quotes, which to use and which was not relevant.

I coded my fieldnotes, by noting keywords and interesting cases and analysed the fieldnotes in connection with the interviews, to find common features and to see if there were difference between word and actions.
Step 2: Constructing networks

After coding the material, I systematized the codes into themes representing patterns and the overall understanding of the data. Thereafter, I arranged the themes into groups and organizing themes. I already knew two of my organizing themes; Misoprostol beyond health care workers control and Unofficial practises in safe abortion care, as these themes represented new and interesting information about abortion provision in Lusaka. From knowing those, I found three other organizing themes representing interesting and common data from my dataset. The names of the other organizing themes have changed a couple of times, but the content has been the same. The names of those are: Uncertainties about the law, Different approaches in patient care and Torn between professional commitments, social norms and Christian values. When I had the construction of those, I found my global theme: Health care workers as moral agents in safe abortion care, which was the starting point of writing my analysis.

From identifying the organizing themes, I structured my codes under these themes and the basic themes were created. The basic themes have also been moved and changed along the way as the thematic analysis has been rearranged on several occasions.

Step 4: Exploring the network

After creating the thematic network with basic themes, organizing themes and global theme, I went back to my filed-notes and transcribed interviews to ensure that I had captured the relevant data and patterns. I had now divided my data into the four organizing themes and read through the data set in the view of those themes. I found this step very useful in my analysis.

When exploring my data, I tried to sort out key findings and find common data. I have made a summary, with sex, gender, work experience and some of the key findings in my data collection (see appendix 13).
Reflexivity

Reflexivity is the process where you reflect both on how you as a researcher and how social and cultural process might shape the data collection (69). I strived to be as objective as possible during the interviews and participant observation. I am passionate about women’s right and I perceive self-determined abortion as a woman’s right. It was a challenge to stay objective when someone spoke against my beliefs and values.

Hospital experience from Tanzania and Malawi, countries with similar culture and socio-economic background as Zambia, prepared me for the fieldwork in Lusaka, and made it easier for me to adapt to the ward. My background, attitudes and understanding might have shaped my material and analysis, However, I tried not to express my opinion on abortion. I rather aimed at capturing informants’ thoughts and ideas about the topic. I have tried to be aware of my preconceptions and influence during the analysis of my data.

I knew basic Nyanja and had cultural knowledge and experience from Zambia, so it was easy for me to get in contact with people. I felt people openly spoke about sexuality and abortion with me. Being a foreigner has advantages and disadvantages. Many perceived me as a doctor being in white uniform, others thought I was a nurse student. However, I tried to remind people that I was doing research, which was a challenge throughout the fieldwork. Even though I was a foreigner, it did not take long until the health care workers perceived me as one of them, sharing all sorts of information with me. I need to keep in mind that being white and studying abortion, some health care workers might say and do what they thought I wanted to hear and see. Yet I did not get the impression that people in the ward were affected by my presence, and due to the long duration of the fieldwork my influence was minimized. I have tried to be aware of my preconceptions and not let it influence my analysis.
Findings: Health workers as moral agents in safe abortion care

Through the analysis of the interviews and observations, I discovered that health care workers in my study faced many dilemmas when offering abortion and were torn between Christian beliefs and professional commitments. Although they implemented policies and offer ways to facilitate abortion service, they had a continuously need to justify their own role as a provider vis a via themselves and others. My findings are divided into five sections reflecting the organizing themes and includes: 1. Uncertainty about the law, 2. Different approaches in patient care, 3. Torn between professional commitments, social norms and Christian values, 4. Unofficial practises to facilitate abortion care and 5. Misoprostol beyond health care workers control as presented below.

Uncertainty about the law

In the following section I will describe the various ways that the abortion law was understood and the consequences their understandings of the abortion law and their practise within the institution.

Ambiguous interpretations of the law-is abortion legal or illegal?

Most of the informants knew about the abortion law and its requirements on which legal abortion could be sought. However, during the fieldwork, I noticed that many junior doctors and newly educated nurses in the ward were unaware of which grounds women could seek the service. One informant noted that the law has been there for a long time, it is just that people do not know about it. “The abortion law in Zambia has been there since 1972, it is just that people are not sensitized so they don’t talk about it, so it looks like it is new”. (Informant 3)

There were different interpretations on the law and several informants gave ambiguous answers on the provision of the service. One informant went to the extent of claiming they are close to have self-determined abortion in Zambia. However, in the same sentence he stated that he as a doctor decides whether a woman qualifies or not. This demonstrates the ambiguity around the interpretation of the abortion law and how the law is practiced. “Actually, it is now that it has been made almost as the right of a woman to request for the
termination of pregnancy, and our job is to see whether this woman qualifies or not. If she doesn’t qualify, then we, we advise accordingly” (Informant 19)

Two informants were unsure about the abortion law and wanted to double-check the law prior to the interview, but during the interview it was clear that they had some knowledge of the law. Only one informant stated that abortion was criminalized after the referendum in 2016, where there was a suggestion on amendments in the constitution stating that life begins at conception:

“Law on abortion, it has always been illegal. So there came a time, I think about two years ago they realized that a lot of girls were dying due to illegal abortion, so they decided to legalize it. I think it only ran for a year, then the government put up a referendum, they changed to say, they will count it as a child when it is upon conception. So, if somebody aborts even at one month, two months it is illegal. They get arrested, they are very strict on that one”. (Informant 13)

Health care workers themselves were uncertain about the law and the legality of abortion at the same time as they were concerned that the public had little knowledge and access to information about the law.

We cannot advertise our services

Since abortion was not discussed openly in public, all the informants mentioned the need for sensitization on the abortion law and abortion service to the general population. “I think the information hasn’t yet reached out to the masses, saying this is a safe and a free procedure, which can be done in a health facility that offer the service or the hospital. I think they still lack information”. (Informant 8)

I visited several health institutions around Lusaka, and I did not see any information about abortion services. Most informants saw sensitization on abortion as a challenge and abortion service as under-utilized. Nevertheless, I was given several examples of how sensitization could be done. Some informants suggested posters and information sheets in the health institution whilst others suggested to inform people through media and create websites for girls and women to seek information about the service. The informant below described
another way to sensitize about abortion. “You see, it is difficult and depends on the setting. One of the things that people can talk about freely is just repeating the information in different less threatening environments. When you talk about Human Immunodeficiency Virus (HIV), you slip in a message about abortion”. (Informant 8)

Several informants explained the challenges to discuss abortion in public, as some doctors have had trouble after discussing safe abortion in the media:

“Sensitization is quite difficult. It is a sensitive issue, and by nature doctors shouldn’t advertise ourselves. You can’t go on radio and say: “Abortion service is offered at UTH between 0800 hours and 1600 hours. (...) So, I think on one hand we are playing on ethical issues to say you can’t go on media, because I know of some doctors ending up having problems when advertising their institution”. (Informant 7)

Moreover, some mentioned further difficulties on sensitization, after the government suggested amendments in the constitution to say that life begins at conception. Therefore, some proposed more involvement from politicians and policymakers and suggested that the government should promote safe abortion:

“It all goes back to sensitization, but who to sensitize them? Where to start from? That is a challenge, because we cannot direct to the church (...) So, if you involve the politicians, they will know what to say, because the politicians usually feature in different programs on the radio and tv. In case they are asked about abortion, they will stand a better position to explain and people will say: “A member of parliament has said something about this. (Informant 2)

Sensitization and information about abortion service in health institutions around Lusaka was limited. In two of the clinics I visited they explained that there used to be posters and adverts about abortion services, but these had been removed due to the stigma attached to abortion, leaving health care workers with few tools to inform the public about abortion, but also with freedom to choose their own approach for instance using HIV as an entry point to inform about abortion.
Different approaches in patient care

This section illustrates the diverse practises in the ward and how health care workers interpreted their job description individually hence the care provided to patient varied.

The importance of not being “judgemental”

During the fieldwork I attended a number of consultations and most health care workers were open minded and friendly towards the patients. However, there were a few situations where health care workers tried to educate and moralize patients:

“I take my time to encourage these girls to be more serious, change the type of friends and ask them: “You see this young lady, this nurse, you can be like her if you want. Do you see the worries you are giving your parents? They can end up hypertensive, how would you feel if they go into a depression? So at least that helps, I think our role is to go a little bit beyond the termination and also counsel them into the future, because some of them keep coming back with the same problem”. (Informant 7)

Furthermore, I observed health care worker withholding the service to patients and clearly demonstrated that they disapproved patient’s behaviour as shown in the case below:

Precious was admitted with vaginal bleeding and the doctors had performed an MVA as part of PAC. She was given PAC by a newly educated nurse together with five nurse students before being discharged. The nurse escorted Precious mother out of the room due to privacy, however the two other patients remained and joined the counselling. The nurse was patronizing when counselling and asked Precious why she was wasting her life and disappointing her parents, as girls her aged should concentrate in school. Furthermore, she said: “I am sure, while you are here bleeding, you boyfriend is busy having sex with other girls”. Part of the counselling is to inform and offer women family planning and in the ward, there was a poster with all family planning methods available. The nurse looked at the patient and concluded that the only family planning method she could explain and offer Precious was condoms. Then she commanded Precious to open a condom and demonstrate how to use it. Precious looked uncomfortable throughout the counselling session.
One nurse expressed her worry as she had observed colleagues insulting patient, which might affect patient’s health seeking behaviour and increase the possibility of them choosing abortion services outside the health institutions. The informants mentioned different reasons why women might choose to seek abortion elsewhere, such as the attitude of health care workers and the fear of being judged:

“There is that fear of being judged, from the people that provide: “You are so young, you are supposed to be in school, how did you get pregnant? You don’t know how to use a condom? Sometimes even the people that provide the service don’t create enough environment that is welcoming, friendly and safe for these people to come”. (Informant 8)

Nearly all of the health care workers I interviewed and observed had chosen to provide abortion. Most informants were therefore, dedicated when offering abortion services, and several informants gave clients their phone number, so it would be easy for patients to get in contact. One nurse shared during the interview that she had been raped and became pregnant when she was an adolescent. Therefore, she tried to be friendly and open-minded towards her patients. The quote below shows the ambiguous attitudes some health care works had towards abortion seeking patients:

“I don’t know about others. I am talking about me. As I said, I have been through that road. So, I am not going to scream at this girl. I am not going to show my attitude. I am going to welcome her, to make her comfortable to talk to me. And when you do that, there is a lot they will tell you. They will open up and tell you every detail”. (Informant 13)

A number of informants acknowledged that patients seeking abortion needs special care, as they often judge themselves. One informant emphasized on the psychological aspect around choosing to abort and to be able to gain trust with the patients:

“I think initially, most of them will hold information, trying to see if they can gain some trust in you. So, it is important not to be judgemental. (...) I think the psychological aspect to the approach is crucial. For them to gain courage to seek and stick around in a big institution and being known by everyone”. (Informant 7)
Health care workers had various approaches towards women seeking abortion or post abortion care, their patronizing attitudes might have consequences for patient’s health seeking behaviour and during the fieldwork I did not see many women seeking abortion directly at the hospital. My informants acknowledge that few women came directly and mentioned fear of being stigmatized and judged by health care workers as possible explanations.

