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

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GOVERNMENT OF THE REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

TABLE OF CONTENTS

FOREWORD

The issue of women dying from pregnancy related complications is not only a sad issue for the families but obviously a developmental challenge for the country. On this score, the Government of Zambia has introduced several measures and integrated interventions aimed at improving pregnancy outcomes for women from all spheres of life both in rural and urban areas.

Even though the country has noted a drop in maternal mortality, the Government is well aware that we are still far from achieving the MDG 5 target. It is in this context that the Ministry is yet again introducing another package of care, the Comprehensive Abortion Care (CAC), which if implemented adequately, will significantly reduce unnecessary deaths from unsafe abortion, a cause that is totally preventable. Evidence points to many women, many of whom are girls, with unwanted pregnancies resorting to unsafe methods to terminate the pregnancy thus endangering their lives. The Government acknowledging the Termination Act of 1972 and also mindful of the many regional and international agreements it has ratified regarding women's health rights like ICPD, Beijing platform of Action and more recently Maputo plan of action to name but a few , has put together these guidelines to facilitate translation of policy into action.

These guidelines should not operate in a vacuum; neither should they imply that abortion is another method for contraception. On the contrary, Family planning and Post abortion Care (PAC) have been integrated as part of CAC and it is hoped that this integration is going to give impetus to more positive Reproductive health outcomes.

It is hoped that all stakeholders working to reduce maternal mortality and morbidity resulting from unsafe abortion will find this document useful and will apply the principles behind it in their programs. More importantly, the women, who hitherto have been victims of unsafe abortion will no longer suffer preventable morbidity and mortality irrespective of their social status or locality as the standards and guidelines will be institutionalized in both public and private health facilities all over the country.

The government counts on your valuable partnership towards realization of the targets for Reproductive health by ensuring that CAC services are implemented as per set out standards.
Lastly, I would like, on behalf of my Ministry and the Government of Zambia, to sincerely thank all individuals and institutional partners that assisted and worked tirelessly to put these standards and guidelines together.

Minister of Health.
MINISTRY OF HEALTH

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Permanent Secretary
MINISTRY OF HEALTH

ACRONYMS

AIDS	**Acquired Immune Deficiency Syndrome**
ANC	**Antenatal Care**
CAC	**Comprehensive Abortion Care**
CBA	**Community Based Agents**
CBDs	**Community Based Distributors**
CEDAW	**Convention on the Elimination of All Forms of Discrimination Against Women**
COC	**Combined Oral Contraceptives**
CRC	**The International Convention on the Rights of Children**
CPR	**Contraceptive Prevalence Rate**
CSO	**Central Statistics Office**
D & C	**Dilatation and Curettage**
D & E	**Dilatation and Evacuation**
DHMT	**District Health Management Team**
EC	**Emergency Contraception**
EHT	**Environmental Health Technicians**
FBC	**Full Blood Count**
FP	**Family Planning**
GMO	**General Medical Officer**
GRZ	**Government of the Republic of Zambia**
Hb	**Haemoglobin**
HMIS	**Health Management Information System**
HIV	**Human Immune Virus**
ICPD	**International Conference on Population and Development**
IEC	**Information Education and Communication**
IOL	**Induction of Labour**
IRH	**Integrated Reproductive Health**
IUD	**Intra Uterine Device**
LMP	**Last Menstrual Period**
MCH	**Maternal Child Health**

MDGs	**Millennium Development Goals**
MOH	**Ministry of Health**
MPAC	**Misoprostol for Post Abortion Care**
MVA	**Manual Vacuum aspiration**
NAF	**National Abortion Federation**
NGO	**Non- Governmental Organisations**
OBGYN	**Obstetrics & Gynecology**
OJT	**On the Job training**
PAC	**Post Abortion Care**
PEP	**Post Exposure Prophylaxis**
POP	**Progesterone only pill**
RCOG	**Royal College of Obstetricians and gynecologists**
RH	**Reproductive Health**
RM	**Registered Midwife**
RPOCs	**Retained products of Conception**
SGBV	**Sexual and Gender based Violence**
SMAGS	**Safe motherhood Action groups**
STI	**Sexually Transmitted Infection**
TBA	**Traditional Birth Attendant**
TOP	**Termination Of Pregnancy**
U/Es	**Urea and electrolytes**
UN	**United Nations**
UTH	**University Teaching Hospital**
WHO	**World Health Organization**
ZDHS	**Zambia Demographic Health Survey**

Legal and operational definitions

Abortion:	Termination of pregnancy, expulsion or extraction of embryo / fetus before viability. In Zambia, 28 weeks is the date of viability.
Adolescent:	An adolescent is a person aged between 10-19 years in school and out of school facility
Audit:	Technical scrutiny or assessment of skills to test a performer's suitability or ability for a service.
Autonomy:	Means that the mentally competent adults do not require the consent (authorization) of any third party, such as husband or partner to access a health services (WHO 2003).
CAC:	A comprehensive abortion care (CAC) is an approach based on the epidemiological concept of primary (prevention of pregnancy), secondary (treatment of unwanted pregnancy) and tertiary (treatment of complications) in health care.
Counselling:	Is a professional process of providing non-judgmental guidance to help a person make an informed decision.
Emergency:	Sudden state of danger or condition requiring immediate treatment or action to restore life of a person or patient.
Emergency abortion Care:	Life-saving services that help to meet the needs of women suffering complications of abortion
Evaluation:	Assessing the relevance effectiveness, efficiency, sustainability and impact of services using service statistics from monitoring and special investigations to assess the extent to which programme goals are being achieved.
Family Planning:	A deliberate method of spacing or limiting births to achieve the desired family size a couple or individuals would wish to have in their lifetime.
Guidelines:	Principles directing actions for implementation according to policies that must be rational, logical and documented.
Legal Abortion:	Termination of pregnancy involving a safe procedure performed under hygienic conditions using appropriate or right equipment by trained providers as laid down by the Termination of Pregnancy Act.
Maternal Mortality Ratio:	The number of women who die due to pregnancy and child birth complications per 100,000 live births in a given year.
Medical Abortion:	Use of pharmacological methods to terminate pregnancy.

Medical practitioners:	Persons licensed and registered under the provisions of the medical and allied professional Act.
Minor:	Any person being below the age of 16 years (See Penal code, Marriage Act of Zambia
Monitoring:	Overseeing the processes of implementing services, including changes overtime using defined indicators.
PAC:	Post abortal care is an integrated package of care for women who have had a spontaneous (miscarriage) or induced abortion with or without its complications. It includes emergency treatment, family planning counselling, linkages to other RH services and community linkages
Reproductive Health (RH):	Is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive health system and in its functions and processes (ICDP 1994). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide when and how often to do so.
Reproductive health care:	Constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems, including that of sexual health.
Skilled Attendant:	A trained provider with a technical competence for providing a health service
Standards:	Measures of performance
Surgical Abortion:	Use of trans-cervical procedures for terminating pregnancy, including vacuum aspiration, dilatation and curettage (D&C), and dilation and evacuation (D&E).
Therapeutic abortion:	All legally sanctioned abortions or medically indicated abortion for women whose life or health is threatened by continuation of pregnancy or when the health of the fetus is threatened by congenital or genetic factors
Unsafe abortion:	A procedure for terminating an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO 1993).
Unintended pregnancy:	Pregnancy occurring unplanned resulting in either wanted or unwanted birth.
Unwanted pregnancy:	Pregnancy which is not desired by the pregnant woman.
Uterine Evacuation:	Is the active removal of uterine contents in the process of terminating a pregnancy either by medical or surgical means.

Introduction

The Government through its Reproductive Health Policy advices that reproductive health needs should be addressed in an integrated manner rather than in parallel compartments more so as reproductive ill health results from complications of pregnancy including unsafe abortion , reproductive tract infections, cancers, STIs, HIV/AIDS, infertility and violence against women which are all interrelated.

Concerned with alarming maternal mortality ratios, Zambia in tandem with other countries, launched the Safe Motherhood Initiative in 1996 in a bid to improve maternal health and reduce maternal mortality. Safe motherhood services have been provided in the past and continue to be provided but there has not been any significant impact on the health indicators of the mother and the newborn. Government, in the past few years, has had to focus on integrated interventions to address the main causes of maternal deaths which include postpartum haemorrhage, sepsis, obstructed labour, hypertensive disorders and abortion complications which in most instances are caused by unsafe abortion.

Unsafe abortion remains a major challenge in Zambia despite an abortion law that is considered favorable and a liberal continental policy framework to which Zambia subscribes. With a maternal mortality of 591 per 100,000 live births, it is estimated that up to 30% of these deaths could be resulting from unsafe abortion. The Ministry of Health also estimated that about 23% of incomplete abortions were among women younger than 20 years, while 25% of maternal deaths due to induced abortions were in girls younger than 18 years. Hospital based studies show that 30 50% of acute gynecological admissions are currently as a result of abortion complications, a big proportion being from unsafe abortion. In 1993, the Ministry of Health indicated that over 16,000 maternal hospital admissions nationally were due to abortions performed in the community by non-professionals.

A needs assessment for Post abortion care (PAC) was conducted in 1998 and findings indicated that complications of abortions were predominant. Family planning use was very low and access to safe abortion services was restricted due to ignorance of the Law on abortion by Policy makers, providers and society. PAC an integrated package consisting of emergency abortion care, family planning and linkage to other RH services was thus introduced. Many successes have been noted with the PAC programme. Many providers including mid-level providers have been trained in the use of manual Vacuum Aspiration (MVA) and because these services have been decentralized to lower level, many women do not have to travel long distances to access services. Contraceptive prevalence rates have also continued to increase as indicated by the Zambia Demographic Health survey. However maternal mortality ratio have not correspondingly come down as many women continue dying from complications of unsafe abortion.

Owing to the foregoing, the Ministry of Health in collaboration with WHO and Ipas Africa Alliance commissioned a strategic assessment into the problem of unsafe abortion in 2008. The exercise had the following three strategic objectives: to ascertain the continued problem of unsafe abortion; to find out how the need for abortion can be reduced and to ascertain how safe abortion services can be enhanced for women in need. The assessment had pertinent findings that spanned across programmatic issues manifest through socio-cultural barriers and policy shortcomings [see report]. One of the main findings was that abortion services are being provided in a vacuum. While the law exists, it does so, on a "*stand alone*" basis with no clear policy framework for standards

and guidelines in implementing services. This led to the MOH taking steps to develop the current document. Through the development of this document, the Ministry of Health hopes to be fully attendant to the challenges of unsafe abortion by introducing a holistic approach of Comprehensive abortion Care.

The approach is based on the epidemiological concept of primary, secondary and tertiary prevention in health care. The best of these is primary prevention which refers to all the actions taken to protect the population from being inflicted by a health problem. In preventing unsafe abortion, primary prevention refers to preventing unwanted/unintended pregnancy. This can be done through abstinence counseling, contraception and prevention of rape and incest and thus is a function for all sectors of society including religious bodies, the school system, families and all socio-cultural structures.

Secondary prevention, on the other hand, is about early detection and management of health problems and aims to prevent complications from happening as a result of treatable health conditions. Applied to the problem of unsafe abortion, this would mean early detection of unwanted/unintended pregnancy and provision of services that will prevent unsafe abortion from happening. The services include adoption services, termination of pregnancy to the full extent allowed by the law and provision of ante-natal services to women who choose to carry their pregnancies to term, whether such women want to keep the baby or give it out for adoption.

The last in the spectrum of comprehensive abortion care is tertiary prevention which in dealing with unsafe abortion would be offering post abortion care. This level of care aims at preventing permanent disability and death in patients who already have complications either from spontaneous or induced abortion.

