4

Vulnerability, inequality and the law: The triple-strand cord choking women's access to comprehensive abortion care in Zambia

Chipo Nkatha

Abstract

Many authors have described Zambia's legal framework on abortion as liberal, second only to that of South Africa on the African continent. However, Zambia's Termination of Pregnancy Act is largely ineffective for facilitating access to safe abortion. This is because it operates in a regulatory environment that supports neither women's access to comprehensive abortion care nor women's holistic realisation of sexual and reproductive health rights. Zambia's legal framework on abortion thus perpetuates health and other human rights violations against women, including perpetuating inequality on account of sex, gender, age, occupation, geographical location, disability, health status and civil status. It makes women vulnerable to unwanted pregnancies, unsafe abortions and all the social, economic, psychological, physical and other consequences that flow therefrom. Zambia's regulatory framework has largely been influenced by the Christian ethos that has painted abortion with an immoral brush. However, women's experiences in Zambia evidence the need for a paradigm shift to address the needs of present-day Zambia. This chapter examines Zambia's regulatory framework and makes a case for a woman-centred approach to regulating abortion in Zambia.

1 Introduction

The United Nations Population Fund (UNFPA) Zambia dashboard of 2021 pegs Zambia's population at 18,9 million people, the majority of

whom are young women.[1] Approximately 25 per cent of the Zambian population consists of adolescents aged between 10 and 19 years.[2] However, the reproductive age range in Zambia consists of persons of 15 to 49 years of age.[3] Women and adolescent girls in these age groups are most susceptible to many harmful social and cultural practices that increase their demand for family planning services, including contraception and abortion. The Zambia Demographic Health Survey 2018 indicates that many women experience their first sexual encounter at the age of 15 years.[4] This is a key statistic for planning access to safe abortion interventions. As noted by the Ministry of Health '[f]or many Zambians' age at first sex for both women and men is an important indicator of exposure to risk of pregnancy and STI'.[5] From the available data, women most in need of safe abortion services in Zambia include adolescent girls, including school-going girls, women in rural areas, women who are in abusive relationships, women who have experienced sexual assault and women who are not financially or psychologically prepared to have a child. These groups of women would further include women who are vulnerable to abuse on account of their criminal activities, such as sex workers; women who already have the desired number of children; women who do not want to raise children without their partners; and women who do not want to raise children because of their HIV or other health or social status. Due to the paucity of data in this field, there is limited to no information in Zambia on access to safe abortion services for women in rural areas, women with disabilities, especially women with mental disabilities, women in places of detention, *lesbian, gay, bisexual, transgender, intersex and queer or questioning* (LGBTIQ) communities, and women living with HIV, among others.

The human rights of many women in Zambia are severely constrained on account of economic, social, cultural, religious and legal restrictions that suffocate their enjoyment of fundamental rights and freedoms on an equal basis with men and among women with multiple minority status.

1 United Nations Population Fund 'UNFPA Zambia', www.unfpa.org/data/ZM (accessed 25 August 2021).
2 As above.
3 Ministry of Health 'Zambia demographic health survey 2018', https://dhsprogram.com>pdf (accessed 19 August 2021).
4 As above.
5 Ministry of Health 'Standards and guidelines for comprehensive abortion care in Zambia' (2017).

Women with multiple minority status are not only susceptible to human rights violations but are also vulnerable members of the Zambian society due to their low social standing. For women in need of safe abortion services, their low human rights and social standing status serves as a barrier to accessing comprehensive abortion care (CAC) services, creating a vicious cycle of vulnerability to rights abuses. Many describe Zambia's legal framework on abortion as 'liberal'. This chapter, however, demonstrates that this is far from the truth for many women in Zambia. Many Zambian women are unable to access CAC services in part due to their marginalisation and unequal treatment and in part due to the existing legal framework.[6]

The vulnerability of women to their sexual and reproductive health rights, including CAC, calls for a re-examination and paradigm shift of Zambia's regulatory approach to abortion towards an inclusive women-centred paradigm that addresses women's vulnerability, empowers them to claim their rights and promotes their access to CAC. Women's experiences in this regard must inform the creation of a regulatory environment conducive to their enjoyment of human rights. A woman-centred approach facilitates access to CAC in a manner that promotes the attainment of the highest or best attainable standards of physical and mental health in line with international and regional human rights standards. When planning and implementing abortion services, it considers an individual woman's health, physical and psychological needs, her circumstances and her ability to access services.[7] Brookman-Amissah describes this as 'a pragmatic approach to meeting the needs of individual women that emphasises access, choice and quality of