Failing routines and practices in safe abortion care

During the fieldwork, I observed how routines differed in the ward when the in-charge was present and not. For instance, the morning report when she was in the ward could last for an hour whilst when she was not present it could take five minutes. Furthermore, when the in-charge was not around, some nurses dodged work on weekends, knocked off earlier than schedule and some junior doctors went home to rest whilst being on call during nightshifts. The case below illustrates how a patient was neglected during her hospital admission:

Faith was admitted with incomplete abortion with haemoglobin level of 3.4 g/dl. During the night, she had received 3 units of blood, but she had continued bleeding. In the morning, her bedsheet was covered in blood and she said: “My friend, the night staff neglected me the whole night. I called and called them, and they just sent in the nurse student, who didn’t know what to do. Not until 0400, that’s when she came”. Her cannula had gone into tissue and the night staff had failed inserting a new one. Faith needed several units of blood, as she was going to theatre. The blood bank didn’t have her blood type and her relatives nursing her did not either have the right blood type or high enough haemoglobin level to donate blood. One of the nurses on duty had the same blood type and went to donate. Unfortunately, she did not have sufficient haemoglobin level to donate blood to Faith.

Occasionally, the blood bank misinformed the wards about their blood stock, so one doctor went there to double check their stocks, and luckily, he managed to find two units of blood for Faith. Faith was taken to theatre and after surgery she was transferred to a different department. The nurse wanting to donate blood went daily to check on Faith’s condition. When Faith was well enough to walk herself, she came into our ward wanting our help, as she claimed nobody had given her better care.
Faiths case shows arbitrariness and lack of routines in provision of care. This was reflected through a number of factors including shortage of staff and lack of supervision. Some routines seemed to be badly practised particularly during nightshifts. Many had other jobs to supply their income, and several nurses in the ward worked doubled shifts continuously for a week in different wards in the hospital and therefore utilized the nightshifts to get some rest when supervision was scarce.

One informant noted that due to shortage of staff, patients seeking abortion are not prioritized. Health care workers decide which patients to attend to first and how they define an emergency:

“We are few and understaffed. Sometimes, there are just the two of us on duty and this is an emergency ward. You would run around. By the time you are knocking off you are very tired. This is what you would find when it is just the two of you on duty. And it is very hard to give quality care to patients, because the ratio nurse to patient is too high. If I have 12 patients and it is just the two of us there is a lot of emergencies coming. Then these patients here are not attended to”. (Informant 14)

Registering vital signs (blood pressure, pulse rate, temperature and respiration rate) is a crucial task that should be done on a routinely basis, several times per day depending on the condition of a patient. However, I observed that the vital signs were not always taken. Nurses commonly wrote random vital signs on admission and after procedures without having done any monitoring. Once I was by the triage table and the ward was hectic, a nurse approached me and told me I was delaying them when triaging: “You don’t need to feel the pulse rate for all patients”. This practise was transferred to the nurse students in the ward, and on several occasions’ patients’ conditions were hidden behind wrong vital signs. As when nurse students were doing vital signs on a patient with septic abortion and returned with unlogic measurements, as a patient with fever of 40,7 rarely has a normal pulse rate and respiration rate. Not monitoring vital signs might affect the care provided to patients and hence affect the outcome for the patient.

The workload varied a lot in the ward and during busy days. Health care workers continuously prioritized patients and procedures according to their own discretion. On several
occasions’ patients were waiting in uncomfortable positions for doctors and nurses to find time to perform procedures.

Angela was referred from a local clinic with incomplete abortion and the doctor decided to perform an MVA on her. She had bled through her clothes and hadn’t brought an extra shift. Angela was taken to the MVA room where she removed her wet clothes and put her feet up in the gynaecological chair. Angela was waiting in the gynaecological chair for 45 minutes before they started the procedure.

Informal practises were developed by health care workers to tackle daily challenges in the ward some developed as a result of lack of resources and workload causing arbitrary care provision and unpredictable quality of service to patients.

The importance of abortion training

From both my observation and the interviews I noticed a difference between health care workers trained in abortion care by IPAS and not. Many of the nurses had only a small orientation from the administration whilst others had several days of specific training, illustrating the importance of abortion training. “I am not doing it for fun, but I am saving a life somewhere. And what gives me confidence in providing the service, I am trained, I am certified. I am not doing it for the sake of doing it”. (Informant 16)

A number of informants stated that the training has made it easier for them to consult patients seeking abortion. One informant suggested regular refreshment trainings to health care workers to keep each other updated. Most informants I interviewed were comfortable to offer abortion. Based on the fact that they been trained and choose to offer the service. “I have been trained, knowing what I am doing is the right thing. Knowing what I am doing is legalized. I was going to be worried if I wasn’t being trained. But I have put myself in those shoes”. (Informant 17)

My informants shared stories that the ward used to be packed with woman suffering from abortion related complication. To reduce the patient load at UTH, clinics and first level hospital have been trained to provide abortion. “I think so far the future looks okay. We are receiving less complication as a result of unsafe methods. And even now as an institution as
UTH, I think the numbers have slightly gone down because so many people in the clinics are being trained, so they are able to provide safe termination as well”. (Informant 19)

Several of the informants suggested that they should increase the number of abortion providers to make abortion care more available and avoid women choosing unsafe methods. However, in some of the institutions I visited it was difficult to recruit health care workers for the training, as many health care workers did not feel comfortable to offer abortion:

“I think they should increase the numbers of providers. When they increase the number of those providing the service, it will be better. People would be coming through the centres to seek the service just like they are getting ART (drugs for HIV). Because we don’t want anyone to die just because they had an abortion”. (Informant 10)

Medical procedures like MVA, is a practical skill where one needs sufficient and regular practise to perform it well. To increase the number of abortion providers without requirements of regular practise of the procedure to keep health care workers confident in performing it, can be fatal, as the maternal death in the case below illustrates:

The night staff reported that the shift had been busy as one patient referred from a local clinic had been restless the whole night. She had removed her cannula and tried to remove her catheter. Charity was 34 years and admitted with anaemia, low blood pressure, high pulse and fever after bleeding for a week. Four days earlier, she had done an MVA at a local clinic. On admission at UTH they did a new MVA and administered intravenous fluids, antibiotics and blood transfusion. Both nurses and doctors had failed to reinsert a new cannula, so she had not been given any fluids or drugs for hours. I asked the nurse if we should try and insert a new cannula, but was told they had called the anaesthetist, who would come. Only minutes later, her relatives came crying out of her room. When we entered, the patient was gasping for air. Charities pulse was weak, and I looked at the nurse and asked what we should do if the patient stop breathing. She looked at me and answered: “There is nothing we can do, unless she has a cannula”. I asked if I could try and insert one, and she said “yes”. The woman was overweight and with the low pulse, it was difficult to find a vein. Shortly after the patients stopped breathing, and the doctor told us to resuscitate. One of the nurses gave two compressions, before he left the room. I started doing the
compressions and asked the other nurse, where he went. “We need a bag”, she replied. I follow the algorithm 30 compressions and 2 breaths. However, the nurses were not used to this algorithm, as I counted up to 30, they didn’t understand that they needed to be ready to ventilate. We continued resuscitating, but eventually the doctor said, there was nothing much we could do. So, we stopped and called the relatives and prepared the body to the mortuary.

Each maternal death needs to be recorded and sent to Ministry of Health. The nurse took his time to write this report. After he had written the report, I asked him what we as health care workers could have done to prevent this death. The nurse answer: “We did everything we could, unless those who did the first MVA, should had done it properly. I think maybe they used unclean equipment”. Forgetting that the lady had been in the ward for hours without any antibiotics or intravenous fluids.

Charity’s life could have been saved if the first MVA was complete, if she had come earlier to the hospital or if she had been given intravenous fluids and antibiotics as prescribed. The nurses working during the night, were newly educated and did not understand that Charity was septic and critically ill. In a system with little resources and follow up health care workers have power over the services they offer, and they can deflect their responsibility which might influences patient’s treatment and outcome. The case above illustrates the value of work experience and abortion training, which could have helped the nurses to better understand Charity’s critical condition and lead them to intervene earlier on.

Throughout the fieldwork I observed the value of abortion training and health care workers in my study trained in abortion care were confident in providing abortion regardless of the moral dilemmas they faced when offering abortion services.

Torn between professional commitments, social norms and Christian values

This section will demonstrate the ethical dilemmas health care workers encounter when offering abortion services with personal stories how and why they choose to provide abortion.
Being a good Christian

UTH is committed to offer abortion to eligible abortion seeking girls and women. As the case below indicates, the right of the abortion seeking woman may be compromised by the antiabortion sentiment of the provider. It appeared that some health care workers were scared to be seen as a non-Christian for offering abortion services. Initially, it was supposed to be a senior doctor offering abortion in all teams at UTH, as all women seeking the service should receive the service. But Hopes case below indicates that the right of abortion seeking women may be jeopardized by the anti-abortion sentiment of the provider:

14-year-old Hope was referred from Children’s hospital around 1400 hours, as she had been defiled and was now 15 weeks pregnant. She was an orphan and was brought in by her aunt, who could not afford supporting another child, so they came for medical abortion. When the senior doctor finally came to the ward the nurse asked him to assist Hope. The doctor looked at the nurse: “Sister, I have two jobs. I am a doctor, but I am also a Pastor. I don’t believe in this termination”. The nurse asked which other doctor was on call, and he answered: “Even my colleague doesn’t believe in that”. Hope was sent home to come back the next day.

Being a good Christian was discussed in the ward and some of the assisting staff were concerned about the increased unofficial abortion provision within the ward. The informant below describes how he had to defend being a Christian and providing abortion services.

“Even if I make this decision, I also go to church. But there is a reason why I make this decision. And which most of the times, listen to the woman, get to know why she is seeking that service, you realize most of the times, she genuinely deserves the service”. (Informant 19)

Furthermore, several informants describe a conflict of interest between being religious and offering abortion:

“Oh the religious aspect, most religions here do not agree in abortion. That’s why there is a problem with faith-based organizations vs the desire to provide the service and spread it out. Cause, there is a debate of life begins at conception, life begins at birth and all those things. So that is a big, big battle. A fight between the science part of providing safe abortion and the religious aspects of playing the part of God”. (Informant 8)
A number of informants emphasized better support from the churches to promote safe abortion. One informant was Catholic and explained how she had convinced herself to provide the service. “It is difficult, because of religion. Like me, I am Catholic and Catholic church doesn’t favour termination of pregnancy (TOP). But from my working environment, when you look at what you are preventing, you just provide. (...) You have to convince yourself “up there” if I have to do this”. (Informant 15)

Some informants highlighted the importance of understanding why women seek abortion, sharing stories of colleagues discouraging women seeking the service, using religion as a tool to moralize women and convince them to keep the pregnancy. Furthermore, informants mentioned difficulties discussing abortion in a Christian nation due to the stigma attached to abortion:

“You know the challenge we have here in Zambia is basically because our country has been declared a Christian nation and based on those Christian names, you may not go to public to start talking about abortion. I cannot for example go public and say: “Now, if you have an unwanted pregnancy and you qualify by the law, please just come, I will be able to provide that service”. I mean society will look at you, they will give you names, they will stigmatize you. You know you are a killer; you know you are an abortionist, this and that. But without knowing that it is part of the service provided for in the department for gynaecology, So, it is just barely because of that tag being a Christian nation and find that people they hide in that. How do we discuss abortion in a Christian nation?” (Informant 19)

During the fieldwork I did not observe healthcare workers being stigmatized by others for offering abortion. However, many informants disclosed being classified as evil and terminators of pregnancy because they provided abortion. One nurse had experienced to be labelled by her in-charge because she was a provider. Luckily, she notified that there is less stigma now, then when she first started providing the service.