By applying all the levels of care to the problem of unwanted/unintended pregnancy, the MOH aims to drastically reduce morbidity and mortality resulting from unsafe abortion. Abortion services will also be used as entry points for other reproductive health services by strengthening the referral within the health system. Comprehensive services will be guided by the principles of a woman's choice to available options, equitability of access to services by women of all socio-economic classes, and high quality of services at all levels of healthcare.

This document will greatly enhance the legislative framework for matters related to or incidental to unsafe abortion. In particular, this document will seek to easy the implementation of the provisions of the Termination of Pregnancy Act, the 2005 amendments to the Penal Code on the treatment of survivors of rape and incest. This document will also further the implementation of some parts of the Nurses and Midwives Act of 1997 and as well as those of the Adoption Act.

This document has been developed within the tenets of the international human rights framework. The Zambian Government, as most other Governments, has ratified a number of "*legally binding*" international agreements that protect human rights, in particular the right to life, liberty and security of the person, the right to the highest attainment standards of health, the right to non-discrimination, the right to be free from inhuman and degrading treatment and the right to education and information.

In consideration of the foregoing, global consensus on the international human rights framework for reproductive health has been reached at various levels including the International Conference on Population and Development, the ICPD+5 review and Appraisal process, the Tehran Proclamation, the 1995 Fourth World Conference on Women and the 2000 United Nations Summit. These global initiatives have yielded enough leverage for municipal laws to provide for women's rights to lead safe and responsible reproductive lives.
Further, the document seeks to operationalize provisions of the Maputo Plan of Action and the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa that are concerned with reproductive health and abortion. The document is especially key in the attainment of the Fifth Millennium Development Goal that aims to reduce maternal mortality by three quarters by 2015. Further, the document seeks to enhance the implementation of ICPD and ICPD +5 plans of action, International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights, CEDAW and CRC.

Situation Analysis

The situation of unwanted pregnancy and its consequences continues being a devastating phenomenon in the country. Unplanned pregnancy is prevalent and common in Zambia. Recent studies show the overall figure of 16 percent of births are unwanted, while 26 percent are mistimed or wanted at a later period (CSO et al. 2009). The outcome of this event has been further felt in cumulative effects of increase in fertility levels and outcome of clandestine abortion due to unsafe abortion increasing risks of morbidity and mortality among women in the country. Fertility has remained at a high level over the last 15 years from 6.5 births per woman in 1992 to 6.2 births in 2007 (CSO et al. 2009). If all unwanted births were prevented, women would have an average of 5.2 live births or less per woman compared with the actual average of current 6.2 births per woman.

Alongside the consequences of this event, teenage pregnancy is also recognized as major demographic and public health challenges in the country. About three in ten young women aged 15-19 have experienced childbearing (CSO et al. 2009). Teenage pregnancy is observed to be precipitated by influences of premarital sexual practices and early marriage practices which are still the social norms of the Zambian societies (CSO et al.2005, 2009). Age at first sex for both women and men is an important indicator of exposure to risk of pregnancy and STI has been found lower (<18 years) among female youths 18-24 years than the male youths (CSO et al. 2009). This has a serious repercussion for teenage pregnancy likely to result in unwanted pregnancy. Other attributes to unwanted pregnancy repercussion have related to gender sexual violence of rape, defilement, incest and gender and women empowerment (CSO 2005, 2009).

The prevalence of unwanted pregnancy culminating into increased incidences of unsafe abortion has resulted in severe consequences of morbidity and mortality. This translates to over 70% of abortion complications being unsafe and six per thousand women die of abortion, most likely due to unsafe abortion (Likwa et al. 2009). Other studies show main factors that are attributed to unsafe abortion have related to stigma associated with unwanted pregnancy; cultural values and religion; socio-economic status; access availability of safe abortion and contraceptives services, especially among vulnerable groups of society and decision-making processes on choice of health services (Ministry of Health and Ipas 2008; CSO et al.2009).

However, despite the overall knowledge of family planning being adequately high and nearly universal since 1996, utilization of family planning services is still quite low. The recent survey show 70% of currently married women have used a family planning method at least once in their lifetime and about three in ten report using a modern method. The most commonly used methods among currently married women are the pill (11 percent), followed by injectables (9 percent) and male condom (5 percent).

Despite the low pace of modern contraceptive use, use of contraception has increased from a rate of 15 percent in 1992 to 41 percent in 2007 (CSO 2009). There has been also a corresponding increase in the use of modern methods from 9 percent observed in 1992 to 33 percent in 2007. The public sector remains the major provider of contraceptive services in Zambia. The distribution of sources of modern methods supplies for current users shows that the majority of users (68 percent) obtain their contraceptives from the public sector. The participation of the private medical sector in family planning service delivery has decreased steadily during the last 15 years from 36 percent in 1992 to 17 percent in 2007. Only 10% of current users obtain their methods from the retail outlets (CSO 2009).

Unmet needs for family planning is still problematic in this country. Overall, 27 percent of currently married women have an unmet need for family planning, 17 percent for spacing births, and 9 percent for limiting births. Unmet need for family planning has therefore remained unchanged since 1996 (CSO 2009). If all women in reproductive ages with an unmet need for family planning were to use a contraceptive method of their informed choice, the contraceptive prevalence rate (CPR) for any method in Zambia would increase from current 41 to 67 percent.

There are existing policies and guidelines for the implementation of reproductive health services to prevent unwanted and unintended pregnancy in the country (Ministry of Health 2008; Ministry of Health 2006). The Reproductive Health and Family Planning Policy (2008), Population Policy (2008), National Child Health Policy (2008), and Girl-Child Education Policy (1997) frameworks are legal instruments facilitating implementation of appropriate measures for the prevention of unintended and unwanted pregnancies in the country.

The parental/guardian consent (authorization) for minors are ratified in the conversion on the Rights of the Child (CRC). Article 5 of the Conversion provides that " states parties shall respect the responsibilities, rights and duties of parents…to provide in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of rights recognized in the present Conversion" (In WHO 2003:66). In Article 3, which contains one of four guiding principles that govern the implementation of all articles of the Convention, states that, "in all actions concerning children (defined as every human being below the age of 18 years) whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration.

Health providers should encourage minors to consult parents or another trusted adult about their pregnancy. If the girl indicates that is not possible (e.g. a parent is abusive) service providers should act in good faith in the interest of the minor. This may involve leaving out parental consent.

Purpose

The purpose of this standards and guidelines document is to ensure that women prevent unwanted pregnancies and those with unwanted/unintended/risky pregnancies get appropriate services to prevent the occurrence of unsafe abortion and associated morbidity and mortality. The document is based on sound current scientific evidence of safe medical practice and therefore provides a basis for the provision of equitable and quality comprehensive abortion services as close to the people as possible.

The document is directed to health providers, managers and policy makers involved in the provision of abortion related services. It contains guidance on what, how, by whom and in which facilities services can be provided.

It is hoped that all stakeholders working to reduce maternal mortality and morbidity resulting from unsafe abortion will find this document useful and will apply the principles behind it in their programs. More important, however, is that women who hitherto have been victims of unsafe abortion will no longer suffer preventable morbidity and mortality irrespective of their social status or the part of the country where they come from because the guidelines will be institutionalized in both public and private health facilities all over the country.

Structure of this document

This document is organized into 4 sections. Section 1 deals with prevention of unwanted and unintended pregnancy, section 2 deals with management of unwanted /unintended and risky pregnancies , section 3 deals with Post abortal care and section 4 provides the monitoring and evaluation framework.

Each section contains medical practice norms broken down into standards and guidelines depending on the level of flexibility which is determined by the extent to which intervention evidence exists. When the outcomes are known, a practitioner has limited choices. On the other hand when the outcomes of an intervention are uncertain or variable, practitioners must be given flexibility to tailor a policy to individual cases. The flexibility is thus dealt with by having two types of practice policies in the document: standards and guidelines.

- **Standards** are intended to be applied rigidly in almost every case, exceptions being rare and difficult to justify. For auditing purposes, standards are used to measure performance.

- **Guidelines** are steering in nature. They do not have the same force as standards. When they are not applied, their justification must be rational, logical and documented. Each guideline specific to a particular standard is indented just under the standard. Broad guidelines that apply to many if not all standards are written at the end of a specific section.

***This document will be supplemented by protocols which give step by step guidance for every procedure*[1].

[1] Protocols will be developed after adoption of guidelines

Section 1 Prevention of unintended and unwanted pregnancy

Policy Statement: Individuals and families should have access to quality and affordable reproductive health services as a way of ensuring their physical, mental, emotional and social development throughout their lives. The provision of these services should be blind to age, colour, creed, religion, gender and mental or socio-economic status. (***Reproductive Health Policy ; b of 24 & g of 25)***

Family planning

Who Should Provide Family Planning Services

Policy Statement: All stakeholders, from community to government, (Appendix 5) should play a role in preventing unwanted pregnancies and so involvement of all stakeholders regardless of creed and belief, is essential for successful interventions

Standard 1: As recommended by FP guidelines and protocols of 2006, family planning services should be provided by trained providers at community and facility level e.g. medical officers, medical licentiates, nurse midwives, clinical officers, trained non medical providers such as community based health workers/agents and traditional birth attendants.

Guidelines:

1. At appropriate level of care, providers must be adequately trained in the provision of both short term and long term methods of family planning.
2. The role of stakeholders such as the church, the media community/traditional leaders, school system should be appreciated in the prevention of unwanted pregnancy.
3. Community-based health workers/agents should integrate provision of information on pregnancy prevention and consequences of unsafe abortion into their work
4. Community-based health workers/agents should integrate provision of contraceptives

How should services be provided

Policy Statement: A holistic approach to Family planning is beneficial to socio-economic development of the country and prevents pregnancy related morbidity and mortality.

Standard 1: All women, men and young people shall be provided with the family planning method they request so long as the request meets the agreed eligibility criteria, without hindrance of personal opinions or pre -conceived biases of the service provider.

Guidelines:

1. Institutions shall ensure that a broad method mix is always available to allow for choice
2. The choice of the client prevails above any other including that of the spouse or guardian or service provider. Services shall be provided without notification or consent of a spouse or partner

Standard 2: Service providers shall respect the client's rights in the provision of family planning services.

Guidelines:

1. Providers shall ensure that they:-
a) Communicate with clients effectively and in culturally accepted ways
b) Treat all clients with respect and dignity
c) Provide quality services in a way that does not infringe upon the client's rights
d) Conduct profiling of the client appropriately
e) Assure privacy and confidentiality

Standard 3: All providers should demonstrate counselling skills in line with the Family Planning Counselling Kit.

Guidelines:

1. The provider must ensure that the counselling is non judgmental
2. Adequate information should be given to each client to enable clients make an informed choice.
3. The provider must ensure that they are responsive to client's concerns

Standard 4: All hospitals, health centres, clinics and community health structures should have physical structures and space conducive for the provision of FP services.

Guidelines:

1. Physical structures should be accessible to all including people who are differently-abled.
2. Physical facilities must ensure adequate privacy
3. The district should ensure adequate provision of community based family planning services.

Adolescent FP Services

Policy Statement: providing adolescents with quality FP services reduces unwanted pregnancies, teenage fertility and risk of unsafe abortion thereby reducing morbidity and mortality

Standard 1: Youth friendly services should be available in all facilities providing Reproductive Health services including those at community level.