6 See A Blystad and others 'The access paradox: Abortion law, policy and practice in Ethiopia, Tanzania and Zambia' (2019) 18 *International Journal for Equity in Health* 126; AM Moore and others 'Comparing women's financial costs of induced abortion at a facility vs seeking treatment for complications from unsafe abortion in Zambia' (2018) 26 *Reproductive Health Matters* 138; E Brookman-Amissah & JB Moyo 'Abortion law reform in sub-Saharan Africa: No turning back' (2004) 12 *Reproductive Health Matters* 229; RN Likwa and others 'Unsafe abortion in Zambia' (2009) 3 *In Brief* Guttmacher Institute 1, https://guttmacher.org (accessed 19 August 2021); MA Castle and others 'Observations on abortion in Zambia' (July-August 1990) 21 *Studies in Family Planning* 231.

7 AG Hyman & A Kumar 'What is woman-centred comprehensive abortion care?', http://www.semanticscholar.or/paper/what-is-woman-centered-comprehensive-abortion-care-Ag-Kumar (accessed 14 October 2021).

services'.[8] It puts her at the centre of programming for abortion and other reproductive health rights. A woman-centred approach thus has to be implemented in the context of a health system comprising public and private health actors.[9] Historically, women's experiences of abortion were never at the centre of legal regulations in Zambia. The approach of the British imperialist was to criminalise abortion as it was considered immoral under Christianity.[10] This legacy has continued to permeate many legal frameworks for abortion, including the so-called 'liberal' Zambian framework, thereby negatively impacting on women's access to CAC.

The chapter opens with a brief discussion of Zambia's pre-colonial approach to abortion, how colonialism impacted on the pre-colonial approach and continues to influence current-day regulations on women's access to abortion services. This is followed by a discussion on the prevalence of unsafe abortion in Zambia and the demographics of women most in need of abortion services. Thereafter, Zambia's regulatory framework for abortion is examined, highlighting its strengths and weaknesses and making proposals for reforms that would bolster the women-centred approach to CAC. Lastly, the chapter examines the concept of a women-centred approach and how it can be adapted to inform legislative and policy reforms.

2 Historical approach to abortion laws in Zambia

2.1 Pre-colonial approach to abortion in Zambia

Zambia has a dual legal system in which customary law operates side-by-side with written laws, both being recognised as valid unless there is a conflict between the two, which is resolved in favour of the written law.[11] Under customary law, girls are allowed to marry as soon as they attain puberty, subjecting many girls to marriage, lowered or no education

8 E Brookman-Amissah 'Woman-centred safe abortion care in Africa' (2004) 8 *African Journal of Reproductive Health* 41.

9 Brookman-Amissah (n 8) 38.

10 AM Kangwa 'The Termination of Pregnancy Act and its relevance in Zambia' (2018), http://155.0.3.194>jspui>bitstream (accessed 10 September 2021).

11 Arts 1 and 7 of the Constitution of Zambia, 1991 as amended by Act 2 of 2016. See also sec 12(1)(a) of the Local Court Act 29 of 1966.

and unwanted pregnancy.[12] Zambia has a high prevalence rate of child marriages, where 5 per cent of girls are married by the age of 15 years and 29 per cent by the age of 18 years.[13]

In pre-colonial Zambia, society was organised around community living. Women held a special status in society as they were actively involved in both production and reproduction, and gender roles were not rigidly defined.[14] However, 'procreation held a prominent position as one of the most important duties that a woman must perform in the course of her lifetime'.[15] Children were required to form part of the labour force for this community that depended for survival on agriculture. Children were also expected to care for the elderly members of the community and, thus, were seen as 'an investment in the future of the community'.[16] Kanim states about the importance of bearing children that