“Yes, when I first started after the training, I was so into it, I used to provide a lot. So, even the boss herself, would say: “Ah, there is a client for you, you who do killing of life” Yeah, that is what she said. I said: “I No, I am not killing a life, I am just providing the service”. But with time I think that they are now used”. (Informant 10)
Clearly the health care workers struggled with tension between being a good Christian and offering abortion services and experienced pressure that made it necessary to justify their work both vis a vis themselves, their colleagues and the community.

The obligation to save lives

The obligation to save lives was used to defend the choice of providing safe abortion. One informant shared an experience which changed his mind to start providing abortion:

“It is normally a challenge cause sometimes it lies between your biblical beliefs and also your professional work. But I feel when it comes to providing the service, I am literally trying to save lives because before I was trained, I had a practical experience where a woman would come, and I said no to the service. Because I felt I was not the right person to provide, I was not trained. What did I see in the next 2-3 days? A woman comes back on a stretcher. I look at her face, the same woman who came seeking for safe termination. You run up and down and find out what has happened, she comes back with a perforated uterus. Before we could take her to theatre to repair, that’s how we lost that lady. So, when the department came and said we want to train people to provide the service, I was one of the volunteers. (...) So, I just said: “I am better placed to be trained and provide the service, of which I feel, that one who died, if we had offered the service, a safe service, she was not going to die. So, it is a challenge, when it stands between your biblical beliefs and your professional work. But I am sure with that background, I am comfortable to provide”. (Informant 19)

The informants listed several reasons for offering abortion, saving lives and to prevent fatal outcomes was mentioned repeatedly. One informant said health care workers should be as liberal as possible and offer the service on request:

“Personally, I don’t usually think about it after I have helped someone. But of course, my aim is to prevent bad outcomes from happening, so that is the reason why I offer the service. I don’t want to have them coming and bleeding and I am unable to resuscitate them, because I have had a few cases like that. Where someone has bled almost completely from home and there is nothing that we can do here, we don’t have blood available and they die while we are watching. So, it has happened. So, I feel good, when I help someone”. (Informant 5)
Some informants had come out and told people that they offered abortion, whilst others kept it a secret to family and friends. One informant had mixed feelings about providing the service and shared that he spent a long time making the decision. “It has taken me quite a lot of time to provide (...) partly I am on the understanding side. But on the other hand, there are times when people make rush decisions”. (Informant 7)

The quote above illustrates the dilemma many health care workers face when taking a stand in abortion provision. During my fieldwork, there were not many women seeking abortion directly at the hospital. One who did was a young lady newly diagnosed with HIV. She had been recommended to terminate her pregnancy due to her health condition, as she had developed Kaposi’s sarcoma (a type of cancer common for people living with HIV). She was in a poor condition when admitted to the ward, and nobody questioned her choice to terminate her pregnancy. If there was a medical reason for terminating the pregnancy, most doctors would perform an abortion, some doctors were liberal and provided abortions irrespective of medical condition whilst others only performed MVAs in cases of emergency. “MVA I am doing, for me it is fine since it is happened, and it is an emergency I do it. But not for TOPs, I don’t accept the termination myself”. (Informant 11)

One informant stated that abortion was illegal during the whole interview, but that she still facilitated safe abortion:

“When they come with illegal abortions and complications our role is to assist. We don’t have to question them as we don’t know to which extent for her to reach the facility. We are not the police; we are health care workers. We are here to save lives. I would rather do an illegal abortion on her, than to have her do it from home, because I know that in my care, she will survive”. (Informant 13)

Health care workers in Zambia has the possibility to claim conscientious objection and refuse participation in abortion services and many claimed this right. Others had personal experienced women dying due to unsafe methods and found it easy to justify their abortion related work as saving lives.
Ambivalent attitudes towards abortion provision

Abortion was debated at UTH, and there was a division among the doctors who provided the service and not. Many informants described how women were discouraged when seeking the service and had ended up taking an abortion outside the health institutions. The hospital department had stated that no woman seeking abortion should leave without being offered the service. “So that’s what we have said is that if you have a personal reason why you cannot provide the service, you are responsible to find somebody who can help the client. That’s not negotiable”. (Informant 8)

A number of informants stated that most doctors not comfortable providing abortion referred the patients. Nonetheless, on several occasions I observed women leaving the hospital without being offered the service. Luckily, most patients seeking abortion were consulted by nurses prior to doctors. The nurses knew which doctors would offer abortion and not, hence the nurse could guide the patient to come back on specific days to see doctors offering the service. However, other informants claim the opposite, that many doctors use their authority to not refer the patients, but rather try to convince them to keep the pregnancy. “No, they are not referring, instead they are sending the patient back. Because they just tell the patient: ”You, go and start antenatal” - Coupled with some Bible verses”. (Informant 19)

Counselling patient is the standard procedure before providing medical abortion. A few informants mentioned that some women just needed some guidance to change their mind and keep the pregnancy. However, informants stated that women who came to the hospital had already made up their mind to go through with it – safe or unsafe:

“For if a woman has made up her mind that “I need to terminate the pregnancy”. No matter how much you educate that woman, she still finds means and ways to terminate the pregnancy and once it is not complete (the abortion), it is incomplete and she still feels shy to go to the health centre she will remain home and have a septic abortion and come here and die in our hands”. (Informant 2)

Health care workers were split between being a good Christian and an abortion provider. Many informants had chosen to offer the service to prevent fatal outcomes and most women seeking the service in the hospital, were offered abortion. However, due to shortage of
abortion providers in the hospital among others, the service was not always available through official channels.

**Unofficial practises in safe abortion care**

This section describes how diverse unofficial practises had developed in the ward. While some tended to facilitate access to safe abortion services for all eligible women, others targeted particular people who had means to pay.

**User friendly certificate**

There are two different certificates of termination: certificate a which requires three signatures and certificate b which only requires one signature. Certificate b is also called an emergency certificate and can be used if there is no other doctor available or if the doctor perceives that there is a high risk of the women obtaining an unsafe abortion. The emergency certificates that did not require the signature of three doctors to allow an abortion to take place (Which is otherwise the formal requirement according to the law), facilitates access to eligible abortion seeking girls and women. From my observations, certificate b is most frequently used. Most of the informants, also stated that certificate b was most commonly used because of shortage of staff, few specialists and the challenge to get enough signatures for certificate a and b.

“Others have got some personal reasons; others got some personal religious thing. Some don’t want to provide, so you find that only a few are willing to. So, to get two doctors to sign, sometimes it is difficult”. (Informant 8)

Using the emergency certificate instead of the regular certificate serves two functions as it facilitates abortion and it eases the work of the provider:

“If I am a provider and the woman qualify, I will sign, make the woman consent and provide the service. Unlike, maybe I am a provider and we are three on duty and the two others are not providers and I need to use form a, who is going to give me those other two signatures? Meanwhile the client is waiting for the service. I have signed the first part, I need two more signatures to make it legal and I go to my two colleagues who says: “No, not with me”. So,
I’ll be stuck, but if I am using form b, I’ll just look at the consent of the woman and if she qualifies by law, I will just sign and provide the service”. (Informant 19)

However, some of the informants did not agree that getting the two other signatures were a challenge as the doctors know which other doctors provides the service, hence they know whom to ask. “No, it is not difficult because the University Teaching Hospital has a lot of doctors. The doctors that perform the termination of pregnancy know which doctor they should see for the signature”. (Informant 3)

One doctor explained that he wants signatures from colleagues in case of any complications. “So, for me, I feel, anyway. It is my opinion that I need more signatures in case of anything they would say: “It is not just one person’s decision”. (Informant 6)

The use of emergency certificate has become the norm in the ward and has made abortion services in health institutions more available in the city.

Pre-signed certificates in lower level health facilities

To solve the issue with few or none medical doctors in clinics and first line hospitals, an international-NGO, IPAS has trained clinicians, nurses and midwives as midlevel providers offering safe abortion services such as PAC and medical abortions. Midlevel providers are not qualified to sign either of the certificates of termination which restrains their possibility to perform their job as desired. Nevertheless, the district office or the nearest hospital with a trained medical doctor has pre-signed certificates a and distributed it to institutions with few or no medical doctors. In all four lower level health institutions I visited they used pre-signed certificate of termination. “Usually doctors are supposed to sign, but because of scarcity of doctors, they have pre-signed the forms in advance”. (Informant 12).

One informant had never heard of the emergency certificate, as every certificate was pre-signed with three signatures in her clinic. “No, we only have one form and the consent of the patient. No, everything is signed by district office”. (Informant 10)

In one of the first line hospitals in Lusaka where it was usually the nurses or midwives performing termination of pregnancy, some informants stated that because of the pre-signed
certificates it is actually faster and easier to get a medical abortion at a local clinic than at UTH. “Better UTH refer cases to here (clinic or first line hospital), we don’t take long in talking to them”. (Informant 17)

Incomplete abortion was one of the most common diagnosis in the ward, and it was not differentiated between incomplete abortion starting spontaneously or those self-induced thus women who had induced their abortion outside the health institutions were not registered or needed to sign any of the certificates of termination. Women who received MVA as part of PAC had to sign a different form than those seeking abortion directly in the health institutions. The MVA form was signed by the one performing the procedure, which in most cases were the junior doctor or a mid-level provider, a ward nurse and the patient. Some informants were unaware of other certificate of termination than this form.