Guidelines:

1. Adolescents need a supportive environment in which they can express their needs, fears and embarrassment without being judged or turned down and therefore:-
   a. Facilities should ensure availability of trained personnel in youth friendly services including psychosocial counselling, at all levels of health care.

a. Facility should ensure adequate privacy and confidentiality including adequate infrastructure.
b. Facilities should sensitise the community on the availability of youth friendly services.
c. Youth Friendly Health Services should be available in the community.

Standard 2: All adolescents and youths, both in-school and out of school, should have access to comprehensive sexual and RH information and services.

Guidelines:

1. Family planning should be integrated in school health services
2. Family planning should be included into the school curriculum
3. Information and services should equip them with basic life skills with a view to enhancing their assertiveness, self-esteem, value clarification and decision-making regarding issues that affect them;
4. Give active institutional support to IEC packages that are meant to address adolescent sexuality and reproductive health needs;
5. Ensure that cost of services does not hinder access of services for adolescents and youths.
6. This may include alternative cost measures for adolescents and youths such as free or minimal costs for all services.

Standard 3: Facilities should ensure that adolescents and youths make informed and free decisions without coercion from interested parties.

Guidelines:

1. Ensure respect of autonomy in decision making without third party authorization.
2. Ensure that the adolescent is adequately counseled.
3. Providers should act in good faith in the interest of the minor and this may involve leaving out parental or guardian consent

Sexual Abuse and Violence

Policy Statement: The prevention and timely management of sexual violence reduces unwanted pregnancy, unsafe abortion and related morbidity and mortality

Standard 1: Community and facility based SRH services should have information and services on prevention of sexual violence

Guidelines:

1. Advocate for enforcement of laws pertaining to penalties against sexual and gender based violence (SGBV)for perpetrators
2. Create awareness about the health risks associated with sexual and gender based violence through media, community participation and other existing structures.

Standard 2: Facilities offering RH services should have protocols for providing services to survivors of sexual violence

Guidelines

1. Build capacity of all providers and institutions involved in handling victims of sexual abuse and violence
2. Ensure provision of emergency contraception
3. RH providers should ensure that all victims of SGBV should be linked to other supportive services including prevention and management of STIs, HIV, unwanted pregnancy and need for Post Exposure Prophylaxis (PEP), psychosocial counselling and shelter.
4. Establish an effective referral systems through formalized agreements between stakeholders

Termination of pregnancy

Legal Provisions and implementation guide for safe abortion services.

This section has been incorporated in the guideline with the aim of enabling all health workers, involved in the provision of abortion care, to be well informed on the law so that they may not only know when and how to apply the law but also inform and educate women and the community at large.

The Zambian legislative framework on the termination of pregnancies is defined by three principal Acts of Parliament. These are the Republican Constitution, the Penal Code and the Termination of Pregnancy Act. The Republican Constitution makes allowance for the termination of pregnancies, provided such is done within the laid down conditions of the law [See Article 12(2)]. On the other hand, the Penal Code makes provision for safe abortion by criminalizing unsafe and illegal abortion methods [See Sections 151 to 153]. The Termination of Pregnancy Act is the principal legislative Act on the termination of pregnancy. It was enacted in 1972 with amendments in 1994. The Termination of pregnancy Act provides for the legal termination of pregnancies within defined spheres.

The Act provides the general framework under which a pregnancy can be terminated. According to the Act, an abortion in Zambia can be conducted under the following circumstances:-

i. Where the pregnancy constitutes a risk to the life of the pregnant woman

ii. Where the pregnancy constitutes a risk of injury to the physical or mental health of the pregnant woman

iii. Where the pregnancy constitutes a risk of injury to the physical or mental health of any existing children of the pregnant woman to such extent that the risk is greater than if the pregnancy were terminated

iv. Where the pregnancy constitutes a substantial risk so much that the child to be born would suffer from such physical or mental abnormalities as to be seriously handicapped

Amendments to the Penal Code

Due to the escalating number of Gender Based Violence cases, the Zambian Parliament in 2005 amended the Penal Code. In particular, sections 151 to 153 dealing with abortion were amended to include terms as female child, rape and defilement.
Section 152[2] provides as follows:-

> *"Any female child being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind commits an offence and is liable to such community service or counseling as the Court may determine, in the best interest of the child"*
> *Provided that where a female child is raped or defiled and becomes pregnant the pregnancy may be terminated in accordance with the Termination of Pregnancy Act*

The following guide has been developed to help providers in applying the requirements of the Act.

1. Implementation Guide for Place for Termination of Pregnancy (section 2 & 3(3&4) of TOP

*Except as provided by subsection (4)any treatment for the termination of pregnancy must be carried out in a **hospital***

- Hospital means public health facility and or private clinic registered with Medical council of Zambia with adequate requirement to perform safe procedures.(Trained personnel, equipment and supplies)

- However, a termination of pregnancy can be carried out in any other "*place*" regardless of level of care, or health facility, if the termination was an emergency one necessary to save the life or prevent grave permanent injury to the physical or mental health of the pregnant woman [See Section 3(4) of TOP].

2. Implementation Guide for Section 3[1] of TOP

Status of Termination of pregnancy

- Termination of pregnancies is legal, provided it is conducted by trained and skilled medical providers within the confines of the law.

- The health provider must bear in mind that the Zambian law is premised on the sound assumption that the life of the mother is paramount to that of the unborn child.

- **"Good faith"** is premised within the tenets of medical ethics of preventing harm. Medical providers are presumed to be acting in good faith unless proven otherwise.

3. Implementation Guide for Section 3[1][a][i] of TOP

Where the pregnancy constitutes risk to the life of the pregnant woman

- The health provider must recommend or conduct termination of pregnancy where he forms the opinion that the continuance of the pregnancy poses risk to the life of the pregnant woman greater than if the pregnancy were terminated.

- The health provider should, in all good faith, follow the knowledge of standard medical indications that necessitate termination of pregnancy to save the life or health of the pregnant woman.

- The health provider must as an ethical consideration not expect the pregnant woman to request for the termination or that the pregnant woman should be in a state of ill health at the time of requesting safe abortion services. The health provider must assess the pregnant woman's conditions and recommend an opinion formed in good faith that the continuance of the pregnancy constitutes a risk to the life of the pregnant woman greater than if the pregnancy were terminated.

- The woman should not necessarily be in a state of ill health at the time of having TOP. Its therefore the responsibility of the provider to assess the woman's condition and determine whether there is a threat to her life

4. Implementation guide for Section 3(1)(a)(ii) of TOP

Risk of injury to the physical or mental health of the pregnant woman

- The health provider should recommend or conduct termination of pregnancy where he/she forms opinion in good faith, that the continuance of the pregnancy constitutes a threat to the physical or mental health of the pregnant woman. Medical providers are presumed to be acting in good faith unless proven otherwise.

- Risk of physical injury should be taken to mean that though no threat to the life of the pregnant woman exists, a threat to her physical wellbeing or limb exists [whose degree is irrelevant] by continuing with pregnancy or that the birth of the child endangers the pregnant woman's mental wellbeing for psychological reasons or otherwise.

- Risk of Injury to the physical health means any such risk of a physical nature that would befall the woman whether actual or reasonably foreseeable environment.(See section 3(2). It up to the health provider to ascertain upon taking a history, making a physical or laboratory including genetic diagnosis/investigation of the pregnant woman.

- Risk to Mental health should be taken to mean any effect upon the pregnant woman premised upon reasons taking into consideration the definition of mental health.

- WHO defines mental health as a part of overall health, “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Mental health includes “subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential” (World Health Organization)

- Because mental health is not just the absence of mental disorders, assessment need not be done by a psychiatrist. The pregnant woman's present social and economic circumstances should be taken into account when assessing risk to mental health as per Section 7 below. Also, the woman's future social and economic circumstances that could result from the birth of a child should be taken into account when assessing risk to mental health.

5. Implementation Guide for Section 3 (1)(a) (iii) of TOP

Risk of injury to the physical or mental health of any existing children of the pregnant woman

- The health provider shall recommend termination of pregnancy where s/he forms opinion that the birth of the child constitutes a risk of injury to the physical or mental health of any existing child/ren of the pregnant woman.

- It is enough that the birth of the unborn child shall constitute a threat to the physical or mental well being of the existing child/ren of the pregnant woman that must be used as a basis for recommendation of the termination of pregnancy

- The health provider must only ascertain that the birth of the child shall endanger or threaten the physical or mental well-being of the existing child/ren of the pregnant woman.

- Risk to Mental health of existing children should be taken to mean any effect on the existing children premised upon reasons taking into consideration the definition of mental health.

- WHO defines` mental health as a part of overall health, “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Mental health includes “subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential” (World Health Organization).

- Because mental health is not just absence of mental disorders, assessment need not be done by a psychiatrist. The existing children's present social and economic circumstances should be taken into account when assessing risk to mental health per Section 7 below. Also, their future social and economic circumstances that could result from the birth of an addition child should be taken into account when assessing risk to mental health.

6. Implementation Guide for Section 3(1)(b) of TOP

Substantial risk that child would be born or suffer from physical or mental abnormalities as to be seriously handicapped

- Health provider should recommend termination of pregnancy where s/he forms opinion that there exist a substantial risk that if the child were to born, it would suffer from such physical or mental abnormalities as to be seriously handicapped

- The degree of physical or mental abnormalities that the unborn child is likely to suffer from is irrelevant, provided that the pregnant woman is duly informed of the likely state of her unborn child and her free consent obtained, termination of pregnancy ought to be conducted as a matter of necessity based on a right.

7. Implementation Guide for Section 3(2) of TOP

Woman's actual or reasonably foreseeable environment

- To assess whether the pregnancy would risk the life or physical or mental health of the woman or her children the provider may consider the situation of the woman as regards to :-
    - Medical
    - Economic situation
    - Social/cultural circumstance
    - Religious etc
    - Age
    - Marital status
- If the woman's actual or reasonably foreseeable environment as outlined above poses a risk to the successful completion of the pregnancy to term, the health provider may consider termination of the pregnancy based on the pregnant woman's free consent.

8. Implementation Guide for Section 4(1 &2) of TOP

Conscientious objection

- The Ministry of Health respects the right of medical providers to conscientious objections in participating in the termination of pregnancy.
  However the client's right to information and access to health care services including termination of pregnancy must also be respected.

- Though individuals have a right to their own belief and moral perspective on abortion, their personal objectives should not hinder access to care for others needing a service.

- If a health care provider feels uncomfortable in dealing with a client who requests termination of pregnancy, the client must be respectfully referred to a colleague who is willing to assist a client in obtaining services.

- No provider has the right to conscientious objection in an emergency situation. [TOP section 4 (2)

- Public health care facilities are public domain. The management of all government health care facilities and facilities supported by government have the obligation to ensure that women have access to the services which they are legally entitled to, except those excluded through specific agreements with Government..

- Conscientious objection should only be dealt with when expressed by individual staff members and **not as a group** action nor as an institution.

- Conscientious objection only applies to the procedure and not broader services and also only applies to the abortion provider and not support personnel.

9. Implementation Guide for Proviso to Section 152 (2) of TOP

Where the pregnancy is as result of rape or defilement

- Termination of pregnancy should be conducted within the wider meaning of Section 3(1)(a)(ii) of the TOP that there is risk of injury to the physical or mental health of the raped or defiled woman or female child

- Termination of pregnancy should be conducted based on the request and the disclosure of the raped or defiled pregnant woman that the pregnancy is as a result of rape or defilement. The pregnant woman's word must be taken as a matter of fact and duly recorded as confidential and private and not subject to the health provider's subjective analysis.

- The health provider must not demand of the pregnant woman to submit evidence of rape or defilement in order to have her pregnancy terminated.