> children also needed to sustain the legacy of the family and the broader community. On an individual level, children were living proof of one's contributions to society, as their physical being was evidence of a successful marriage. Those marriages that did not produce children were generally understood to be incomplete or unfilled. At the community level, the significance of childbearing was even greater ... the failure to bear children was arguably 'worse than committing genocide', as it signified a rejection of societal custom and marked a woman as the 'dead end of human life' for herself and for her lineage.[17]

Pre-colonial Zambia conceived sex and child bearing as a preserve for marriage.[18] Seemingly, no regulations were made for abortion services for women. Although child bearing was highly valued, there does not appear to be any evidence that procuring an abortion was criminalised or socially frowned upon. Christian values did not regulate pre-colonial

12 MC Milimo and others 'Zambia strategic country gender assessment: A report of the World Bank' (2004) 50, https://www.documents1.worldbank.org/curated/en/569301468044 (accessed 1 October 2021).

13 https://www.girlsnotbrides.org/learning-resources/child-,marriage-atlas/atlas/zambia/# (accessed 20 February 2024).

14 AL Moagi & B Mtombeni 'Women in pre-colonial Southern Africa' (2019) 1-3, https://www.academia.edu/43488525/Women_in_Pre_colonial_Africa_Southern_Africa (accessed 29 December 2021).

15 CH Kanim 'Maternal health in rural Zambia: Challenges in the age of globalisation' (2018) 40, https://udspace.udel.edu (accessed 10 October 2021).

16 As above.

17 As above.

18 M Tembo 'Role of sex in marriage' *The Zambian Cultural Heritage* 5 February 2014; see also Every Culture 'Countries and their culture: Culture of Zambia', https://www.everyculture.come/To-Z/Zambia.html (accessed 12 December 2021).

reproductive practices in Zambia.[19] Women's worth and contribution to society were primarily judged on their ability to bear children.[20] This informed the prevalent customary reproductive practices and regulations and, in many respects, continues to date in many Zambian cultures. One key practice was that traditional midwives, who often were elderly women in the community, were assigned to an expectant woman to care for her and the unborn baby and to ensure safe delivery.[21] They were also expected to train younger relatives to ensure continuity of services. Another practice was that once born, the child belonged to the community. While the individual woman and her relatives bore the responsibility of bearing and ensuring the safe delivery of the child, the community bore the responsibility for its upbringing.[22] Another practice was that women were to breastfeed their babies for two years and in this period abstain from sexual intercourse until they were ready to conceive another child.[23] Women's reproductive roles elevated their status and entitled them to decision-making powers in the public domain as rulers and in religion as diviners. Moagi and Mtombeni argue that contrary to gender oppression schools of historical analysis, which present women in pre-colonial Southern African countries as relatively powerless and occupying low social status, these women were independent, able to control their bodies and shape their destinies.[24]

As illustrated in the next part, colonialism manipulated pre-colonial social arrangements leading to the prescription of strict norms that minimised women's bodily autonomy and decision-making powers. The influence of colonialism also lowered women's social standing as reproductive (and productive) citizens through the use of disempowering legal provisions. The next part is illustrative of this.

19 MM Munalula 'Regulating to liberate Zambia's population policy through the reproductive rights lens' (2013) 44 *Zambia Law Journal* 77.
20 Kanim (n 15) 40-41.
21 Kanim (n 15) 41.
22 SD Taylor *Culture and customs of Zambia* (2006) 107.
23 Kanim (n 15) 43.
24 Moagi & Mtombeni (n 14) 8.

2.2 Colonial and post-colonial approach to abortion laws in Zambia

Zambia was colonised by Britain from 1888 to 1964 when it gained its independence. Its colonisation saw an importation of a wide array of laws of England as well as the enactment of tailor-made laws by the imperialist. For abortion laws, the influence of the United Kingdom's Offences Against the Persons Act, 1861 (OAPA) was instrumental in shaping the abortion regulatory framework in the colonial era and beyond. Ngwena states about the influence of colonisation on the reproductive landscape of colonies the following:[25]

> The advent of colonial regimes radically changed the position and rendered abortion the object of regulation by penal laws. A feature common to all colonial abortion laws is that they all criminalised abortion and were all replicas of laws in penal codes of the imperial powers ... colonial laws purported to reflect a sense of religious sin derived from their own ecclesiastical law in sixteenth century Europe. The ostensible rational for criminalising abortion was that it served to protect the spiritual values inherent in unborn life.