Records and unclear diagnosis

Misclassification and underreporting of abortion were common and getting accurate hospital statistics on abortion was a challenge during the fieldwork. The ward had different types of registers, one for all patients passing through the ward, one for women admitted to the ward, one for women receiving MVA and one for women seeking medical abortion. I tried to follow up patients by checking the different registers in the ward, and a lot of patients’ admissions were missing. For instance, I was attending a PAC counselling where two of seven women had received medical abortion within the ward without being registered in the book for medical abortions. Furthermore, many women seeking abortion did not pass through the normal route of admission but knew someone working in the ward offering the service. This is further explained by one nurse who assisted friends to receive abortion unofficially, when she worked nightshift:

“If I am working night and somebody from where I stay complains and I want to assist them. I tell them: “No, come at 1800 hours, when I start working”. She will come at 1800 hours and I give her the misoprostol. Or maybe I have given her before I left home. Then I tell her come at 1800 hours and by the time she is coming, she is already bleeding”. (Informant 13)

The practise described above is one way to avoid registration of induced abortion. Some women left the ward without being registered and when it was busy, registering patients was
not prioritized. Furthermore, because of shortage of staff, the hospital relies on nurse students for their daily operation to flow. Nurse students are on rotations to different wards each week and only receive a short introduction in the ward. Thereafter it is expected that they know what to do. When students were in the ward, registering patients was one of their responsibilities, and often they forgot to register:

Fatima was the only patient revealing that she had bought misoprostol from the pharmacy, therefore I tried to follow her case in the different register books in the ward. She was supposed to be registered in the admission book, MVA book and the book for receiving family planning. She was only registered in the family planning book.

As the case above indicates registers may not be complete. Some health care workers explained difficulties getting accurate statistics on abortion, as most women came to the ward with incomplete abortions. It is difficult for health care workers to know whether the abortion was induced or started spontaneously. “No, most of the times those that would come with incomplete abortion, we are unable to pinpoint what caused it. They would just say: “Its spontaneous, then it became incomplete”. (Informant 6)

Women presenting as incomplete abortion, but not in need of an MVA were given misoprostol and sent home. When they were only given misoprostol and not the combined pack with mifepristone, there was no documentation required. To get the combine pack of misoprostol and mifepristone, both a nurse and a doctor needed to sign. On several occasions I observed women receiving this combined pack, without any certificate of termination being signed, demonstrating unwritten practises in the ward. Failing to register induced abortion may be associated with unofficial practises where doctors or nurses charge women for abortion services.

There are numerous explanations why obtaining data on abortion during the fieldwork was complicated; many women acquired abortion unofficially in the hospital, whilst others obtained abortion through other arenas and presented in the hospital as incomplete abortion, receiving PAC.
Unofficial payments – The expected amount

Health care in Zambia is supposed to be free of charge. However, some health care workers were making a profit of women in need of abortion service and both the health care worker and the patient maintained the unwritten practice of informal payments. “People are just taking advantage of lack of knowledge of the people that need the service. Otherwise, if people are knowledgeable, it is supposed to be free service, because we have to prevent fatal effects”. (Informant 15)

Some health care workers came evenings and weekends, to perform abortions privately. I never got to know where they got the clients from. But often they came in their personal attire and performed surgical abortions. When I asked the nurses on duty what happened, I was told: “This one comes every now and then”. They used the MVA room, hospital equipment and nothing was documented. When I asked if the client was charged the nurse replied: “It depends, if it is a friend or not, some charge 1600 kwacha, some more, others less”.

Some of the informant stated that people charging for abortion services, is a barrier for women to seek the service, and some informants were shocked that other health care workers asked for money. Yet, in one of the clinics I visited it was expected that women paid, and the nurse did not see that as a barrier for women to seek the service. In that clinic, the expected amount was between 150-250 kwacha. The nurse explains how the clinicians makes a profit out of these women:

“Like I refer someone to my male colleague: “Can you help me with this service?” The male clinician will ask me; “Sister, have you already told them that they are supposed to pay?” Then I will say: “No, I didn’t tell them that, isn’t it for free?” “Yes, it is free but, I think there is no medication” Since the woman is desperate, she will pay: “Okay, maybe I can pay, when can I come for the tablets?” Those are really experiencing that I am sharing with you”. (Informant 10)

One doctor explained that nurses expected him to charge woman for the service and had experienced nurses approaching him after the procedure:
“I can only assume that despite having the doors open to these services, there was that suspicion from some nurses, if you are offering these services, they label you like you are benefitting. Personally, I got upset one time when a patient that came for TOP and I offered the service. Everyone who was seeing me there was looking very suspicious; What is he doing? Maybe he has gotten the money? I don’t know if it was joking but they were saying: “But doctor also give us some money”. But I don’t do that on principle”. (Male doctor 34)

The informants listed a range of different amounts patients were charged for the service, and some even admitted they had accepted payment themselves:

“They can charge that much, and you know it is expensive. Now the question is, how many can afford that? Do you think a 16-year-old who’s scared of the parents at home would give you 3000 Kwacha to abort? No. But if she comes to me, I’ll do it. I won’t lie, once or twice she will give me something for a drink, like 50 Kwacha, 100 Kwacha “Thank you sister, you can buy yourself some lunch” “Oh, thank you, you are welcome”. But if it is the doctors, they will charge them, even nurses will charge them 1700”. (Informant 13)

Private arrangements and informal payments were common in the ward. These practises are known and sustained by both health care workers and patients. Health care workers can withhold the service to women not willing to pay and some women may want to pay in secrecy to avoid the service to be documented out of fear of being stigmatized.

Unofficial channels to seek abortion

There were a lot of unwritten practises and under the table arrangements concerning abortion which might impact the everyday life in the ward. I was first told by a maid to pay attention to all the women in the kitchen waiting for doctors. Most of these women had not passed through the normal route of admission but knew someone who knew doctors in the ward. Eventually, I observed doctors seeing clients in between their normal duties, some even walking around with the drug for medical abortion in their pockets. “Actually, very few come directly to seek the service. Most would do it illegally from home (..). But I think one out of ten come direct, and if they do, it must be through someone they know from within the health facility”. (Informant 13)
A nurse was found with the combined pack with misoprostol and mifepristone and another nurse stated: “Look at her. Again, she has been taking these things (the drugs). I asked the latter nurse if they did not keep any record of the drugs and she replied:” Anyway, there is no problem, as you can just say that it was so busy that the doctor did not find time to write the prescription”. When I interviewed the nurse found with the drugs, she acknowledged that she occasionally asked the doctors to prescribe the abortion pills for her. “I will ask the doctor to write me a prescription. Me on my case, I have been here for a long time, a lot of doctor they know me”. (Informant 13)

The informants listed a range of possible explanation why women sought abortion outside the health institutions, thus avoiding avoid ques, questions and the risk of not qualifying for the service:

“Then, when you match the reasons for wanting the service, to what the law says you find that the woman does not qualify, so you start telling the woman: “No, according to the law, you can only receive this service if you got the following condition or reasons”. So, you find that woman would opt to go for shortcuts to go to a chemistry and negotiate with a seller (Pharmacist) to buy this drug. Unlike coming to the hospital, because of the procedure to receive the service”. (Informant 19)

During the fieldwork I did not see any women admitted with complications from traditional unsafe methods such as perforated uterus due to sticks or women intoxicating themselves to induce the abortion. This has eased the workload in the ward and was also confirmed by informants:

“We used to have cases where women came with cassava stick and different things in their cervix just for the pregnancy to come out (...) because they didn’t know where else to go. So, by late those things have reduced. Though we have cases of septic abortions, we cannot go without them. But it is nothing compared to five years ago”. (Informant 1)

I saw several traditional healers advertising service for unwanted pregnancies. Traditional healers are mostly from Congo and do not speak the local language. I contacted one per telephone and presented myself in English as a young pregnant school girl wanting to abort. He asked me if I was ready to abort the pregnancy and when I had my last menses. When I
told him, it was six weeks ago, he said there was no problem to abort the pregnancy and told me to meet him. I continued by stating I was unsure and scared and asked for the price and the procedure. The price was 850 kwacha (750 NOK) and that he was going to use my shadow whilst I drank something. Some hours later, I would start bleeding equal to my regular menses. I said I was going to contact him after discussing with my friends. From the traditional healers’ description of the procedure, it is not unlikely that the traditional healer was going to give me misoprostol to induce my “unwanted pregnancy”. As less women present with complications from traditional methods to terminate their pregnancies it is a reason to believe there has also been a transformation in the way traditional healers are performing their abortion services. This transformation affects the workload and the daily life of health care workers in the hospital.

While poor women often resort to unsafe methods to induce their unwanted pregnancies, wealthier women often prefer to get an abortion done through a private practise, where they often overcharge for the medicine. “Medical people take advantage to prescribe and to do termination outside the hospital. They will say: «If you go to the hospital, they will ask you a lot of questions and they might not do it for you. But me, I can do it for you. Maybe give me 1000 kwacha, and I will give you the medicine” (Informant 8).

It is well known in Lusaka that Chinese clinics offer medical abortion. A taxi driver told me that he recently had taken one of his friends to a Chinese clinic for an abortion. He took me to the same clinic, but when I asked for the service the doctor said that abortion was illegal in Zambia, so she could not help me.

According to health care workers reports and observations it seemed that the majority of women sought abortion through private arrangements or private clinics. These practises affect the working day in the hospital.

**Access to misoprostol beyond health care workers control**

This section will describe how the access to misoprostol has changed abortion care in Lusaka and health care workers thoughts and concerns regarding this development.
Increasing demand for PAC

According to the informants, the number of women admitted with severe complications due to unsafe abortions has been dramatically reduced the past years in Zambia, hence also the workload in the ward. Many informants highlighted the introduction of misoprostol as a possible explanation for the reduction and the majority of informants were worried about this change as patients often got complications from the drugs they bought off label. “But I think most of them still comes as incomplete miscarriages somehow, somewhere. Because what happens is that people use these drugs blindly (...) So where do they go when they start bleeding profusely? They will have no choice but to end up in the same clinic they initially avoided”. (Informant 7).

During the fieldwork, I only saw one patient admitting having bought misoprostol at the pharmacy. Illustrating the stigma and fear attached to abortion:

Fatima grabbed my arm when I was taking a patient from triage to admission room and complained about vaginal bleeding. When triaging, I asked the regular question on the duration and severity of the bleeding and to my surprised Fatima opened her handbag and showed me three empty pill packages of misoprostol. She said that she had bought them over the counter at a pharmacy and got worried as the bleeding did not stop. Fatima was examined and the doctors performed an MVA on her before she was discharged.

There is a high number of incomplete abortions in Lusaka and several informants explained that many women refuse to have interfered with their pregnancies. Others said women could reveal that they had interfered with the pregnancy, if misoprostol had been found during examination. “Actually, we have received some people coming with signs and symptoms of abortion. Okay, you ask them what has happened, they would say it just started spontaneously. You do an examination and you find they have misoprostol”. (Informant 6)

The informants mentioned multiple reasons why women delayed seeking health care after having induced an abortion such as denying the pregnancy, being scared or not being aware of the legalisation of abortion in Zambia. On several occasions during the fieldwork women
were admitted with vaginal bleeding but refused to be pregnant or to have interfered with the pregnancy:

Sara was referred from a local clinic with haemoglobin level of 2.8 g/dl. In the referral letter it was written that she had presented with vaginal bleeding in the morning. However, on admission Sara had stable vital signs and most likely she had been bleeding for several days. Sara denied being pregnant, but during examination, the doctor found remaining products of conception and they had to perform an MVA. Sara was transfused and given PAC before discharged home.