General Guide to the TOP Act

Within the scope and framework of the TOP, management of unintended pregnancies would entail the termination of such pregnancies such risk of injury to the physical or mental health of any existing children of the pregnant woman or one that had adverse effects on the foreseeable environment of the pregnant woman. It would stand to logic to argue that under the TOP, unintended pregnancies are those whose termination ought to be justified within social or economic reasons.

Implementation Guide to Adoption

- The Zambian legislative framework has provided for matters related to or incidental to adoption through the Adoption Act [Chapter 54].

- Any person resident in Zambia, who for any reason might not be in a position to look after their child/ren, are allowed to place such child/ren under adoption with some people or registered adoption agencies.

- Accordingly, for individual persons, Section 3(1) of the Adoption Act provides that the Court must on application of interested parties, make an order authorizing such applicant/s to adopt a child [Child defined as an infant below the age of 21 years-Adoption Act Section 2] if the following criteria is met that one of the applicants-

    a) Has attained the age of twenty-five and is at least twenty-one years older than the infant; or

    b) Has attained the age of twenty-one years and is a relative of the infant; or

    c) Is the mother or father of the infant

- Societies or organizations that adopt children must be registered as an adoption society with the Commissioner of Juvenile Welfare.

Who Should Provide Termination of Pregnancy Services (TOP)

Policy Statement: TOP is a safe procedure when performed by a trained service provider.

Standard 1: According to the TOP Act pregnancy termination must be performed by trained registered medical providers in the provision of abortion care.

Guidelines:

1. Considering that medical practitioners may not be sufficiently available in all institutions at all times, the Permanent Secretary shall make provision for all trained and skilled health providers to administer drugs and or MVA for termination of pregnancy in accordance with the Termination of Pregnancy Act and Midwives Nurse Act.

2. With appropriate training, health care providers who are not doctors (mid level providers) can provide first trimester manual vacuum aspiration abortions as safely as doctors can.

Standard 2: All providers performing TOPs must receive training in the performance of abortions and in the prevention, recognition and management of complications.

Where Can Pregnancy Termination Be Performed

Policy Statement: Termination of pregnancy is a safe procedure when performed under hygienic conditions with the right equipment by trained providers.

Standard 1: According to the Law, elective termination can only be performed in approved registered medical institutions, both public and private

***Guidelines*:**

1. Public health facilities are legally obligated to provide abortion related services.
2. Private facilities registered by medical council and having adequate requirements are eligible to provide termination of pregnancy.

Standard 2: Pregnancy termination for pregnancies up to 14 weeks from the last menstrual period may be performed as an out patient procedure

Standard 3: Pregnancy termination for pregnancies above 14 weeks from the last menstrual period should be performed in facilities with hospitalization amenities with access to blood transfusion services.

Standard 4: Pregnancy termination for pregnancies due to pathology that poses a major risk for the patient and where the pregnancy is desired, should be performed only in the OBGYN sections of the hospital units with ease of access to the neonatal unit.

Standard 5: All institutions performing elective pregnancy termination should be guided by protocols based on the current standards.

Standard 6: The procedure room must have emergency equipment and supplies

General Guidelines:

1. The method used to provide termination of pregnancy will determine the level of health system where the patient will be cared for

2. If a patient who requests pregnancy termination in a medical institution that cannot offer the procedure, the patient must be duly informed about the existing alternatives including facilities and this information must be documented.

3. Appropriate referrals should be available for patients who cannot be cared for in a particular facility.

Counselling and Informed Choice

Policy S**tatement:** A patient's informed and free choice is essential for performing a quality pregnancy termination procedure

Standard 1: All women undergoing pregnancy termination must be appropriately and accurately informed in order to be able to make a decision.

Guidelines:

1. Community- based health workers must inform women how to obtain safe, legal abortion care without any delay and refer women with complications of unsafe abortion for appropriate care.
2. Staff providing counselling must be non-judgmental, particularly perceptive to and respectful of the state of the woman emotionally.

Standard 2: Accurate information on the risks and benefits of abortion must be given to all women undergoing termination of pregnancy.

Guidelines:

1. Information on the risks and benefits of abortion must include
   a) Alternatives to pregnancy termination such as adoption or carrying the pregnancy to term:-
      - She can continue the pregnancy and parent the child
      - She can continue the pregnancy and release the child for parenting by others including adoption
   b) Support that the woman is entitled to get by the law
   c) Institutions that may provide this support
   d) Pregnancy termination techniques and potential risks of each procedure
   e) Potential complications and long term sequalae

2. Information about clinical procedures, aftercare should be given to patients.

3. Counselling should be in a language that the patient is able to understand and may be accompanied by written information where available

Standard 3: Contraceptive counselling and methods for those who chose it, must be provided to all women undergoing Termination of pregnancy.

Standard 4: All women undergoing pregnancy termination must, depending on the situation, have either certificate of opinion A or B completed prior to the procedure under section 3(1) of the Act

Guidelines:

1. Certificate A is completed in elective cases.
2. Certificate B, which requires only one signature of the practitioner, is completed in emergency or urgent situations.

a. In assessing what constitutes an emergency, the practitioner will not only consider the present circumstances but would also take into account the foreseeable circumstances including the risk of unsafe abortion and associated morbidity and mortality.

3. The Certificate should be kept safe and must not be destroyed within three years of the date of operation/procedure.

Standard 5: All women undergoing pregnancy termination must sign an informed consent before undergoing the procedure. (*appendix 3*)

Guidelines:

1. Informed consent should include the patient's affirmation that she understands the procedure and its alternatives, potential risks, benefits and complications and that the decision is uncoerced and that she is prepared to have an abortion
2. The health worker should determine whether the woman understands medical explanations before signing consent
3. In the case of conflict between the woman and the partner/spouse, the woman's decision takes precedence

Standard 6: If the patient's age is below that of legal consent (<16years of age) the parent's or legal guardian approval to terminate pregnancy must be documented

Guidelines:

1. The best interest of the minor will take precedence over that of parent or guardian and must be made on the principle of the evolving capacities of the minor to participate in decision making affecting her life.
2. Providers should recognize that pregnancy in a minor under 16 years of age is the result of statutory defilement. Such minors are entitled to services as provided by law (Penal Code amendments No 15 of 2005 the proviso to section 152 (2).
3. The confidentiality of the minor should be respected subject to the usual exceptions that apply to patient-provider confidentiality. No information about the minor should be disclosed to anyone other than the adult who provides consent.
4. The service provider should encourage minors to consult a parent or a trusted adult if they have not already done so.
5. A parent, next of kin or another adult acting in loco parents can give consent on behalf of the minor

Standard 7: All reasonable precautions must be taken to ensure the patient's confidentiality

General Guidelines:

1. Counselling should be non-mandatory, non-directive and available before and after the abortion

2. Counselling in abortion care does not require professional counselors but can be provided by nurses, midwives, doctors, social workers including nurse assistants.

3. Supportive counselling may be necessary for :
   a. Adolescents
   b. Emotionally distressed women
   c. Women suffering complication of pregnancy
   d. Women having therapeutic termination of pregnancy
   e. Rape/incest victims
   f. Women infected with HIV
   g. Once a woman has made an informed decision to seek an abortion, and meets current legal requirements, she should have access to an abortion without delay.

Pre - Procedure Care

Policy Statement: A Client's good overall health is important when undergoing medical or surgical procedures.

Standard 1: For all patients, a pertinent medical history and physical examination must be obtained and documented.

Guideline:

1. Vital signs e.g. blood pressure, pulse, temperature etc) and physical exam should be done as indicated by medical history and or patient's symptoms and signs.

Standard 2: Confirmation of pregnancy must be documented.

Guideline:

1. Confirmation of pregnancy and gestation age can be done clinically using history, physical exam and pregnancy test where necessary. Where a variance occurs, Ultrasound may be. may be used, if available

Standard 3: When a patient with a positive pregnancy test presents with vaginal bleeding and /or pelvic pain, ectopic pregnancy should be considered.

Guidelines:

1. Where necessary and available, the following tests could be done:-
   a. Pregnancy test to confirm pregnancy.
   b. Hb if the patient is clinically anemic.
   c. Ultrasound scan to confirm gestation age, rule out abnormality where indicated, rule out ectopic where there is suspicion and to confirm

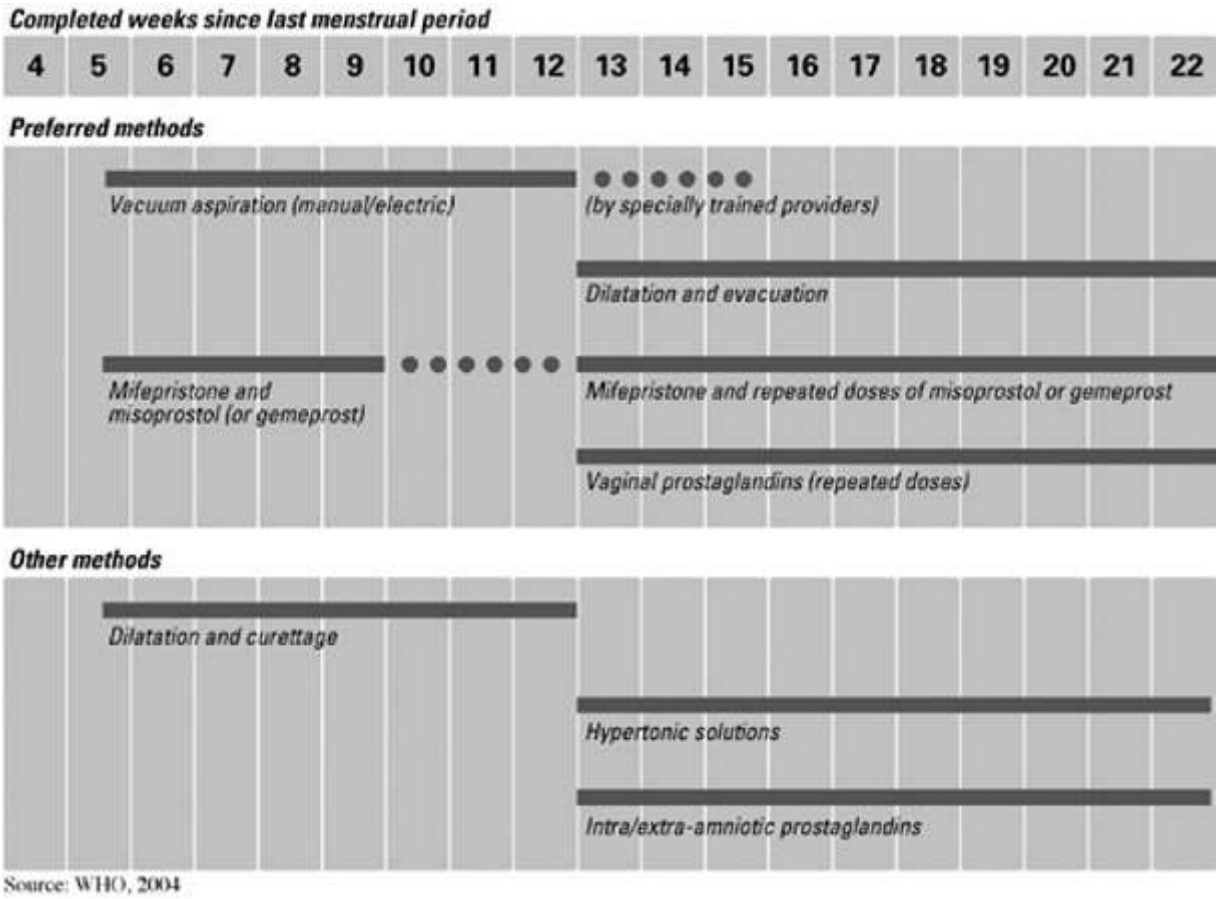
completeness of uterine evacuation where necessary.