In England, Christian values only started having an influence in reproductive practices in the period of the thirteenth to the sixteenth centuries.[26] The policy considerations that influenced approaches to reproductive laws in the United Kingdom and other parts of Europe were supported by powerful sources that, once adopted, inevitably influenced their colonies.[27] Having been colonised by Britain, Christianity permeated and shaped the Zambian legal framework on abortion. Using the Christian influence and the criminal law instrument to proscribe the termination of pregnancy by women, child bearing no longer was the responsibility of the individual woman and her relatives. The state could now interfere in decisions about procreation. The OAPA sanctioned control of women's bodily autonomy, stifling women's individual choice and creating new systems of control that fostered negative cultural transformations.[28] Its proscription of intentional abortion of an unborn

25 CG Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 829.
26 Munalula (n 19).
27 Centre for Feminist Foreign Policy 'The globalisation of punitive abortion law: The colonial legacy of Offences Against the Person Act 1861' (March 2020), www.centreforfeministforeignpolicy.org (accessed 25 August 2021).
28 As above.

child also limited women's access to reproductive health institutions, goods and services as well as determinants for women's health and other human rights.[29]

In the post-colonial era, women and young people are contributing much more in the social, economic and political lives of Zambian society in ways that were not supported in the colonial era.[30] The emergence of human rights principles has significantly impacted the rigid adherence to traditional gender and sex roles, leading to widespread questioning of these norms, if not their outright dismantling in many areas.

Many regulatory frameworks are increasingly recognising and protecting the human rights of children and young persons, enabling them to achieve their full potential and development in modern society. Sexual and reproductive health rights have taken on a new paradigm that is not dependent on the wills and preferences of the man or a community, but views women and men as equally entitled to enjoy these rights severally and jointly. Women's safe delivery or, indeed, safe abortion is not wholly in the hands of a midwife. Instead, women share in the exercise of rights and discharge of responsibilities for enjoying a good reproductive health. While colonial powers used law as an instrument of oppression, the present-day use of law as an instrument for positive change cannot be ignored. An appropriate and well-informed regulatory framework may promote women's sexual and reproductive health rights. It may thus counter patriarchal control that robs women of their bodily autonomy, among other rights.

Zambia does not have up-to-date aggregated national data on the prevalence of abortion and resultant morbidity and mortality rate.[31] In 2009 the Ministry of Health estimated that 30 per cent of maternal deaths arose from unsafe abortions.[32] In the revised Standards and Guidelines for Comprehensive Abortion Care in Zambia 2017, the Ministry of Health finds that 6 per cent of women die from unsafe abortion, and more than 70 per cent of abortion complications result from unsafe abortion.[33] The

29 As above.
30 Moagi & Mtombeni (n 14) 1-3.
31 E Freeman and others 'Men's roles in women's abortion-trajectories in urban Zambia' (2017) 43 *International Perspectives on Sexual and Reproductive Health* 90.
32 D Parmar and others 'Cost of abortions in Zambia: A comparison of safe abortion and post-abortion care' (2017) 12 *Global Public Health* 236.
33 Standards and Guidelines for Comprehensive Abortion Care in Zambia (n 5).

policy offers no explanation for the significant drop in mortality cases from unsafe abortions, but this most likely is a result of inaccurate data arising from inconsistent and non-comprehensive research studies on the subject. The policy further indicates that abortion is one of the top five causes of maternal mortality in Zambia.[34] The Zambian maternal mortality rate (MMR) in 2018 stood at 252 deaths per 100 000, showing an improvement from 398 deaths per 100 000 recorded in 2013 to 2014.[35] The National Gender Policy identifies a number of factors that lead to high mortalities in Zambia, including teenage pregnancies; negative cultural practices; long distances between healthcare facilities and the communities they serve; the inadequate number of skilled personnel to handle pregnancy and delivery complications; and a high prevalence on home deliveries compared to health facility deliveries.[36] Other studies have shown varying statistics relating to unsafe abortions and post-abortion complications. In one study, 60 per cent of women aged 15 to 19 years were said to have been hospitalised for complications arising from clandestine abortion procedures in Lusaka.[37] In another study, 'the abortion-related near-miss rate across Central, Copperbelt and Lusaka Provinces is 72 per 100 000 women and the abortion-related near-miss ratio is 450 per 100 000 live births'.[38] Marie Stopes Zambia, an international non-governmental organisation (NGO), reports preventing 44 334 unsafe abortions and 109 030 unintended pregnancies in 2018.[39]