A female nurse with previous work experience elsewhere was not used to women seeking abortion and compared the high numbers of incomplete abortion in Lusaka with malaria to illustrate how common incomplete abortion has become and how the context differed. “I saw just miscarriages. Not just women that came to seek termination or maybe to see a lot of woman bleeding, coming as incomplete abortions. But here it is common. Every day, it is like people are suffering from malaria”. (Informant 9)

A number of unwritten practises has developed for women to access these drugs unofficially and illegally both within health institutions and outside health institutions leading health care workers to offer PAC more than safe abortion services.

The problem of allowing anybody to offer the medication

The law states that abortion should be done by a health personnel in a health facility. Nevertheless, women can buy the combined pack with misoprostol and mifepristone and single dosages of misoprostol without prescription in various pharmacies in Zambia. Several informants were worried about this practise:

“The law allows someone being trained or understand the safety of the procedure to administer the drug, as you also have to consider the environment where the patient is. Do the patients know what to do, if the patient does it from home and bleeds a lot? So, our pharmacies, I know they understand how the medicine works, but they haven’t been trained in how to go about it. What are they going to do if surgical management is required? Are they
able to help the patient when it comes to that? So, I think we still have a problem allowing anyone to offer the service without passing the hospital”. (Informant 5)

The availability to buy misoprostol off label at the pharmacies has made medical abortion highly available in Lusaka, and the increased availability of misoprostol concerns several of the informants as incorrect management of the drug may lead to complications:

“But there are these pharmacies, and unfortunately that’s is what has happened. The teenagers and clients end up having those pharmacy guys as their consulting health care provider for termination: “I got a two-month pregnancy, so which drug are you going to give me to terminate?” This person who doesn’t assess, doesn’t even know whether she had an operation before, has no idea about the uterine size, no scan”. (Informant 7)

Informants explained how women who do not qualify for a legal abortion could buy the medication at the pharmacy and the instructions they were given. I went into different pharmacies around Lusaka and was able to buy both the combined pack with misoprostol and mifepristone and single dosage of misoprostol. Some pharmacist asked for a scan and prescription, but I was able to buy without any of the two. One informant recognizes that the availability of misoprostol off label has led to less complications related to unsafe methods, but he emphasized that the drugs should be taken under the right circumstances:

“It has reduced. Because people are using the correct drug, but in a wrong environment. Unlike before, people never used to go to the chemistry. They used to use drugs to swallow, they would put roots inside the vagina. We used to find a lot of drugs inserted in the vagina. Those are wrong, wrong methods. A lot of infections and complication. But now they are able to go to a chemistry, be sold this drug which is correct and safe. Except that they do it from a wrong place all together”. (Informant 19)

Informants were worried that patients were given the wrong dosage of misoprostol at the pharmacy which can lead to a number of complication health care workers need to deal with later. This can be associated with the high number of women presenting with incomplete abortion:
“So, they are going to give them underdosage. If I am going to abort, I rather use 800 mg misoprostol that will initiate the abortion. But these people don’t know, and you find that the pharmacies only sell two tablets, which is 400 mg. So, with that dosage, it is obvious that not all the content is going to come out. Those are the ones that come here with incomplete abortion”. (Informant 13)

Weekly women were admitted as incomplete abortion with very low haemoglobin level. Normally when someone presents with haemoglobin level under six, they are in need of an emergency blood transfusion. However, if the patient has been bleeding over several days, the blood transfusion is not as acute, and this happened each week during the fieldwork. Many informants associated incomplete abortions with women getting misoprostol off label at the pharmacy and they emphasized on better communication between the pharmacies and the hospital, to avoid serious complication for women:

“Our friends the pharmacist once they give out these drugs, it be misoprostol or mifepristone. They don’t give them enough information to say: “The moment you start bleeding, go to the hospital, so they can do an MVA”. They just tell them: “You start bleeding and things will come out”. So, a woman may be bleeding for a week or two weeks and by the time they come to us they are almost purple white with a haemoglobin level below 5 sometimes below 4. So, we need to sensitize our colleagues that yes, being a pharmacist, you have this woman that will come asking for these services. Please let’s give out the correct information, so that we don’t leave these women to be susceptible for infections which may result in serious complications. Even some of them ending up with pelvic abscess and we end up removing the uterus or even failure to conceiving in future. So, it is important that a link is also there with our pharmacist that they are able to advice the woman, the clients correctly”. (Informant 19)

During my observations in UTH, incomplete abortions were among the most common diagnosis. Many women never revealed that they started the process from home. As Elisabeth when she was admitted to the ward:

Elisabeth was sweating with high fever, abdominal pain and high pulse. She denied having interfered with her pregnancy. However, less than 30 minutes after admission, Elisabeth was in labour and gave birth to a live male baby around week 25. The baby cried immediately, yet, the baby was weak, and the mum look apathetic. I was asked
to take the baby to Neonatal intensive care. When I entered with the new-born, the staff looked at me and said: “You people like bringing small babies, what do you want us to do?” I explained that there was no equipment for resuscitating babies in the ward and that the baby was still alive. The baby was only 1,1 kg, with low respiration and pulse rate.

I went back to the ward and explained the baby’s condition to the nurse and said that most likely he would not survive. I asked her to explain the situation to the mum. However, for simplicity, the nurse told Elisabeth that the child had fifty percent chance to survive. When I asked her why she told the mum that, I was told that whilst the patient delivered Elisabeth’s mum contacted the in-charge to say that she had taken pills to remove the pregnancy.

In the case above, the patient had an unwanted pregnancy and tried to terminate the pregnancy from home. Even though the doctors asked her on admission if she had interrupted the pregnancy, she refused to have done this. I never asked the patient why she had aborted, as this whole situation must have been difficult for her. The way the nurse handled the situation might imply that it was difficult for her as well. This case illustrates the challenges both health care workers and patients face concerning abortion and the transformation in abortion service after the introduction of misoprostol.

Both from my observations and interviews it seems that Misoprostol off label is high available around Lusaka. Misoprostol has made unsafe abortion safer, but many women are not given the right information about the drug and end up with wrong dosage, remaining products of conception and hospital admission. Misoprostol off label has changed health care workers role and everyday life performing safe abortion care.
Discussion

The theory of street-level bureaucracy by Lipsky (66) and the concept of practical norms, by Herdt and Sardan (67) will be used to discuss my findings; The tension between religious and professional commitments; Facilitation for safe abortion service; Private arrangements and unofficial payments: and De-medicalisation of abortion service in Lusaka. These frameworks will illustrate health care workers important role as gatekeepers in access to safe abortion care in Lusaka.

The tension between religious and professional commitments

In Zambia the discourse on sexuality and reproduction cannot be understood without recognising the important role of Christianity in defining social norms, especially regarding abortion. My data suggest that Christianity was the major factor contributing to health care workers moral dilemma regarding abortion provision. Personal beliefs and religious convictions likely affected the health care workers in their daily activities and duties. Most informants in my study could identify the grounds for when abortion was allowed, but there were different interpretations and implementation on service provision. The ambiguity around the abortion law in Zambia gives health care workers room for interpretation and by using their discretion they can implement the abortion policy according to their own judgements. Sakupapa’s (45) historical review on Christianity in Zambia support my findings and described how Christianity has shaped Zambia both socially and politically during the last centuries. The impact religion has on provision of abortion service has also been found in other studies conducted in Africa concluding that negative attitudes from health care workers affects access to safe abortion service (30) (47) (51) (64).

Health care workers in Zambia can demand to be conscientious objectors due to personal beliefs and thereby refuse participation in abortion service (42). Despite the huge impact religion (45) has on people in Zambia, the majority of health care workers I encountered during my fieldwork were willing to offer or facilitate abortion to eligible girls and women. Furthermore, nearly all informants in my study claimed they offered abortion in case of emergency. Nevertheless, I observed some health care workers practising their right to be conscientious objectors to abortion. Health care workers offering abortion often had abortion training and justifies their role to abortion with the commitment to prevent fatal outcomes.
Health care workers attitudes and approach towards abortion seeking girls and women has an impact on patient’s health seeking behaviour and patients access to legal abortion services. Lipsky describes a street level bureaucrat as a worker establishing routines in their daily duties by modifying their practise and how they handle their clients (66). Health care workers in my study acted as street level bureaucrats and used their discretion in interpreting the abortion law and implementing abortion service to patients.

The policy document “Standards and Guidelines for Comprehensive Abortion Care in Zambia” (42), states that a client has the right to get accurate information and access to abortion if they meet the criteria for safe abortion. Therefore, the girl or woman should be respectfully referred to a health care worker willing to assist her in obtaining the service. I found that some doctors did not refer patients despite being obliged to refer eligible abortion seeking girls and women, even girls being defiled, as what happened to Hope presented in the findings chapter. Not referring abortion seeking patients is a way non-providers, use their discretion as doctors to try and convince women to keep their pregnancies. This is an expression of how front-line workers use their power to decide how policies should be implemented (66). Herdt and Sardan (67) defines practical norms as unwritten practises established purposely by civil servants to fill the gap between policies and practise. Due shortage of abortion providers several unwritten norms have developed in the ward to facilitate safe abortion services Unofficial practises like pre-signed forms and the use of form b clearly aimed to make abortion more accessible, and nurses referring patients to doctors whom they knew would provide the service, but the picture is not that clear when it comes to the other practises, as some practises could be seen as money making.

Stigma surrounding abortion is often related to Christian norms and beliefs. Many informants in my study felt stigmatized by colleagues, family and friends for offering abortion service and being blamed for non-Christian practises. They reported that they often had to defend their choice to perform abortion and justify their own role in abortion provision. A study from Zambia revealed structural stigma within the health institutions where junior doctors were caught in-between abortion providers and non-providers. Non-providers indirectly implied career penalties to junior doctors referring abortion seeking patients and some refused to assist them to perform surgical abortion in emergency situations (47). Some informants disclosed that they did not reveal to family and friends that they offered abortion. Hence, for health care workers it seems to be a dilemma between how society will judge them and on the
other hand what is expected of them in the hospital. Based on my observations it seemed that some doctors found it more acceptable to assist girls or women with abortion who had been defiled or raped, than those that wanted the service due to unwanted pregnancies with either their husbands or boyfriends. Irrespective of the law, health care workers used their discretion and judged the moral eligibility of the girls and women and tended to treat them differently accordingly. This finding is in agreement with a study conducted in Zambia, investigating how health care workers beliefs and practises concerning abortion provision was shaped by contextual factors and how health care workers choose to offer abortion service on a daily basis depending on the request of the woman and on which grounds she was seek abortion (47).