Standard 4: Anti D should be offered to non immunized RH negative women especially after the first trimester.

Uterine Evacuation Procedures

Policy Statement: Pregnancy termination either by medical or surgical methods, is one of the safest procedures. The following standards and guidelines add to its safety.

Figure 1: Preferred methods of abortion by gestation age



Source: WHO, 2004

For pregnancies up to 12 weeks of gestation
Methods used for evacuation include:

- Surgical ; manual vacuum aspiration (MVA) or electric vacuum aspiration(EVA)
- Medication (misoprostol only or combined with mifepristone or methotrexate)

Surgical methods

Standard 1: Vacuum aspiration (MVA) or electrical (EVA), is the preferred method for evacuating the uterus in the first trimester.

Guidelines:

1. Consideration should be given pre-procedure ripening of the cervix using either Physical or medical means especially in the later weeks for the following category of patients:
    - Nulliparous women over 12 completed weeks gestation,
    - Women less than 18 years old, and

2. The facility must have the appropriate adequate equipment and supplies for termination of pregnancy.

Standard 2: Pertinent medical history must be obtained and documented.

Standard 3: Gestational age must be documented.

Standard 4: Patient comfort during the procedure must be considered.

Guidelines:

1. Analgesics or other comfort measures should be offered.

Standard 5: Appropriate dilatation of the cervix must be obtained.

Standard 6: All instruments entering the uterine cavity must be sterile.

Standard 7: All patients should receive prophylactic antibiotics.

Standard 8: Completion of the procedure must be verified and documented by the provider.

Guidelines:

1. In most cases, completion should be verified on clinical grounds but where necessary or in doubt, Ultrasound can be used for confirmation if available.

Standard 8: Clinical protocols for post operative care must be followed.

Guideline

1. Follow-up arranged if wished or clinically indicated, but is not mandatory.

Medical methods

Standard 1: Either mifepristone and Misoprostol combined or Misoprostol alone should be used according to the local protocols.

Guidelines;

1. Mifepristone and Misoprostol can be administered either at the facility or at home.

Standard 2: Pertinent medical history must be obtained and documented.

Standard 3: Gestational age must be documented.

Standard 4: The patient must be informed about the need for follow- up contact to ensure that she is no longer pregnant.

Standard 5: The patient must be informed about the efficacy, side effects and risks with medications to be used.

Guidelines:

1. The patient must be informed that should medical abortion fail, surgical method may be used.
2. The facility must provide an emergency contact on a 24 hour basis and must assure referral for uterine aspiration if indicated for patients self administering at home.

Standard 6: Patient's instructions must include information about use of medication at home and symptoms of abortion complication.

Standard 7: Patient's comfort level during the abortion procedure must be considered.

Standard 8: Completion of the abortion through clinically means and where necessary by ultrasound must be documented.

Guidelines:

1. If a patient has failed to return for follow up as planned, attempts should be made to locate her and this should be documented.

After 12 weeks completed weeks of gestation

Surgical methods

All cases above13 weeks of gestation should only be managed in a unit staffed by a specialist or trained medical officer in consultation with a gynecologist as it requires providers with special training and experience.

Standard 1: Dilatation and Evacuation is the preferred method for evacuating the uterus in the second trimester after cervical preparation/priming/ ripening.

Guidelines:

1. Cervical preparation (ripening/priming) is recommended for:
   - Nulliparous women
   - Women less than 18 years old, and
   - All women beyond 12 completed weeks of gestation.

2. The facility must have the appropriate adequate equipment and supplies for termination of pregnancy.

Standard 2: Pertinent medical history must be obtained and documented .

Guidelines:

1. Although abortion is safest when performed in the first trimester, health care providers should appreciate that late presentation is not necessarily the fault of the client/patient.

Standard 3: Gestational age must be verified by history, clinically and where necessary and or available by ultrasonography prior to termination of pregnancy.

Standard 4: Patient comfort during the procedure must be considered.

Guidelines:

1. Analgesics or other comfort measures should be offered.

Standard 5: Appropriate dilatation of the cervix must be obtained.

Standard 6: All instruments entering the uterine cavity must be sterile.

Standard 7: All patients should receive prophylactic antibiotics.

Standard 8: Completion of the procedure must be verified and documented by the provider

Guidelines:

1. In most cases, completion should be verified on clinical grounds and though not necessary if in doubt, ultrasound (if available) can be used for confirmation.

Standard 9: Clinical protocols for Post operative care must be followed.

Medical methods

Standard 1: Either mifepristone and Misoprostol combined or Misoprostol alone can be used according to the local protocols.

Standard 2: Pertinent medical history must be obtained and documented.

Standard 3: Pregnancy must be confirmed and Gestational age documented.

Standard 4: The patient must be informed about the need for follow- up contact to ensure that she is no longer pregnant.

Standard 5: The patient must be informed about the efficacy, side effects and risks with medications to be used.

Standard 6: Patient's instructions must include information about use of medication at home and symptoms of abortion complication.

Standard 7: Patient's comfort level during the abortion procedure must be considered.

Standard 8: Patients must be advised that administration of prostaglandins may precipitate rapid onset of uterine contractions and expulsion.

Guideline

1. The facility must provide an emergency contact on a 24 hour basis and must assure referral for uterine aspiration if indicated for patients self administering at home.

Standard 9: Patients must be given instructions to contact the health care facility when regular contractions begin for those self administering at home.

Standard 10: Once regular contractions have been confirmed, patients must be monitored regularly until expulsion of products of conception.

Standard 11: Completion of the abortion must be documented through clinically means and where necessary by ultrasound.

Guideline

1. Expulsion of a live fetus is a possibility which fact must be discussed with patients.

Standard 12: A trained personnel must be accessible for emergency care when need arises

Guidelines:

1. Patients suspected of having post abortion complications must be evaluated by a trained clinician so that appropriate care can be determined.

2. The patient must be informed that should medical abortion fail, surgical method may be used.

Third Trimester (Therapeutic).

Although this document is on reducing mortality and morbidity resulting from unsafe abortion, it is recognized that the TOP Act covers all trimesters of pregnancy. This section therefore provides guidance on third trimester termination of pregnancy.

Policy Statement: Termination of pregnancy in the third trimester (Induction of labour) is sometimes necessary to save the life of a pregnant woman even though it may predispose to a higher neonatal morbidity and mortality.

Standard 1: termination done in third trimester on medical grounds with a viable fetus, should be done in OBGYN sections of hospital units with ease of access to neonatal units to improve outcomes.

Standard 2: All facilities should have protocols for termination of pregnancy in the third trimester.

Standard 3: Hospitalisation is required for all patients having termination of pregnancy in the third trimester

Standard 4: Bereavement counselling should be offered to all women with poor pregnancy outcomes.

Guidelines:

1. The patient must be informed that should medical methods fail, surgical methods may be used such as hysterotomy or caesarean section.

2. Expulsion of a non-live/non viable fetus is a possibility which fact must be discussed with a patient.

3. For facilities with no neonatal unit, in- utero transfer to a facility with neonatal ICU is recommended.

Pain Management in Termination of Pregnancy

Policy statement: Client satisfaction can be enhanced through minimizing pain and anxiety during pregnancy termination procedures.

Standard 1: All patients undergoing termination of pregnancy must be provided with pain management.

Guidelines:

1. Pain management should include psychological support, non pharmacological and pharmacological support.

2. Where needed general anaesthesia may be used.

3. Social support person may be needed to compliment pain management to the extent that this does not breach a patient privacy and confidentiality.

Standard 2: Local anesthesia is recommended for Uterine Aspiration .

Guideline

1. If general anesthesia is used a qualified anesthesia personnel must be present in the room to monitor the patient and provide anesthesia care.

Standard 3: When conscious sedation[2], deep sedation[3] or general anesthesia is used, monitoring of the patient's level of consciousness and vital signs must be documented.

Use of Peri-Procedure Antibiotics

Standard 1: Routine prophylactic use of antibiotics is recommended for abortion procedures.

Guidelines:

1. Where antibiotics are not available the procedure can still be performed. The risk of infection is low if strict aseptic techniques are observed
2. Facility based protocols will be used for the choice of specific antibiotics

[2]A minimal depressed level of consciousness that retains the patients ability to maintain a patent airway independently and continuously to be easily aroused and to respond appropriately to physical stimuli and verbal commands
[3]A controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes including inability to maintain a patent airway independently and/or to respond purposively to physical stimulation or verbal commands. It can result from sedative and analgesic administration intended to produce only conscious sedation.

Immediate Post Procedural Care (For all surgical and Third Trimester Terminations)

Policy Statement: Most serious abortion complications are detectable in the immediate post procedure period. Appropriate and accessible follow up care is essential to patient's well being.

Standard 1: Completion of the termination process must be verified and documented in accordance with local protocols.

Standard 2: Until medically stable, all patients must be observed during the recovery period by a health provider trained in post procedure care.

Standard 3: Prior to discharge the patient must be ambulatory with a stable blood pressure and pulse and well controlled pain and vaginal bleeding.

Standard 4: The patient must be given instructions outlining the danger signs and symptoms of post procedure complications.

Guidelines:

1. Discharge instructions must be explicit and well understood by the woman before she leaves
2. Instructions should include:
   a. Danger sins requiring immediate emergency care
   b. What to do and where to go if complications arise
   c. Side effects to be expected
   d. Instructions for taking medication that have been prescribed
   e. After care including personal hygiene
   f. A return visit will be at the discretion of the woman and the provider.

Standard 5: Before leaving the facility all patients must be informed counseled on existing birth control options and provided with their chosen method on site unless the method is contraindicated.

Standard 6: All women needing other Reproductive health services must be referred and the action documented.

Guideline:

1. All patients must be observed at least one hour after the surgical procedure is completed if there are no complications.

Management of Complications of Procedure

Policy Statement: Prompt recognition and optimal management of complications related to pregnancy termination, reduces morbidity.

Standard 1: Functioning equipment and appropriate medication must be available on site to handle medical emergencies.

Standard 2: Surgical evacuation of the uterus is recommended in cases of failed or incomplete abortion.

Standard 3: When there is excessive bleeding the surgeon must institute measures to identify the etiology and control it.

Standard 4: The patient must be referred to a higher level of care when the bleeding does not respond to therapeutic measures or when the patient is hemodynamically unstable.

Standard 5: If perforation of the uterus is suspected close observation and follow up must be done.

Standard 6: If infection sets in, prompt treatment with appropriate antibiotics is required.

Guidelines:

1. Facility should have a specified area for emergency equipment to include oxygen, medications and supplies.
2. Emergency drill protocols should be in place to ensure ongoing training of staff in emergency preparedness.

Section 3 Post Abortion Care (PAC) services

Who Can Provide PAC

Policy Statement: quality PAC services reduce morbidity and mortality from complications of abortion when provided by trained health workers.

Standard 1: PAC should be provided by trained registered providers.

Guidelines:

1: Providers include doctors, medical licentiate, clinical officers, Nurse Midwives and nurses

2. All providers that have been properly trained should provide emergency evacuation of the uterus up to 14 weeks gestation.

3: Training can be done pre-service or in-service centrally or using the On the Job Training (OJT national curriculum.

Where can PAC be provided

Policy Statement: PAC is safe when provided in environment with adequate hygiene and equipment.

Standard 1: All institutions offering PAC services should be registered by appropriate regulatory authorities.