It is evident from the above discussion that the high prevalence rates of unsafe abortion in Zambia are affected by women's vulnerability and inequality as well as the lack of a conducive regulatory framework that responds to women's health and social needs. An examination of Zambia's regulatory framework on abortion is necessary for ascertaining its role in enhancing women's access to comprehensive abortion care.

34 As above.
35 Ministry of Health (n 3).
36 Republic of Zambia Nation Gender Policy 2023 12.
37 Brookman-Amissah & Moyo (n 6).
38 JA Cresswell and others 'Does supportive legislation guarantee access to pregnancy termination and postabortion care services? Findings from a facility census in Central Province, Zambia' (2018) 3 *BMJ Global Health* 4, www.gh.bmj.com/content/3/4/e000897 (accessed 13 October 2021).
39 L Kalifungwa 'Abortion rights in Zambia increasingly under attack' *New Africa Daily* 14 April 2020, http://newafricadaily.com/abortion-rights-zambia-increasingly-under-attack (accessed 18 August 2021).

3 Examining Zambia's regulatory framework on abortion

Many laws, policies and protocols are potentially relevant to women's access to comprehensive abortion care (CAC) due to the multifaceted nature of the subject. The women-centred framework is anchored on the rights-based approach and, thus, it is necessary to appreciate human rights standards applicable to Zambia. Zambia is bound by several treaties that it has ratified as a member of the United Nations (UN) and the African Union (AU). For instance, under the UN it ratified the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural rights (ICESCR) on 10 April 1984; the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) on 21 June 1985; and the Convention on Rights of the Persons with Disabilities (CRPD) on 1 February 2010. Under the AU, Zambia ratified treaties such as the African Charter on Human and Peoples' Rights (African Charter) on 10 January 1984; the African Charter on the Rights and Welfare of the Child (African Children's Charter) on 2 December 2008; and the Protocol to the African Charter on the Rights of Women in Africa (African Women's Protocol) on 2 May 2006. The aforementioned treaties set standards for the protection of women's sexual and reproductive health rights, among others.

Whereas most of the treaties do not specifically guarantee the right to abortion, they all guarantee freedom from discrimination, the right to security of the person and bodily integrity, dignity, life and health, among others. The standard for the right to health guaranteed under these treaties is 'the highest or best attainable standard of physical and mental health'. This includes the highest or best attainable standards of sexual and reproductive health. Whereas all the treaties proscribe discrimination and promote equality in the enjoyment of fundamental rights and freedoms, specialised treaties such as CRPD, CEDAW, the African Children's Charter and the African Women's Protocol tailor-make their provisions to suit the experiences of the target groups of people they protect. Thus, CRPD proscribes discrimination against persons with disabilities in their enjoyment of health rights. Similarly, CEDAW and the African Women's Protocol proscribe discrimination against women in the enjoyment of their health rights. Further, the African Women's Protocol is unique in that it is the only human rights

treaty applicable to Zambia that expressly provides for medical abortion as a means of protecting women's reproductive rights.[40] Although some scholars have criticised the Women's Protocol for holding back on the protections it offers to women's access to safe abortion,[41] it nonetheless is progressive to the extent that it is the only human rights treaty that creates visibility of abortion as a human rights and women's rights issue[42] and provides guidance on women's access to CAC. Its provisions, thus, can be used for 'transforming national-level abortion laws and serving as a critical resource in advancing law and policy reform'.[43] Read together with other human rights treaties, article 14 of the African Women's Protocol can be used to foster the paradigm shift from a punitive approach to a women-centred approach that advances women's health rights. Zambia thus is bound by its human rights obligations as espoused in the aforementioned treaties and must, therefore, ensure that its regulatory framework conforms to the minimum standards they set for women's enjoyment of CAC.