There is a lot of stigma surrounding abortion in Zambia (29) (47) (53). The general public has limited knowledge about the law and poor access to abortion services (50). Informants in my study reported difficulties to sensitize people about abortion and mentioned lack of engagement both from leaders and politicians. Religion in combination with the suggested amendments in the constitution in 2016, has created further confusions surrounding legislation on abortion, also among some of the informants in my study (48). In the context where health care workers should not advertise their services, some informants I interviewed had redefined their role in order to sensitize people about the service on other less stigmatized arenas such as outreach school programs. Other informants suggested using social media to reach adolescents and to advertise abortion using posters and flyers in the health institutions. Zambia Association of Gynaecologists and Obstetricians reports on varying views about safe abortion among their members, which has resulted that only individual members of the association advocates for safe abortion (60). In combination with the United States expansion of the global gag rule prohibiting NGOs receiving US fund to provide information and abortion services has further contributed to obstacles in sensitizing about safe abortion (22). The abortion law in Zambia is liberal, however considering the suggested amendments in the constitution and poor sensitization on the service, it seems like policymakers in Zambia may have reservations about sensitizing the public about the abortion law and making abortion more accessible. This finding is supported by several other studies conducted in Zambia, which also concludes that there is a need of increased awareness on abortion service and involvement from policymakers and stakeholders (25) (29) (32) (54).
In a context where both seeking and providing abortion services was highly stigmatized, the health care workers negotiated their role and used their discretion in interpreting and implementing abortion policies vis a vis the abortion seeking woman.

**Facilitation for safe abortion service**

In Zambia termination of pregnancy has been legal under relatively broad grounds. Nevertheless, abortion has hardly been accessible and informal practises has developed, both to facilitate abortion for eligible seeking women and to facilitate an extra income for providers. From my interviews and observation most women seeking abortion at UTH, only get the signature from one doctor despite not being in a critical condition. Cleaver (74) states that people shape norms and institutions through necessary improvisation of daily practises, such as doctors at UTH choosing the emergency certificate over the regular certificate. There are multiple explanations for this practise, which has become the norm in the ward and based on my observation and interviews, it did not seem to have any implications whether the regular certificate or the emergency certificate was used. Some doctors stated that they preferred to use the regular certificate, but due to workload and difficulties getting the two other signatures, they used the emergency certificate. Lipsky (66) differentiates between weak and strong discretion. Doctors and nurses often exercise strong discretion, which entails deciding the criteria for decision making and making the decision. By using their discretion, they have the power to decide which laws and procedures to follow and implement. Doctors at UTH use their authority to decide when to have one or three signatures and act as street level bureaucrats to make the service more available and occasionally less available for eligible abortion seeking girls and women. This finding is to my knowledge not described from any studies conducted in Zambia.

The practise of using the emergency certificate over the regular certificate is an expression how health care workers justify their role and make judgements based on their interpretation on right and wrong. Health care workers often make decisions in complex situations hidden away from the public.

Practical norms are by Herdt and Sardan (67) described as the real everyday practise of a profession, and can vary from one location to another. Practical norms in a hospital setting is often a result of health care workers use of discretion when implementing policies. Hardly
any of health facilities in a study from Zambia had sufficient doctors to complete the criteria with three signatures for a legal termination of pregnancy (57). In clinics and hospital with few or no medical doctors around Lusaka, the District health office has pre-signed termination of pregnancy certificates. This unwritten practical norm that has developed in the absence of adequate doctors to facilitate safe abortion service in health institutions with only mid-level providers (e.g. midwives, nurses and clinical officers). In these health institutions, mid-level providers act as street level bureaucrats and decided who is eligible for abortion and when they can get the service. This practise has made access to abortion services easier for women in a lower level health facility in Lusaka than UTH, as ques are shorter and they do not need to wait for a medical doctor to sign the certificate.

Several practical norms have developed to solve the issue of impractical requirements where three medical doctors including one specialist need to sign the certificate of termination for women to receive abortion. Due to these unwritten norms, women can receive abortion unofficially, in the interest both of the health care worker and the women.

**Private arrangements and unofficial payments**

Hahonou (75) describes corruption in health care as a major concern in many African countries. Bribing health care workers for better access to health care is common, and a practical norm well developed both by clients and providers regulating the daily activities in the health institutions. During my fieldwork, I only observed a few women seeking abortion service directly at the hospital and I anticipate that there are multiple reasons for this (e.g. unaware of the legalisation, long ques, stigma, fear and the risk of not qualifying for the service). It took some time before I realized much of the unspoken logistics and practises in the ward. I know of several health care workers helping family and friends to receive unofficial abortion and I observed several health care workers offering abortion privately during working hours, whilst others came to the ward evenings and weekends and performed abortion without documenting the procedure. In the absence of control mechanisms and available doctors, private arrangements and consultations have become a practical norm, benefitting both patients and providers and is a way health care workers use their discretion to offer abortion service, even to women not eligible to the service according to the law. Nurses in the ward knew which doctors offered private consultations and, on several occasions,
nurses arranged for patients to come back on specific days to see specific doctors offering abortion. Private consultations seemed to be a common practise at UTH, which might have developed due to stigma health care workers face for offering the service in combination of health care workers benefitting financially for offering these services. Private arrangements within health institutions is also described in another study from Zambia, that revealed the complex pathways women use to get an abortion, where women try multiple alternatives including private and public health institutions as well as unqualified providers (31).

Public health care in Zambia is supposed to be free of charge (59). However, in several of the institution I visited, charging for the service seemed to be the norm. Several informants denied that informal payments were a barrier for women seeking abortion, since she had already made up her mind prior to visiting the health institution. Sex and unwanted pregnancy are taboos in Zambia, as in most other Sub-Saharan African countries, and women were willing to pay to get the abortion done unofficially. Nevertheless, charging for abortion services creates inequality, as women with a lower socio-economic background might not have the economy to pay for an abortion and hence obtains lesser safe methods to terminate their pregnancies. My findings reveal that some health care workers provide abortion out of financial reasons and charge large amount of money for offering the service. This is supported by several studies from Zambia investigating the economic burden of abortion care, concluding that unofficial payments were the major expense for women receiving abortion services regardless if the abortion were safe or unsafe (28) (29) (31). One study (29) further concluded that health care workers exploits women’s poor knowledge about the law and the stigma attached to abortion.

However, based on my observations I would argue that some health care workers genuinely wanted to help women as several informants reported that health care workers gave out their private numbers to potential patients. On the other hand, health care workers have autonomy in the way they practise their job and giving out their private number can be a way health care workers advertise for abortion services unofficially, as they might charge for the service to be performed. This is potentially a practical norm benefitting both the health care worker and the patients and a way health care workers act as street level bureaucrats to provide the service to girls and women. It is difficult to identify what motivates each health care worker to offer the service, but I think the picture is mixed and something that should be of interest to further investigate.
The access to medical abortion has helped in reducing severe complication from unsafe abortion tremendously, both in countries where abortion is permitted on request and where it is highly restricted as medical abortion is safe and effective (7). AT UTH the combined pack of misoprostol and mifepristone is supplied by an international-NGO, IPAS, and for a patient to get the medication, signatures are needed from both a nurse and a doctor. Documentation was seldom controlled, and it seemed that it was easy to write any name and number to get the medication and offer the service unofficially. On several occasions I observed health care workers coming from other departments in the hospital, waiting for specific doctors and leaving with drug for medical abortion. Offering abortion privately is illegal according to the law and such actions disturbs the normal activities in the ward as health care workers might prioritize these services due to the possibility of extra income. It would be interesting to further investigate why both providers and patients prefer to seek abortion unofficially and risk imprisonment when abortion can be performed legally under broad grounds. One can assume that there is little knowledge about the law and the penalties referred to in the penal code are seldom followed and put into action. Herdt and Sardan (67) defines practical norms as the practise of civil servants not following official regulations. Choosing not to document medications and procedures might be a consequence of lack of control and few available doctors and it is another example how practical norm develops and a way health care workers use their discretion to decide who can get an abortion.

Studies report on difficulties to get accurate data on abortion (25) (32) and a study conducted in Ghana (30) reported that health care workers balanced between their religious beliefs and personal experience when offering abortion services and how many health care workers rather helped women in secrecy to avoid confrontations from senior doctors and the need to document the procedure. Manipulating medical records to help women who have induced abortion illegally is also documented from a study in Senegal (26). During the fieldwork I observed that documentation was done sporadically, with various possible explanations such not prioritizing documentation, due to shortage of staff and not documenting the procedure because of informal payments. This can be a consequence of health care workers using their discretion and power to offer abortion unofficially or a result of few doctors and lack of routines in the ward.

Informal payments accounts for largest economic burden for women seeking abortion in Zambia (29) and illustrates how health care workers use their discretion to decide who gets an
abortion and not. Furthermore, informal payment is an expression on how practical norms develops and how it is utilized and accepted by both health care workers and patients especially regarding the drugs used for medical abortion.

**De-medicalisation of abortion service**

Misoprostol is a drug that requires prescription in Zambia, nevertheless in several pharmacies around Lusaka women can buy the drug over the counter even if she is not eligible to get the drug according to the law. During the fieldwork only one patient admitted having bought misoprostol over the counter. Yet, it is likely that both Sara and Elisabeth presented in the findings chapter had induced their abortion using misoprostol. Several of my informants raised concern about this practise and based on the interviews and my observations, I assume doctor were worried about losing control over medical abortion out of different reasons such as not having the power to decide whom to get an abortion, not being able to monitor the procedure and prevent complications and losing access to extra income.

Complications resulting from unsafe abortion was a major health concern in Zambia (25) (42). However, the numbers of severe complication from unsafe abortion have reduced dramatically during the last years and eased the everyday life for health care workers in the acute ward at UTH. It is likely that the introduction of misoprostol has contributed to this reduction (31) (57). I observed few women seeking abortion directly in the hospital, however as I was only attending one shift a day, I did not capture all patients. To get a more correct estimate I additionally went through files and documents registering the number of abortions performed at the hospital. These numbers suggest that few women formally seek abortion service. Incomplete abortion was commonly diagnosed in the ward and several informants linked the high number of incomplete abortions with the availability of misoprostol from pharmacies off label. This is in agreement with findings from a study conducted in Zambia, that reported that only twenty percent of patients were seeking abortion directly at the hospital, whilst the majority had signs of incomplete abortion, which could be caused by the use of misoprostol (54). Another study from Zambia (47) also concluded that it was easier for health care workers to assist women presenting with incomplete abortion compared to those seeking safe abortion services directly. The reasons might be dilemmas health care workers face between saving the life of the mother on one hand and “taking” the life of an unborn
foetus on the other hand. Therefore, when women have induced the abortion themselves, it is their actions and not the action of the health care worker and health care workers are not confronted with the same dilemmas of religion or personal beliefs. So, on one hand I would claim that some health care workers are positive towards the increased access to medical abortion, as they do not need to offer the service directly, whilst others are negative as they lose control over medical abortion and the possibility of extra income.

The accessibility of medical abortion off label is well known in the communities and has made unsafe abortion safer and reduced the workload for health care workers in the acute ward at UTH. Nonetheless, to take these drugs without medical surveillance does not come without complications and according to the health care workers should be avoided. Moreover, the availability of the drugs off label is an expression of health care workers are losing control over medical abortion and thus over an area of potential income.