Guideline:

1: PAC can be provided from health levels as low as the health post (depending on available skills) up to tertiary level. (*See appendix 5*)

Standard 2: All institutions providing PAC should be guided by local protocols

Standard 3: All procedure rooms providing PAC must have equipment and supplies to deal with emergencies (*see 10)*

Guidelines:

1. Emergency preparedness should be available in all facilities providing PAC All facilities should be able to stabilize, treat or refer patients with post abortal complications

2. The equipment and supplies needed will, to some extent, depend on the type of procedures to be offered at the facility.

Standard 4: All institution providing PAC must have strong referral linkages to the next level of care.

Standard 5: Equipment needed for treatment of serious complications should be available at referral institutions.

Emergency Treatment

Pre Procedure

Policy Statement: prompt assessment and quality counselling reduces morbidity and mortality associated with abortion related complications.

Standard 1. All patients with abortion related complications should have a rapid assessment for presence of life threatening conditions and treatment given accordingly.

Guidelines:

1. Assessment should include assessment of vital signs and indication of how clinically stable the patient is.

2. Any patient discovered with a life threatening condition such as shock, ectopic pregnancy, sepsis or torrential hemorrhage should have resuscitative measures instituted immediately.

Standard 2: A pertinent medical history must be obtained and documented together with physical examination and laboratory findings.

Guidelines:

1. Physical examination should include a pelvic examination noting any vaginal discharge, uterine size and presence of retained products of conception (RPOCs).
   Signs of infection including fever, foul smelling discharge, and tender uterus should also be documented.

2. If infection is suspected, appropriate laboratory specimens should be taken but should not delay initiation of treatment.

3. Appropriate laboratory tests such as HB, blood grouping and cross matching and any other as tests indicated by the medical condition of the patient.

Standard 3: Time of arrival of patient and attendance must be documented.

Guideliness:

1. The time of arrival should be when she is getting registered at the facility (getting hospital card/file)

2. The time she is first attended to is the time when she is in contact with a provider who may be a nurse or clinician.

Standard 4: All patients should have counseling about the procedure, pain management, risks benefits and alternatives.

Guideline

1. Pre procedure counseling should include
   - Options of management either using MVA or Misoprostol for PAC (MPAC)
   - Counselling about the proposed treatment plan
   - Contraceptive counseling

2. Life saving procedures should not be delayed by counselling as this can be completed after the procedure.

Standard 5: An informed written consent should be obtained from all patients under going surgical procedure.

Guideline:

1. In an emergency, consent maybe given by, next of kin or hospital administrator or senior service provider present.

Standard 6: Resuscitation, stabilisation and prompt referral of the patient is essential if equipment for treatment is absent or staff not trained.

Guideline:

1. Basic elements of resuscitation should include
   a. management of airways
   b. control of bleeding
   c. intravenous fluid replacement
   d. control of pain

Procedure

Surgical procedure

Standard 1: The preferred method of uterine evacuation up to 12 weeks uterine size is MVA.

Guideline:

1. Where MVA is not available, then the uterus may be evacuated by dilatation and curettage and or evacuation

Standard 2: For uteruses above 12 weeks evacuation should be completed digitally or usually ovum forceps plus or minus blunt curettage/ MVA.

Standard 3: Patient comfort should be considered during the procedure.

Standard 4: All instruments entering the uterus must be sterile.

Guidelines:

1. Before re-use cannulae need to be sterilized or high level disinfected

2. MVA syringes must be clean and disinfected but it's not necessary to sterilize them.

Standard 5: Completion of the procedure must be verified and documented.

Standard 6: Routine prophylactic use of antibiotics is recommended for abortion procedures.

Guideline:

1. Where antibiotics are not available the procedure can still be performed. The risk of infection is low if strict aseptic techniques are observed.

2. Facility based protocols will be used for the choice of specific antibiotics.

Medical method (Use of Misoprostol for Post Abortion Care - MPAC)

Standard 1: Misoprostol should be offered to all patients who qualify.

Guideline

1. To qualify, the patient must have uterine size less than 12weeks and not having any contraindications to Misoprostol e.g. allergy.

Standard 2: The efficacy and side effects of Misoprostol must be explained to all patients

Guideline

1. Patients should be made aware that if Misoprostol fails then surgical evacuation is necessary.

Standard 3: All facilities should follow protocols on follow-up of patients with MPAC.

Management of other complications

Policy Statement: Prompt recognition coupled with optimal management of complications related to abortion, reduces morbidity and mortality.

Standard 1: Functioning equipment and appropriate medication must be available on site to handle medical emergencies.

Guidelines:

1. Facility should have emergency equipment to include oxygen, medications and supplies.

2. Emergency drill protocols should be in place to ensure ongoing training of staff in emergency preparedness.

Standard 2: Every facility should be able to stabilize and treat or refer a woman with any complication as quickly as possible.

Guideline

1. All patients should have IV access and facilities need to have crystalloids and plasma expanders at all times.

Hemorrhage

Policy Statement: Timely treatment of excessive blood loss is critical as delays in controlling blood loss and replacing fluid or blood volume can be fatal.

Standard 1: For any client presenting with hemorrhage, measures should be undertaken to identify the cause of the bleeding and control it.

Guideline;

1. Blood loss can be assessed by measuring blood pressure, pulse rate and urine flow.

2. The cause of hemorrhage should be established and managed accordingly. Hemorrhage can be caused by retained products of conception (RPOCs), trauma or damage to the cervix or uterine perforation.

3. Uterotonic agents should be administered if excessive bleeding is caused by atony.

Standard 2: All patients presenting with shock should be referred to a higher level facility after stabilization.

Standard 3: All facilities must ensure that appropriate precautions are taken in screening and transfusion of blood..

Infection (Septic Abortion)

Policy Statement: patients suspected with sepsis must be promptly treated with therapeutic doses of broad spectrum antibiotics.

Standard 1: all patients with symptoms of infection should be assessed for shock, causes and managed accordingly.

Guidelines:

1. Assessment of infection should include ruling out retained products of conception (RPOCS,) and perforation of uterus and /or injury to abdominal organs.

2. Patients with suspected perforation may need laparotomy.

3. Accurate diagnosis of septic shock may require insertion of a central venous line.

Standard 2 Patient with septic shock should be referred to 1st level hospital or higher after stabilization.

Standard 3: Patients with postabortal sepsis should have broad spectrum antibiotics intravenously.

Guidelines:

1. Facilities should follow local protocols on which antibiotics to use.

Standard 4: All patients with sepsis due to RPOCs should receive at least 2 doses of IV antibiotics prior to evacuation with MVA, provided the patient is not bleeding significantly

Management of toxic and chemical reactions

Patients may occasionally present with poisoning secondary to substances used to procure an abortion.

Standard 1: in all cases of poisoning, measures should be undertaken to establish the causative substance and an antidote administered accordingly.
Standard 2: all patients with poisoning should be referred appropriately

Guidelines:

1. Patients may need ventilation support or specialist care (renal or any other organ failure) and so should be referred to institutions where these services are available.

2. Resuscitative measures and other supportive therapy should be instituted before referral.

Post Abortion Contraception

Policy Statement: Post abortal contraceptive counselling and provision after an abortion prevents repeat abortions and should be made available to all women

Standard 1: All women receiving PAC should be availed family planning counseling and services

Guidelines:

1. Counselling should be profiled to the patient's needs (*refer to the FP counselling kit)*
2. Counselling can be provided individually or in group basis bearing in mind individual needs of each patient and upholding the patient's confidentiality.

Standard 2: All facilities offering PAC should be able to provide a broad mix of contraceptives, according to the level of care and provider skills.

Guidelines:

1. Patients should be referred appropriately to the next level of care if chosen method is not available or if the provider has no skills to give patient the method.

2. Almost all methods can be given to women after an abortion according to the eligibility criteria.

Standard 3: The provider must ensure documentation of the woman's informed choice of contraception.

Guidelines:

1. Whether the woman opts not to have any contraception or opts for a method, this should be documented.

2. If a method is chosen, information on the method and follow-up should be communicated to the patient to ensure correct and continued usage, the method

Linkages to Other RH services

Standard 1: all women should be referred to other reproductive health services according to their needs.

Guidelines:

1. These services should include cervical cancer screening, STI including HIV screening. Women who have had a spontaneous abortion and desire to have a child should be referred to a specialist for assessment. Other services should include psychosocial counseling in cases of rape, defilement or incest.

Follow up

Standard 1: All women must have follow up instructions according to the protocols

Other issues related to abortion procedures

Confirmation of Fetal tissue

Policy Statement: Identification of products of conception helps confirm diagnosis of intrauterine pregnancy and prevents complications of abortion.

Standard 1: all evacuated uterine contents must be examined visually before the woman leaves the facility.

Guidelines:

1. When insufficient tissue or incomplete products of conception are obtained the patient must be re evaluated and re-suctioning should be considered.

2. The presence of ectopic pregnancy should be considered and ruled out if there are no products of conception.

3. Formal histopathology examination maybe required when there are copious amounts and grapelike products of conception to rule out Molar pregnancy. If confirmed it should be managed accordingly at appropriate levels.

Fetal Tissue Disposal

Policy Statement: Proper disposal of fetal tissue reduces spread of infectious disease and stigmatisation of abortion services. For this reason, procedures on disposal of tissue should be available.

Standards 1: Fetal tissue must be considered biohazard and be disposed in accordance with protocols.

Guideline:

1. Universal precautions must be observed by all personnel handling fetal tissue (*see appendix 7)*

Standard 2: all fetuses born dead before or after 28 weeks should be notified and disposed of according to the local regulations and wishes of the patient.

Guidelines:

1. Fetuses expelled after 28 weeks may be incinerated or buried if the patient so wishes.

2. Fetuses expelled before 28 weeks may be incinerated or buried if the patient so wishes.

3. In case of a fetus born alive in an unwanted pregnancy, efforts should be made to preserve its life with a view of facilitating appropriate social services.

Emotional support for health care providers

Policy Statement: Provision of emotional support to providers of abortion services enhances quality of care.

Standard 1: Facilities should draw up protocols to address emotional needs of staff providing abortion services.

Guideline:

Regular meetings to share experiences and value clarification exercises should be held.

Section 4 Standards for audit, monitoring and evaluation

Policy Statement: Monitoring and evaluation ensures highest possible quality of care.

A system should be created and implemented to audit, monitor and evaluate services in accordance with these standards and guidelines.

Monitoring and evaluating (M&E) can be achieved using three approaches; Routine service statistics, periodic evaluation (internal & external) and patient information. (see appendix 6) This can be done at all levels- facility, regional and national levels:

Routine service statistics involves:

- Regular monitoring and evaluation (M/E) at the facility level are key to maintaining and improving the quality of services delivered.
- Facility managers /staff supervisors are needed to provide supportive supervision in routine monitoring and give appropriate recommendations to improve quality of care. This can be achieved through:
    - Analysis of patterns or problems in services using service statistics
    - Proportion of women seeking repeat abortion.
    - Observation of counseling and clinical services to assess quality of interaction with the woman throughout the process, to correct any shortfalls in adherence to technical standards, or other practices that jeopardize quality of care (e.g. judgmental attitudes, imposition of "informal charges".
    - Functioning of logistics system to ensure regular supply of equipment and consumables.
    - Regular aggregation of data from facility level upwards.
    - Utilisation of aggregated data by the facility for service improvement.
    - Assessment of progress to remedy problems identified in routine monitoring.
    - Engaging staff in a participatory process to implement recommendations for service delivery improvement

Periodic evaluation:

- Client based through exit interviews, observations and questionnaires
- Provider based surveys looking at, among others;-

    Skills of providers

    Perception

    Application of theory to practice

    Supportive systems in the delivery of the health services

    Facility level: case reviews, registers, observation, checklists, facility surveys and maternal death audits.