3.1 Laws regulating women's access to abortion services in Zambia

3.1.1 Constitution of Zambia

The Constitution of the Republic of Zambia (Constitution) is contained in the Constitution of Zambia Act.[44] It is the highest law of the land and contains the Bill of Rights which guarantees to persons in Zambia limited fundamental rights and freedoms.[45] Thus, although the Constitution guarantees the right to life, it does not guarantee the right to health. A threat to life that arises from the violation of the right to health may nonetheless be relied upon to seek recourse for a right to health violation. This assumes that the courts would be willing to take a wide interpretation of the right to life and recognise the interdependence of rights. This approach, while constitutionally sound, may not be

40 Art 14(2).
41 Ngwena (n 25).
42 As above.
43 JB Fine and others 'The role of international human rights norms in liberalisation of abortion laws globally' (June 2017) 19 *Health and Human Rights Journal* 69.
44 Constitution of Zambia (n 11).
45 Art 11.

practical in all circumstances due the limited way in which the right to life is couched. The Constitution proscribes the intentional deprivation of life except where it is done pursuant to a court sentence in a criminal case established under Zambian law.[46]

The other situation in which the Constitution proscribes the intentional deprivation of life is when it relates to termination of pregnancy unless done pursuant to an Act of Parliament.[47] The Constitution fails to guarantee women's rights to choose whether or not they want to keep a pregnancy, but instead criminalises the decision to terminate pregnancy. Further, the Constitution fails to recognise the importance of a good quality of life. Instead, it merely guarantees the right to be alive by proscribing the intentional deprivation of life. This constitutional approach has a disproportionate effect on women who seek termination of pregnancy on account of a threat to their quality of life by the continued pregnancy. Although the negative mental consequence of an unwanted pregnancy is a recognised ground for abortion under the Termination of Pregnancy Act, one would aver that the medicalised approach of this law would require medical practitioners to establish that the pregnant woman risks or would suffer from a mental illness if she continued with the pregnancy. Thus, in this context, mental illness must be imminent for it to suffice as a ground that can be relied upon for abortion. The failure of the Constitution to recognise the vulnerability and inequality experienced by women in Zambia exacerbates the negative impact of unsafe abortions.

The constitutional provisions can be strengthened by amending the right to life provision to guarantee quality of life as well as expand the Bill of Rights to include the right to sexual and reproductive rights, generally, and specifically the right to safe abortion services. Further, the Constitution must be amended to ensure that women's rights to equality is brought in conformity with international human rights standards.

46 Art 12(1).
47 Art 12(2).

3.1.2 Penal Code and Termination of Pregnancy Act

The Penal Code (PC)[48] provisions criminalising termination of pregnancy gain their legitimacy from the Constitution. The PC provisions on abortion are contained in the part that deals with offences against morality.[49] This positioning is indicative of the influence of the colonial world view on abortion. Criminalising abortion on account of morality affects the law's ability to effect a women-centred approach to abortion. According to section 151 of the PC, any person who attempts to procure an abortion of a woman, whether she is actually pregnant or not, commits a crime and is liable to 14 years' imprisonment. This provision could be useful in cases where a woman is forced to terminate a pregnancy or where an abortion procedure is administered to her without her consent. Section 151 was drafted to proscribe abortions with or without the woman's consent and, hence, it does not provide for consent. In view of women's *sexual and reproductive health and rights*, this provision could be amended to reflect the importance of a woman's consent. The PC further criminalises a woman who subjects herself to an abortion either by administering to herself or permitting someone to administer to her a poisonous or other noxious matter or by using force of any kind.[50] This provision augments the argument that Zambian abortion laws deprive women of their enjoyment of bodily autonomy and abortion choices. The PC also proscribes the supply of drugs or any equipment for the procurement of abortion, thereby denying women access to CAC.[51]

The principal law on abortion in Zambia is the Termination of Pregnancy Act (TOPA) by virtue of the subject matter it regulates and the fact that the government uses its provisions to guide its programming of abortion services.[52] It was enacted in 1972[53] and amended in 1994.[54] It came into existence when the Penal Code provisions criminalising abortion were already in existence. The purpose of TOPA is to 'amend and clarify the law relating to termination of pregnancy by registered

48 Ch 87 Laws of Zambia.
49 Secs 151-153.
50 Sec 152.
51 Sec 153.
52 Ch 304 Laws of Zambia.
53 Act 26 of 1972.
54 Act 13 of 1994.