Strengths and limitations

Qualitative method was the most suitable method for data collection in my study as I was interested in health care workers practises, interaction, attitudes, perceptions and experiences with safe abortion care. By combining participant observation where I was actively participating in the daily duties in the ward with semi structured interviews, I captured different aspects of the service and observed the gap between words and practise. To further increase the trustworthiness of my study, I had initially planned to conduct focus group discussions. However, as health care workers were unlikely to participate after working hours, focus group discussions were not carried out. Furthermore, as abortion is a sensitive and debated topic in the hospital with many unspoken unofficial arrangements, it was likely that their answers would not be as open or honest as in interviews. Moreover, I felt that interviews and participant observation covered many aspects of abortion provision and were sufficient to answer my research questions.

A medical doctor assisted me in recruiting informants for the interviews I conducted prior to the participant observation. Therefore, I put emphasis on informing the informants that participation was voluntary, and they read through the information sheet before signing the consent form. Several of the interviews that were arranged prior to the participant...
observation, were never conducted due to the informants not showing up for the appointment nor responding to either my text messages or phone calls.

In the interviews I focused on those willing to provide abortion. The replies made by my informants might therefore not represent the entire picture, as those that were conservative and anti-abortion due to either social norms or religious beliefs were unlikely to perform abortions. Moreover, due to unwritten practises in the ward where most abortion seeking women met doctors willing to offer the service, I only observed health care workers using their conscientious objection. There was a tension in the ward among abortion providers and non-providers and, it would be interesting to do further research and also interview non-providers and comparing the knowledge and attitudes between abortion providers and non-providers.

Considering time and resources I only conducted interviews within Lusaka. However, to increase the transferability of the study, I should additionally have conducted interviews in rural areas. As access to abortion service are better in Lusaka and there is little research on health care workers role in safe abortion care in Zambia, I chose to focus on urban areas as understanding factors affecting abortion service in urban areas, could be of relevance to rural areas as well.

Furthermore, I could have conducted more interviews to assure that the point of saturation was achieved, and it would be interesting to interview more doctors. However, to interview doctors was challenging in practise, due to the fact that doctors at the hospital were busy performing their duties at the ward and gave me excuses for not having time for an interview. There might also be other explanations for doctors not willing to participate in the study, such as not wanting to discuss their attitudes and beliefs concerning abortion.

To increase the trustworthiness of my study, I could have abstracted data systematically from registers, but due to inadequate documentation and informal arrangements, I did not see registers as a good source of information.

I chose to code the interviews and use them as guidance when coding and analysing the fieldnotes. I chose to emphasize on coding the interviews because they were structured from my research questions and were organized better than my fieldnotes. Fieldnotes were my
observations and reflections on what I observed during my presence in the ward and is based on my background and experiences in combination with my field of interest. My findings from participant observation might not be as reliable as the findings from the interviews, as another researcher might observe situations differently. During the interviews I asked all participants the same questions, so it might be easier for other researcher to obtain the same result as I did.

Reflection of methodology

The interviews were carried out in private offices or rooms in the health institutions to avoid being disturbed or that colleagues could hear the replies of the informants. Regardless of these precautions, several interviews were interrupted by people entering the room or colleagues who were looking for the informant. These interruptions might potentially have influenced the answers given by the informants and affected the flow of the interview, but as I observed it, the interruptions seemed to have little impact on my informants. Some of my informants had a busy schedule, and I therefore felt that we rushed through some of the interviews, I believe that more detailed answers and information could have emerged if their schedule allowed sufficient time for the interviews.

The weakness with interview as a method is that you only get to know what people say, not what they actually do and occasionally I felt that some informants gave me the “politically correct” answer according to institutional policies or the answer they thought I wanted, this seemed especially to be the case with questions regarding routines and practises in the hospital. For instance, several of the doctors claimed that they always used the regular certificate of termination requiring three signatures, but in the ward, I observed several of them using the emergency certificate despite the woman not being in a critical condition. This weakness was reduced as I combined the interviews with participant observation.

In total I spent three full months of participant observation in the ward and I would argue that participant observation was the most valuable method in my study, as I got an insight in the daily activities and observed routines and practises in the ward. The combination of interviews and participant observation, where I could observe words for action and get a better understanding of the phenomena of interest. Conducting participant observation was
engaging and at the same time demanding and I faced a lot of ethical dilemmas. One recurrent
dilemma was for me to differentiate between the role as a nurse in the ward and a researcher
collecting data, being an “insider” but also an “outsider”. Becoming an “insider” you get
access to information you would not get if you were only an “outsider” (70). However, as a
researcher you are always an “outsider” continuously reflecting on situations based on
previous experiences and knowledge. As an ”outsider” you have a different origin than an
“insider” and you can gain a lot of interesting information from the power of a conversation
(70).

I had not applied for an authorization to work as a nurse in Zambia and therefore I was not
licenced to practise nursing. But what to do when the ward was hectic with critical ill patients
and the other nurses were occupied? I chose which situations to interact with and not
according to the condition of the patient. For instance, there was one patient actively bleeding
waiting for surgery, where the doctor ordered several units of intravenous fluids instead of
blood. I asked the doctor if it was not better to commerce blood to avoid diluting her
remaining blood which would increasing her bleeding tendency and potential put her life in
danger. The doctor was very determined to save the blood for surgery and said he was not
worried about giving her intravenous fluids. In that situation I knew the patients was not
given up to date treatment, but I also knew that I could not go further into that discussion due
to my role as a researcher. I had regular meeting with my local supervisor in Lusaka to
discuss these dilemmas.

Participant observation was a challenging and interesting process. One needs to adapt to
different situations continuously and on the one hand build trust and get to know the
informants and on the other hand staying as objective as possible as an observer. As a
researcher, you need to be aware that you as an observer might unintentionally impact your
informants and thus try to minimize your influence on their decision making (68).

The participant observation was done by me, and the analysis of the observation is based on
my background and thoughts about what I observed. I was aware that by using qualitative
methodology, I played an active role in shaping the findings through my approached and
interpretations. I was constantly worried about being too active and influencing health care
workers on their decision making. Hence, I need to consider that my attitudes and
participation might have impacted the informants and thus my findings. However, due to the
duration of the fieldwork where I became part of the daily working environment, I believe that this influence gradually reduced.

As abortion is often hidden away from the public with many unwritten practises and norms, it was very valuable to be an "insider" and part of the nursing team at the hospital to retrieve as much information as possible. Retrospectively, I believe I would have missed out on a lot of information if I was not “one of them”. Being an "insider" also gave me time to speak with the health care workers in a more natural setting than an interview. A lot of interesting information emerged from such discussions, such as personal stories on how they utilize the service unofficially and their thoughts why few women seek abortion services at the hospital.
Conclusion

This study reveals that health care workers had varying knowledge about the abortion law which had implication for the abortion service in practise. My study has demonstrated that health care workers assisting women to terminate their pregnancies experienced moral dilemmas associated with Christian beliefs and social values and they tended to justify their role in abortion care as “saving lives” and preventing bad outcomes.

Furthermore, my study illustrates that health care workers are important gatekeepers and may facilitate or prevent access to safe abortion care through flexibly implementing routines and developing new norms. The practises of using the emergency certificate instead of the regular certificate is one expression how health care workers increase the accessibility of safe abortion care. This finding is not described in previous studies from Zambia. Some practises acted in the favour of both women seeking abortion and health care workers through for instance, informal payments and private arrangements where health care workers got extra income and women utilized the service unofficially thereby avoided stigma. However, these practises are illegal according to the law and they maintain stigma surrounding abortion. If abortion services were known, available and accessible, it is likely that less women would restore to unsafe methods to terminate their unwanted pregnancies and health care workers would have a more predictable working day and possibly have more time to attend to patients admitted in the ward.

The recent transition to medical abortion accessible off label through pharmacies in Lusaka, was reflected in health care workers observations of fewer cases of abortion complications associated with other clandestine methods. Nevertheless, the practise is less safe due to inadequate instructions and follow up. The lack of control over the marketing and distribution of misoprostol is unfortunate in a situation where the Termination of Pregnancy Act allows safe abortion to happen on broad grounds. In order to avoid abortion related deaths in the future, the law should be made operational by the distribution of guidelines and training of health care workers in safe abortion care and stigma reduction vis a vis both other health care workers and vis a vis the general public.
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64. Rehnström LU, Gemzell-Danielsson K, Faxelid E, Klingberg-Allvin M. Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data. BMC Public Health. 2015;15(139).
Appendix 1

Certificate A and B

(Regulation 2)

IN CONFIDENCE

CERTIFICATE A

(Not to be destroyed within three years of the date of operation)

THE TERMINATION OF PREGNANCY ACT

CERTIFICATE TO BE COMPLETED BEFORE A TERMINATION OF PREGNANCY IS PERFORMED UNDER SECTION 3(1) OF THE ACT

I, ...................................................................................................................................................
(name and qualifications of practitioner in block capitals)

of, ..................................................................................................................................................
(full address of practitioner)

and I, ..................................................................................................................................................
(name and qualifications of practitioner in block capitals)

of, ..................................................................................................................................................
(full address of practitioner)

and I, ..................................................................................................................................................
(name and qualifications of practitioner in block capitals)

of, ..................................................................................................................................................
(full address of practitioner)

hereby certify that we are of the opinion, formed in good faith, that in the case of

(full name of pregnant woman in block capitals)

of, ..................................................................................................................................................
(usual place of residence of pregnant woman in block capitals)

1. The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;

2. The continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;

3. The continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;

4. There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers.

SIGNED, ............................................................................................................................................

DATE .............................................................................................................................................

SIGNED, ............................................................................................................................................

DATE .............................................................................................................................................

SIGNED, ............................................................................................................................................

DATE .............................................................................................................................................

39

Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia
Appendix 2

IN CONFIDENCE

THE TERMINATION OF PREGNANCY ACT

CERTIFICATE TO BE COMPLETED IN RELATION TO TERMINATION OF PREGNANCY IN EMERGENCY UNDER SECTION 3 (4) OF THE ACT

I, .................................................................................................................................
(name and qualifications of practitioner in block capitals)

Of .................................................................................................................................
(full address of practitioner)

Hereby certify that I *am/was of the opinion formed in good faith that it *is/was necessary immediately to terminate the pregnancy of
.................................................................................................................................
(full name of pregnant woman in block capitals)

Of .................................................................................................................................
(usual place of residence of pregnant woman in block capitals)

in order-
1. To save the life of the pregnant woman; or
2. To prevent grave permanent injury to the physical or mental health of the pregnant woman.

(Ring appropriate number)

This certificate of opinion is given-
A. Before the commencement of the treatment for the termination of the pregnancy to
Which it relates; or

B. Not later than 24 hours after such termination.

SIGNED.................................................................................................
DATE .................................................................