Patient information must include: (see appendix 6.)

- Total number of clients seen, their demographic information
- A record of abortions provided, methods used, pain management provided
- Women seen but not provided with services,

- Women referred to higher levels of care,
- Treatment of complications of abortion
- Contraceptive methods accepted and initiated.
- Feed-back mechanism for all referrals

Managers should ensure good supervision of services, including monitoring and evaluation of quality of care. Monitoring data should be used to make decisions about changes or improvements necessary in services, as well as to provide performance feedback to providers and staff.

Each facility should periodically review their own statistics with a view of improving their quality of care. Selected data should be sent routinely to higher levels to enable cross monitoring of facilities and geographic areas and be used at national level for policy formulation and planning. These data will be used to monitor costs to health facilities of providing legal abortion and of treating complications of unsafe abortion.

Evaluation should be based on core measurable indicators, and there should be some consequence for the findings, such as awards for high quality services

Standard 1: All abortion procedures must be documented.

Guideline:

1. Records should be accurate, complete and well organized.

Standard 2: All levels of care must conduct regular audit of the care they provide and below are some examples of audits that can be performed.

Organisation of services

- Assess whether decision-to appointment intervals fall within acceptable guideline target
- Assess case notes of women undergoing abortion to determine percentage performed as day cases

Information for women

- Audit the extent to which they provide accurate and unbiased information regarding induced abortion especially with regard to potential sequalae using patient surveys.

Pre- abortion management

- Assess proportion of clients being given antibiotic prophylaxis.
- Assess proportion of patients having documented evidence of being screened for other medical conditions.

Abortion procedures

- Case note review could be conducted to see which prostaglandin/s is being used for abortion procedures.
- Percentage of women offered and accepting local anesthesia could be reviewed.
- Proportion of providers offering services who have been formally trained.

Post procedure care

- Assess percentage of women receiving information on danger signs post operatively.
- Audit number of women who end up with complications following elective termination.
- Proportion of terminations being reported.

Standard 3: All termination of pregnancy services must be reported as required by the law.

Guidelines:

1. Complete certificates A or B should be sent to the Permanent Secretary

2. Monitoring and evaluation of comprehensive abortion care services should be integrated in the existing HIMS.

Standard 4: All deaths resulting from abortions must be reviewed according to local nationally accepted maternal death review protocols.

Standard 5: Managers must ensure inventory control and maintenance of equipment.

Guidelines:

1. In planning, inventory control and maintenance system; include:
    a. The quantity and types of equipment and supplies to be kept in stock
    b. Adequate storage facilities
    c. Monitor of stock levels
    d. Re-ordering of stock
    e. Security of stock
    f. Procedure for re-supply
    g. Routine maintenance and repair of equipment

2. There should be protocols for routine maintenance of equipment

Bibliography

1. Central statistical office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC), University of Zambia, and Macro International Inc. 2009. *Zambia Demographic and Health Survey 2007*. Calverton, Maryland, USA: CSO and Macro International Inc.

2. Constitution, The Republican, Chapter 1 of the Laws of Zambia

3. Continental Policy Framework on Sexual and Reproductive Health and Rights. Adopted at the 2nd Ordinary Session of the Conference of African Ministers of Health, Gaborone, 10-14 October, 2005.

4. Engender Health 2003. *Comprehensive Counselling for Reproductive Health: An integrated Curriculum- Trainer's manual*, 2003, New York.

5. Ghana Health service, May 2005. A Strategic Assessment of Comprehensive Abortion Care in Ghana. Report.

6. Ghana Health Service, June 2006. *Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services Standards and Protocols*

7. GRZ 1997. The Nurses and Midwives Act, 1997; No 31 of 1997 pp295-318.

8. GRZ 2005. Penal Code Amendment No 15 of 2005

9. GRZ 2007. Zambia Sexual Behaviour Survey 2007

10. Guthrie K, Waudby C, Arnott P. (2004) A termination of pregnancy Care Pathway: worth the effort? Abstract. *The European Journal of Contraception & Reproductive Health Care.* The 8th Congress of the European Society of Contraception, Edinburgh June 2004.

11. Hyman, Alyson G. and Laura Castleman. 2005. *Woman-centered abortion care: Reference manual*. Chapel Hill, NC, Ipas.

12. Maputo Plan of Action on Sexual and Reproductive Health and Rights, 2007-2010. Special Session of the African Union Conference of Ministers of Health entitled “Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa”. Maputo, 18-22 September 2006.

13. Documents and Decisions of the Special Session of the African Union Conference of Ministers of Health, Maputo, 18-22 September 2006.

14. MOH Ethiopia, June 2006. *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia.* Addis Ababa

15. MOH Zambia, 2007. *Pregnancy, Childbirth, Postpartum and newborn care guidelines. Agenda for essential practice in Zambia.*

16. MOH Zambia, 2006. Zambia family planning guidelines and protocols.

17. MOH Zambia, 2007. Integrated Reproductive Health Supervisory Tool.

18. National Abortion Federation (NAF) 2008. *Clinical policy guidelines.* Washington (DC): National Abortion Federation (NAF); 2008.

19. Penal Code, Chapter 87 of the Laws of Zambia

20. Protocol to the African Charter on Human and Peoples' Rights of Women in Africa.

21. RCOG 2004. The care of women requesting induced abortion (evidence-based clinical guideline number 7). Setting standards to improve women's health.

22. TAUC (The African Union Commission). Plan of Action on Sexual and Reproductive Health and Rights (Maputo Plan of Action)

23. Termination of Pregnancy Act, Chapter 304 of the Laws of Zambia

24. Warriner I, et al (2006) *Rates of complication in first trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: a randomised controlled equivalence trial*. The Lancet November 29, 2006 DOI:10.1016/S0140-6736(06)69742-0

25. WHO 2003. Safe Abortion: Technical and Policy Guidance for Health Systems.

26. Worsley, Kate G. August 2007. *Marie Stopes International Recommended standards for Abortion Services.* London United Kingdom. MSI.

Appendix 1: The Zambian TOP Act , 13 October 1972 with Schedules/Certificate A & B

Section 1. This Act may be cited as the Termination of Pregnancy Act.

Section 2. In this Act, unless the context otherwise requires

--“hospital” means any institution run as such by the Government or any other institution approved in writing for the purpose of this Act by the Permanent secretary, Ministry of Health;

--“the law relating to abortion” means sections 151-153 of the Penal Code, and includes any written law or rule of law relating to the procurement of abortion;

--“registered medical practitioner” means a medical practitioner registered as such under the provisions of the Medical and Allied Professions Act.

Section 3. (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if he and two other registered medical practitioners, one of whom has specialised in the branch of medicine in which the patient is specifically required to be examined before a conclusion could be reached that the abortion should be recommended, are of the opinion, formed in good faith

(a) that the continuation of the pregnancy would involve

(i) risk to the life of the pregnant woman; or

(ii) risk of injury to the physical or mental health of the pregnant woman; or

(iii) risk of injury to the physical or mental health of any existing children of the pregnant woman;

greater than if the pregnancy were terminated; or

(b) that 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.

(2) In determining whether the continuation of a pregnancy would involve such risk as is mentioned in paragraph (a) of subsection (1), account may be taken of the pregnant woman's actual or reasonably foreseeable environment or of her age.

(3) Except as provided by subsection (4), any treatment for the termination of pregnancy must be carried out in a hospital.

(4) Subsection (3) and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination of pregnancy is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Section 4. (1) Subject to subsection (2), no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.

(2) Nothing in subsection (1) shall affect any duty to participate in any treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

(3) In any proceedings before a court, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorised by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1).

Section 5. (1) The Minister may, by statutory instrument, make regulations for the better carrying out of the provisions of this Act and, without prejudice to the generality of the foregoing, such regulation may make provision for

(a) anything which is to be or which may be prescribed under this Act;

(b) requiring any such opinion as is referred to in section three to be certified by the registered medical practitioner concerned in such form and at such time as may be prescribed by the regulations;

(c) the preservation and disposal of certificates made pursuant to the regulations;

(d) requiring any registered medical practitioner who terminates a pregnancy to give notice of the termination of pregnancy and such other information relating to the termination of pregnancy as may be prescribed;

(e) prohibiting the disclosure, except to such persons or for such purposes as may be prescribed, of notices given or information furnished pursuant to the regulations.

(3) Any person who willfully contravenes or willfully fails to comply with the requirement of regulations made under subsection (1) shall be guilty of an offence and on conviction shall be liable to a fine not exceeding two hundred kwacha.

Section 6. For the purpose of the law relating to abortion, anything done with intent to procure the miscarriage of a woman is unlawfully done unless it is done in accordance with the provisions of the Act.

Termination of Pregnancy Regulations (Statutory Instrument No. 219 of 1972).

Section 1. These Regulations may be cited as the Termination of Pregnancy Regulations.

Section 2. (1) Any opinion to which section 3 of the Act refers shall be certified in the appropriate form set out in the First Schedule.

(2) Any certificate of an opinion referred to in subsection (1) of section three of the Act shall be given before the commencement of the treatment for the termination of pregnancy to which it relates.

(3) Any certificate of an opinion referred to in subsection (4) of section three shall be given before the commencement of the treatment for the termination of pregnancy to which it relates or, if that is not reasonably practicable, not later than twenty-four hours after such termination.

(4) Any such certificate as is referred to in sub-regulations (2) and (3) shall be preserved by the practitioner who terminated the pregnancy to which it relates for a period of three years beginning with the date of such termination and may then be destroyed.

Section 3. (1) Any registered medical practitioner who terminates a pregnancy anywhere in Zambia shall, within seven days of the termination, give to the Permanent Secretary, Ministry of Health, notice thereof and the other information relating to the termination in the form set out in the Second Schedule.

(2) Any such notice and information as is referred to in sub-regulation (1) shall be sent in a sealed envelope marked “Confidential” to the Permanent Secretary, Ministry of Health, P.O. Box 205, Lusaka.

Section 4. A notice given or any information furnished to the Permanent Secretary, Ministry of Health, in pursuance of these Regulations shall not be disclosed except that disclosures may be made

(a) for the purposes of carrying out his duties, to an officer of the Ministry of Health authorised by the Permanent Secretary, Ministry of Health; or

(b) for the purposes of carrying out his duties in relation to offences against the Act or the law relating to abortion, to the Director of Public Prosecutions or a member of his staff authorised by him; or

(c) for the purposes of investigating whether an offence has been committed against the Act or the law relating to abortion, to a police officer not below the rank of Assistant Superintendent or a person authorised by him; or

(d) for the purposes of criminal proceedings which have begun;

(e) for the purposes of bona fide scientific research; or

(f) to the registered medical practitioner who terminated the pregnancy; or

(g) to a registered medical practitioner, with the consent in writing of the woman whose pregnancy was terminated.

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 ……

IN CONFIDENCE CERTIFICATE B

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

Appendix 2: : Chapter 87, The Penal Code Act (Amendment) No 15 of 2005 (section 151-153)

151. Any person who, with intent to procure the miscarriage of a woman or female child, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding seven years.

Attempts to procure abortion
(As repealed and replaced by Act No. 15 of 2005)

152. (1) Every woman being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used, commits a felony and is liable, upon conviction, to imprisonment for a term of fourteen years.