medical practitioners' and provide for matters incidental to this objective.[55] However, the TOPA does not identify itself as the principal law on abortion. It defines the 'law relating to abortion' as sections 151 to 153 of the Penal Code (PC) which proscribe various activities related to termination of pregnancy.[56] By referring to the PC provisions as 'the law relating to abortion', the TOPA implies that the main law on termination of pregnancy is the PC. This is further supported by section 6, which is a consolidation of the PC provisions, and section 3(1) which reads:

> (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 continuance 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 continuance 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.[57]

It is evident that section 3 is an exception to the general rule, which is that procurement of abortion is illegal. Under this provision, a woman can only terminate a pregnancy on the listed grounds. Many have argued that grounds for legal abortion in Zambia are relatively liberal.[58] However, TOPA fails in its current state to foster a women-centred approach on account that it limits women's choices for, access to and quality of safe abortions by allowing criminal provisions to prevail over its provisions. The experiences of women in Zambia attest to the chilling effects that the criminalisation of abortion has on access to CAC. Evidence also

55 Preamble.
56 Sec 2.
57 My emphasis.
58 UNFPA (n 1).

suggests that the chilling effects of criminalising abortion extends to medical practitioners who fear to carry out abortions without approval from law enforcement agencies, even on grounds that are legalised, such as rape.[59] By focusing on moralistic reasons for permitting abortion, the TOPA creates an environment where choices of, access to and quality of abortion services are seriously compromised. As a starting point, the TOPA as the *de facto* principal law on abortion needs to be amended and asserted as the *de facto* and *de jure* principal law on abortion. This will position the law, and in particular section 3, as the main provision that permits or legalises abortion and not as an exception.

Second, the grounds stipulated in section 3(1) are limiting. Other authors have argued why grounds such as those listed in section 3 fall short in recognising women's human rights and agency.[60] The grounds stipulated in section 3 are limiting in that they promote negative social attitudes based on moralistic connotations that women who seek abortion services for reasons other than those permitted in the law are immoral. Section 3 grounds for abortion are also limiting in that they do not capture many other possible reasons women may seek abortion services. The Act envisages that the woman seeking abortion services will only do so on medical grounds, hence the requirement for registered medical practitioners to provide expert medical advice. Therefore, it does not promote informed and supported decision making even for women in vulnerable situations who may have reasons other than medical reasons for terminating an unwanted pregnancy. Further, the provision is limiting in that the requirement for three registered medical practitioners to consent to the abortion is too onerous in a country such as Zambia with very few registered medical practitioners.[61] This is exacerbated in rural areas where even one registered medical practitioner is hard to come by. This provision must be amended to recognise women's agency and to provide the support they require to make informed decisions for access to safe abortion. Further, it should be amended to allow for training of a broad-based section of public, private and community-based health personnel who can perform uncomplicated abortion procedures in

59 Freeman and others (n 31).
60 Ngwena (n 25).
61 T Fetters and others 'Moving from legality to reality: How medical abortion methods were introduced with implementation science in Zambia' (2017) 14 *Reproductive Health* 26.

the first trimester.[62] This will facilitate not only the exercise of choice, but bolster safe abortion choices as opposed to clandestine ones that do not require such onerous requirements. It will also bolster access to healthcare services.

The TOPA also provides that, except in emergency situations, all abortion services must take place in a hospital.[63] Section 2 defines a hospital as a government institution that operates as a hospital and any other institution the Permanent Secretary of the Ministry of Health (MoH) approves in writing to carrying out services in line with the objects of TOPA. Thus, private actors cannot conduct abortions unless they have written permission from the MoH. This creates a barrier to accessing services for women as they have limited healthcare facilities to attend to their needs. Curtailing the provision of abortion services by private actors places a greater burden on the government to offer such services. When the government fails to meet the demand, as it often does, women ultimately suffer the most. This provision must be amended to allow effective partnerships where private actors can provide CAC. Further, the law must establish community-based maternity homes, including in rural areas, in which trained community-based healthcare practitioners could be provided with sanitary environments for childbirth and safe abortions.