*Delete as appropriate

Standards and Guidelines for reducing unsafe abortion morbidity and mortality in Zambia
Appendix 3

Appendix 3: Sample of Consent Form

Informed Consent form for legal abortion procedure

1. I, the undersigned, wish to undergo the procedure for safe termination of pregnancy, and understand the following:
   1. I have received comprehensive counselling about all of my options regarding the current pregnancy.
   2. Like many medical procedures, there are some risks and side effects, the details of which have been thoroughly explained to me.
   3. I have applied for the procedure of my own free will without coercion or inducement.
   4. All of the above information has been explained to me in a language I understand.

   [C] [ ]

   Client's name (print)             Client's signature/thumb print

   [ ]

   Date

   [ ]

   Name of provider                Signature of provider

   In loco parentis, as applicable:

   [ ]

   Name                          Signature
MINISTRY OF HEALTH
WOMEN AND NEW BORN UNIVERSITY TEACHING HOSPITAL
MANUAL VACUUM ASPIRATION (MVA) CONSENT FORM

To: The medical staff and Committee of the University Teaching Hospitals – Mother and Newborn.

I, ........................................................................................................................................................................................................................................

........................................................................................................................................................................................................................................

(Address) hereby consent to have the procedure of Manual Vacuum Aspiration (MVA) done on

........................................................................................................................................................................................................................................

(Name of patient) by any trained medical personnel.

• I understand a Manual Vacuum Aspiration (AVM), a procedure that will empty my uterus. This procedure may be used as a suction abortion or as a treatment for a miscarriage, a failed medical abortion or for abnormal urine bleeding.

• I understand that if I am pregnant, my three options regarding this pregnancy are parenthood, adoption and abortion. I understand that if I am pregnant, the MVA will end my pregnancy.

• I understand that before the MVA, I may have blood tests done to check me for anaemia and I will have to document my Rh type by history, blood donor card prior to blood test or a new blood test. If I am Rh negative, I will be offered a short term anti-D.

• I understand that I might be offered medication before the MVA: such as Ibuprofen, morphine, to lessen the pain. I will have local anaesthesia with Lignocaine injected. To the best of my knowledge, I am not allergic to Ibuprofen or Lignocaine.

• I understand that the possible implications from MVA include: incomplete emptying of my uterus, infection, bleeding, allergic reaction and perforation.

• I have read this form and I have had time to think about it. I have had all of my questions answered.

• I have been given an information explaining how to get help should a question or problem arise after the procedure.

• In the event of an unexpected complication during the MVA, I request and authorize the Physician to do whatever is needed to protect my health and welfare.

Signature of patient/thumb: ___________________________ Date: ___________________________

Witness: ___________________________ Date: ___________________________

Signature of provider: ___________________________ Date: ___________________________
Appendix 5

Information on research study

Dear Sir/Madam

My name is Gunhild Stølen Ugelvik, I am a nurse and a master student at the university of Bergen, Norway. I am doing my fieldwork in Lusaka for my master thesis. The aim of my research is to explore health care workers’ role in providing safe abortion care to adolescents and young women in Zambia. This is an information sheet for potential participants for my research.

Zambia did not manage to meet United Nations Millennium Development Goal to reduce maternal mortality rate, one of the explanations might be the high rate of unsafe abortion in the country. Zambia has a large young population and adolescent pregnancies is a major health and social concern. Health care workers’ play a crucial role in good access and good quality abortion care and it is therefore important to know your experience working with abortion.

There is voluntary participation in the research, and you will be asked to sign a consent form. Participation implies that I will interview you whilst I tape record. The interview is expected to last between 45- 90 minutes. Confidentiality will be obtained through the research and all data will be anonymously. All data collected will be securely stored in a password protected computer. The record data will be deleted when the study ends in December 2018.
Appendix 6

Consent form health care workers’

Exploring health care worker’s role  
in providing safe abortion care  
to adolescents and young women in Zambia.

Background and purpose
This is a request for your participation in a research that intends to explore health care worker’s role in providing safe abortion care to adolescents and young women in Zambia. Abortion related complication are common in Zambia, but there is little knowledge about health care workers’ perspectives and experiences related to care provision.

You have been chosen as a potential participant in the study as you are a health professional working on abortion in Zambia.

The study is part of a master thesis in international health conducted by a student from Center of International Heath (CHI) at the University of Bergen in Norway.

What does the study entail?
You are going to be interviewed by a master student, who will take notes during the interview. The interview is going to be tape-recorded. The interview has 12 questions and is expected to last between 45-90 minutes.

What will happen to the information about you
The data from the interview will only be used in accordance with the purpose of the study as describe above. All the data will be processed without name or other directly recognizable information.
Voluntary participation
Participation in this study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. If you agree to participate at this time, you may later on withdraw your consent without any consequences. If you wish to participate, sign the declaration of consent below. In case you have any questions, do not hesitate to contact either me or my supervisor.

Gunhild Stølen Ugelvik
Email: gunhild.s.u@gmail.com
Number: +47 45454186

Karen Marie Moland
Email: Karen.moland@uib.no
Number: +47 92628226

Joseph Mumba Zulu
Email: josephmumbazulu@gmail.com
Number: +260971591388

Consent for participation in the study

I am willing to participate in the study

(Signed by the project participant, date)

I confirm that I have given information about the study

(Signed, role in the study, date)
Appendix 7

Interview guide

Age:
Sex:
Profession:
Years in duty:

1. Can you describe a usual day at work?

2. Tell me about your interpretation on the current abortion law in Zambia?
   - Whom utilize the law?
   - How is the law used in daily life?

3. Can you explain the use of certificate of termination?
   - What differs the forms?
   - Which form is used and why?

4. How do you see religion and tradition in relation to abortion?
   - Access and utilization

5. What training do you have in abortion care?
   - Are there any specific training and/or guidelines towards adolescents and young adults?

6. What is your experience with misoprostol off label?

7. Adolescent pregnancy rate is high in Zambia, do you have any explanation for this?

8. In your opinion how accessible and available is abortion service to adolescent and young women in Zambia?
   - Is there any difference between women from urban/rural areas?
9. What do you do when an adolescents/young woman seek abortion care in your clinic?
   - How often does this occur?
   - Whom do they come with?
   - Where do they come from? Referred?

10. Do you find it different to treat adolescents and young women?
    - What is the most challenging part in treating this age group?

11. Which preventive method to unsafe abortion is most commonly see in Zambia, and why?
    - Youth friendly service
    - Sexual education
    - Family planning
    - How do you see accessibility and availability of preventive methods?
    - Any abortion prevention campaigns?

12. Abortion is a sensitive topic in Zambia, especially in relation to adolescents and young women. Do you have any suggestion on how to make it more open and to improve service to this age group?

13. How do you feel working with abortion?
Appendix 8

Regional Committee for Medical and Health Research Ethics, Western-Norway

To whom it may concern

Our ref
2017/1746

Date
12.01.2018

Confirmation

I hereby confirm that the project “Health care workers' role in providing safe abortion care among adolescent and young women in Zambia”, by project manager Karen Marie Moland, is reviewed and approved by the Regional Committee for Medical and Health Research Ethics, Western-Norway.

Best regards

Fredrik Rongved
Committee secretary
Appendix 9

THE UNIVERSITY OF ZAMBIA

BIOMEDICAL RESEARCH ETHICS COMMITTEE

Telephone: 260-1-250067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: +260-1-250753
E-mail: urzarc@unza.zm
Assurance No. FWA0000338
IRB00001131 of IOHG0000774


Your Ref: 009-01-18.

Ms. Gunhild S. Ugelvik,
University of Bergen,
Centre for International Health,
Department of Public Health & Primary Care,
P.O. Box 50110,
Lusaka.

Dear Ms. Ugelvik,

RE: RESUBMITTED RESEARCH PROPOSAL: “THE ROLE OF HEALTH CARE WORKERS IN PROVIDING SAFE ABORTION CARE TO ADOLESCENTS AND YOUNG WOMEN IN ZAMBIA” (REF. No. 009-01-18)

The above-mentioned research proposal was presented to the Biomedical Research Ethics Committee on 23rd January 2018. The proposal is approved.

CONDITIONS:

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this Committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported at once to this Committee.
- Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a Progress Report (Progress Report Forms can be obtained from the Secretariat).
- Where appropriate, apply in writing to National Health Research Authority for permission before you embark on the study.
- Ensure that a final copy of the results is submitted to this Committee.

Yours sincerely,

[Signature]

Dr. S. H Nzala PhD
VICE-CHAIRPERSON

Date of approval: 25th January, 2018.

Date of expiry: 24th January, 2019.
31st January, 2018

Ms Gunhild S. Ugelvik
University of Bergen
Centre for International Health
Department of Public Health & Primary Care
P.O. BOX 50110
LUSAKA

Re: Request for Authority to Conduct Research

The National Health Research Authority is in receipt of your request for authority to conduct research titled: “The Role of Health Care Workers in Providing Safe Abortion Care to Adolescents and Young Women in Zambia”. This study has been approved to carry out the above mentioned exercise on condition that:

1. The relevant Provincial and District Medical Officers where the study is being conducted are fully appraised;
2. Progress updates are provided to NHRA quarterly from the date of commencement of the study;
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Directors of Health where the study was being conducted, and all key respondents.

Yours sincerely,

Dr Godfrey Biemba
Director/CEO
National Health Research Authority
14th February, 2018

Gunhild S. Ugelvik,
University of Bergen
Norway

RE: PERMISSION TO CONDUCT A STUDY AT UTH ENTITLED "THE ROLE OF HEALTH CARE WORKERS IN PROVIDING SAFE ABORTION IN ADOLESCENTS AND YOUNG WOMEN IN ZAMBIA"

 Provincial health office acknowledges the receipt of your request to conduct above study at UTH. Note that UTH reports directly to the Permanent Secretary and not to Provincial office. As such request directly from University Teaching Hospital – Women and New Born Hospital (WNH).

Thank you.

Dr. Kakumzi Simbikaye
Provincial Health Director
Lusaka

Physical Address: 3 Salse Road, Longacres, Lusaka, Zambia
26th February 2018

Gunhild Stolen Ugvelvik (Ms)
University of Bergen
NORWAY

Dear Ms. Ugvelvik,

RE: AUTHORITY TO CONDUCT RESEARCH IN LUSAKA DISTRICT

We are in receipt of your letter over the above subject.

Please be informed that Lusaka District Health Office has no objection for you to conduct research on “The role of health care workers in providing safe abortion care to adolescents and young women in Zambia”.

Kindly ensure that your findings are shared with the health facility and District Health Office and that the normal operations of the facility are not disrupted.

By copy of this letter, the Medical Superintendents/Medical Officer In-Charge for Mtendere, Chilenje, Kanyama and Matero 1st Level Hospitals are kindly requested to facilitate accordingly.

Yours faithfully

Dr. C. Mbwili-Muleya
Principal Clinical Care Officer
For/District Health Director
LUSAKA DISTRICT HEALTH OFFICE

C.C: Medical Superintendents/Medical Officer In-Charge: Mtendere, Chilenje, Kanyama and Matero 1st Level Hospitals
## Appendix 13

### Analysis

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