(2) Any female child being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind commits an offence and is liable to such community service or counseling as the court may determine, in the best interests of the child: Provided that where a female child is raped or defiled and becomes pregnant, the pregnancy may be terminated in accordance with the Termination of Pregnancy Act. Cap. 304
(As repealed and replaced by Act No. 15 of 2005)

Abortion by pregnant woman or female child

153. Any person who unlawfully supplies to or procures for any person any thing whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman or female child, whether she is or is not with child, commits a felony and is liable, upon conviction, to imprisonment for a term not exceeding fourteen years.
Supplying drugs or instruments to procure abortion
(As repealed and replaced by Act No. 15 of 2005)

Appendix 3: Sample of Consent Form

Informed Consent form for legal abortion procedure

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.

_____ _____

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

_____

Date

_____ _____

Name of provider Signature of provider

<u>In loco parentis, as applicable:</u>

_____ _____

Name Signature

Appendix 4; Instruments and Supplies for Manual Vacuum Aspiration (MVA)

Basic Supplies

- Intravenous infusion set and fluids (sodium lactate, glucose, saline)
- Aspiration (syringes) (5,10 and 20ml)
- Needles (22 gauge spinal for paracervical block; 21 gauge for drug administration.
- Sterile gloves (small, medium, large)
- Cotton swab or gauze sponges
- Water based antiseptic solution (not alcohol-based)
- Detergent or soap
- Clean water
- Chlorine or glutaraldehyde for disinfection/decontamination
- High level disinfection or sterilization agent.

Instruments and Equipment

- Vaginal speculum
- Tenaculum
- Sponge (ring) forceps or uterine packing forceps
- Pratt or Dennison dilators: sizes 13 to 27 French
- Container for antiseptic solution.
- Strainer (metal, glass, or gauze)
- Clear glass dish for tissue inspection.

Medications

- Analgesia medication (e.g. acetaminophen, ibuprofen or pethidine)
- Anti-anxiety medication (e.g. diazepam)
- Anaesthetic- chloroprocaine (1-2%) or lidocaine (0.5-2%) without epinephrine.
- Oxytocin 10units or ergometrine 0.2mg.

MVA Instruments

- Vacuum aspirator
- Flexible cannulae of different sizes
- Adapters, if needed
- Silicone for lubricating syringes, if needed.

Appendix 5: Abortion services & Equipment by level of care

Level of care	Type of health personnel available	Abortion related services	Equipment /drugs
Community	Community residents with basic health training · Traditional birth attendants (TBAs) · Community health workers (CHWs) · Community based distributors (CBDs) · Safe motherhood action groups(SMAGs) Church groups and traditional groups	· Recognize signs and symptoms of pregnancy · Recognize signs and symptoms of abortion and its complications · Provide RH education, including FP and the risks of unsafe abortion · Distribute appropriate contraceptives including emergency contraception · Inform communities and women on the legal provisions for safe abortion. · Timely refferal of women to formal care for PAC or safe abortion · Abstinence · Life saving school	· Some contraceptives (OCP, Condoms, spermicide, EC etc) as prescribed to be dispensed · Health education material · IEC · Referral/communication links
Health posts/stations	Frontline health workers · Nurses	The above activities plus; · Check vital signs · Provide pain medication · Diagnosis of stage of abortion and PAC (depending on training) · Initial resuscitation and treatment (depending on training) would be good to specify the treatment as uterine evacuation using appropriate technology · Referral to next level · Miso is listed on the drug/equipment list. Are midlevel's allowed to administer for PAC? Include this here if so.	***Depends on skill available*** Syphigmanometer, Stethoscopes, Thermometers Examination couch with light source Vaginal specula Protective clothing including Gloves IP Supplies Standard emergencey kit Essential drugs Misoprostol Essential drugs Some Contraceptives Transport for referral MVA and Infection prevention supplies & equipment

Health centers	· Doctors · Clinical officers · Midwives and nurses, **Supportive staff** · **laboratory technicians** · **EHT (?write in full)**	The above activities plus; · Counseling (FP,Options · PAC · Vacuum aspiration up to 12 completed weeks of pregnancy · Medical abortion up to nine completed weeks of pregnancy · Administer antibiotics and IV fluids · Resuscitation and initial treatment. · Simple Laboratory tests like Hb · Orient and supervise community level workers · Refer as needed · Local anesthesia	Syphigmanometer, Stethoscopes, Thermometers Examination couch with light source Vaginal specula Protective clothing including Gloves Infection Prevention Supplies Standard emergency equipment and supplies for resuscitation Essential drugs Misoprostol Essential drugs including oxytocics Contraceptives including long term methods Laboratory equipment & supplies Oral and parenteral antibiotics Radio communication (? telephone?) Transport MVA Sterilisation equipment Disinfectants Local anesthesia Sedatives Analgesics Needles and syringes IV fluids and equipment
District hospital	· Same as above, plus GMOs, with or without an obstetrician-gynecologist	The above activities plus; · Uterine evacuation for second trimester abortion · Induction of labour (IOL would remove all 3rd trimester related activities from this guideline · Treatment of most complications · Blood cross-matching and transfusion · Local and general anesthesia · Laparatomy and indicated surgery · Diagnosis and referral for serious complication such as peritonitis and renal failure · Train all cadres of health professionals (pre and in-service) · Refer as needed	Sufficient quantity of uterine evacuation for projected case load Essential drugs for first level hospital Laboratory equipment and reagents for microscopy, culture and basic hematology Blood or blood substitutes Blood collection, transfusion and storage equipment Anesthetic equipment Standard laparotomy serts Ambulance Full range of contraceptives

2nd level and Referral hospitals	· Same as above plus obstetrician - gynecologists	The above activities plus; · Treatment of severe complication (including bowel injury, tetanus, renal failure, gas gangrene, severe sepsis) · Therapeutic terminations · Treatment of Coagulopathy	All those above plus ICU facility Neonatal ICU Specialized X ray equipment Sonographic equipment Minimally invasive surgical equipment and supplies Blood bank Cytotoxics
Approved Private facilities:			
Lower clinics	· Staffed by nurses and Clinical officers	· Perform function described under health posts/stations	
Medium clinics	· Staffed by a health officer or GMO and a team of other health workers	· Perform function described under health centers	
Higher clinics/hospitals	· supported by a specialist and a team of other health workers with hospitalization facilities	· Perform function described under district Hospital	
Higher hospitals	· Staffed by specialist (obstetricians/gynecologists), and a team of other health workers	· Perform function described under 2nd level and referral hospitals depending on status	

Appendix 6. Suggested data sources and indicators for monitoring and evaluating abortion services.

Routine service statistics

- Number of abortions provided, by completed week of pregnancy and by type of procedure.
- Time between first consultation and abortion.
- Number of women referred elsewhere, by reason.
- Number of women seen but not provided with services, by reason.
- Number of women treated for complications, by type of abortion procedure.
- Contraceptive provided, by type.
- Referrals for contraceptive.

Periodic Evaluation.

- Percentage of service delivery points offering abortion care and their distribution by geographic and level of the health care system, and patterns of utilization.
- Number of providers performing abortion and their distribution by geographical area and level of health system.
- Number of health workers trained, by type; assessment of quality of training.
- Costs of abortion services and of treating the complications of abortion, by type of procedure and type of provider and any fees charged.
- Periodic special studies (client satisfaction, proximity of women to facilities, costs, impact, etc)
- Number of staff needing in- service training and numbers trained.

Patient Information (kept in patient file)

- Age, parity, marital status, religion, educational level, occupation and residence.
- Reason(s) for referral
- Reason(s) for refusal
- Follow up care given
- Contraceptive methods chosen
- Fee charged, if any

Source: WHO 2003

Appendix 7. Universal Precautions and Instrument Processing

Health care workers involved in providing abortion services should follow these universal precaution measures in order to prevent the transmission of infections from providers to patient, from patient to providers, and to the community;

- Wash hands thoroughly with soap and water immediately before and after contact with each patient
- Use high level disinfected or sterile gloves, replacing them between patients and procedures
- Never use gloved hands to open and close doors or to process instruments.
- Wear clean gowns, apron, goggles and masks
- Clean floors, beds, toilets, walls and rubber draw sheets with detergents and hot water. If they are soaked with blood or body fluid, use a 0.5% chlorine solution.
- Wear heavy duty gloves when cleaning surfaces and washing bed sheets spilled with blood and body fluids and when processing equipment for reuse
- Dispose of waste contaminated with blood , body fluids, laboratory specimens or body tissues safely , following facility protocols
- Avoid recapping needles whenever possible. If necessary use the scoop method
- Dispose of sharps in puncture-resistant containers and bury or incinerate them.
- All reusable instruments should be soaked in 0.5% chlorine solution and cleaned with soap and water immediately after use and sterilize or high level disinfect.

Appendix 8: Monitoring tool

Province _____District_____

Name of health facility_____

Reporting period_____prepared by_____

	Safe abortion	Post abortion Care		Third trimester termination	Total
		Possibly unsafe/illegal	spontaneous		
Number of women who received abortion care					
Age of women					
< 16 years					
16 -30					
> 30 years					
Occupation					
Student					
unemployed					
Informal employment					
Formally employed					
Marital status					
Married					
Single					
Divorced					
Widow					
Completed gestation weeks					
Less than 9 weeks					
9 – 12 weeks					
Greater than 12 weeks					
Greater than 28 weeks					
Type of procedure					
Vacuum Aspiration					
D & C					
Medical methods					
Other (specify)					
Women who received a contraceptive					
Type of contraceptive					
COC					
POP					
IUD					
Implants					
BTL/vasectomy					
Condoms					
Women with major complications					
Bleeding					
perforation					
Infection					
Other specify					
Women who died from complications of the procedure					

Appendix 10 - EMERGENCY RESUSCITATION EQUIPMENT AND DRUGS

Elements of Emergenc y Resuscitation	Materials
Management of the airway and respiration	Ambu bag and mask ((Adult and neonatal)) Oral airway O_2 Cylinder Suction machine Laryngoscope Endotracheal tubes (Adult and neonatal) Laryngoscope(Adult and neonatal)
Rapid assessment	Diagnostic set Torch Syphgmomanometres Thermometre Stop watch Multipurpose scissors
Control of bleeding/haemorrhage	Oxytocic drugs (ergometrine, xytocin)
Intravenous fluid replacement	IV fluids IV setup IV poles Cannulae Strapping/splint
Rx Cardiac arrest	Sodium bicarbonate Epinephrine hydrocortisone
Control of pain/anesthesia	Atropine Diazepam Ether Nitrous oxide Oxygen Suxamethonium Thiopental Lidocaine Pethidine Naloxone
Transferring patients	Stretchers Wheel chairs Emergency and recovery trolleys
Blood products	Blood Fresh frozen plasma
Anticoagulant and antidote	Heparin Protamine sulphate Vit K
Anticonvulsants	Magnessium sulphate Diazepam
Diuretics	Furosemide

Antihypertensives	Hydralazine Nifedipine
Cardiac stimulants	Epinephrine Nitroglycerine
Anticholinergic	Atropine
Corticosteroids	Hydrocortisone
Bronchial dilators	Salbutamol inhaler
Other drugs	Calcium gluconate Potassium Chloride
Skin Disinfectants*	Ethanol/spirit Polyvidone iodine Chlohexidine
Sera, immunoglobulins and vaccine	Anti-D immunoglobulin (human) Tetanus antitoxin (antitetanus immunoglobulin human) Tetanus toxoid
Intravenous solutions	Water for injections Compound solution of Sodium lactate (commonly known as Ringer's) Glucose 5%, 50% Glucose with sodium chloride Potassium chloride Sodium chloride
Bladder catheterization	Foley/s catheter Urine bag