Section 4 of TOPA allows for registered medical practitioners to object to participating in an abortion for conscientious reasons such as their faith or other personal values. This may leave many women vulnerable to lack of services. One respondent in a study by Blystad and others stated: 'I'm sure you know the picture in Zambia, we do not have sufficient health personnel, so already we have a limited number of doctors, but our law also offers conscientious objections. So the doctor … what if all three say, "I don't want to participate in this process", then you do not have anybody to consent for the services.'[64]

To adequately safeguard women's rights to CAC, conscientious objection must be allowed in situations where the healthcare facility has alternative medical practitioners to perform the procedure or can facilitate a timely external referral at its own cost. It should also be clear

62 Brookman-Amisaah & Moyo (n 6).
63 Secs 3(3) & (4).
64 Blystad and others (n 6).

that medical practitioners would not be allowed to use conscientious objection as a ground to discriminate against women.

Section 5 of TOPA empowers the Minister of Health to make regulations for its implementation. The subsidiary legislation made pursuant to this provision adds several barriers to the exercise of choice and access to quality abortion services in Zambia.[65] One of the provisions in the regulations is to prescribe the form for certification of medical practitioners' opinion required under section 3.[66] The regulations require a mandatory certification of opinions prior to the abortion procedure or within 24 hours of the procedures if the former is not reasonably practical.[67] Some doctors in the private sector have described these requirements as extremely costly for them, thus posing a barrier to access to services for women.[68] It is also burdensome and possibly an infringement of women's rights to require medical practitioners to keep a record of the certificate for three years from the date of termination of the pregnancy.[69] The regulations also require medical practitioners who carry out abortion procedures to provide notice of the termination to the Permanent Secretary of the MoH within seven days.[70] Not only do these administrative processes negatively impact on access to quality and timely abortion services, including post-abortion care, but they also solicit the illegitimate sharing of personal details of women seeking abortion services from a medical facility. The forms prescribed for recording practitioners' opinions, certification and notification to the Permanent Secretary all solicit the name and address of the woman, her marital status, occupation as well as the occupation of her spouse, the date of the woman's last menstrual period, previous pregnancies and their status, number of existing children and grounds for termination of pregnancy, among others.[71] The regulations further require the notice to be mailed to the Permanent Secretary through the post. This is costly and makes access to the service even more difficult as many rural areas do not have post offices. The risk of women's personal information getting lost

65 Termination of Pregnancy Statutory Instrument 219 of 1972.
66 Reg 2(1).
67 Reg 2(3).
68 Blystad and others (n 6).
69 Reg 2(4).
70 Reg 3.
71 Schedule 1 & 2.

in the mail and finding itself in the public domain can be very damaging to the woman, her family and the entire public health system as she may be shunned. With the advent of social media, personal information can easily be spread throughout the country to the detriment of women and their families and ultimately the entire public health system as it would not garner the confidence of the public to utilise its services.

Although the regulations provide restrictions on disclosure of information provided to the Permanent Secretary, it permits disclosure of information on grounds primarily targeting criminal prosecution of women, including enabling '(i) an officer of the MoH to carry out their duties as authorised by the Permanent Secretary; (ii) the Director of Public Prosecutions to carry out their duties relating to offences under the Act; and (iii) a qualified police officer to investigate whether an offence has been committed under the Act or the Penal Code'.[72]

The disclosure of such private information is also permitted for purposes of scientific research as well as to registered medical practitioners. The woman's consent is only solicited if the medical practitioner with whom the information is shared did not perform the abortion procedure.

Because these provisions violate women's human rights, notably their sexual and reproductive health rights, their rights to privacy, dignity, bodily autonomy and freedom from discrimination, the regulations must be amended to ensure that only quality assurance and oversight requirements for CAC are provided for. Regulations must guarantee that women are free to exercise their choice to abortion without fear of prosecution and that doctors are equally free to offer abortion, thereby increasing the availability of services for women. The regulations must also require a public fund to meet the administrative costs of all healthcare providers for regulations aimed at MoH's provision of oversight and quality assurance for CAC and integrated services. This cannot be achieved under the existing TOPA regulations as they do not take a women-centred approach.

72 Reg 4.

3.1.3 Statutes regulating healthcare professions

Two key statutes regulating healthcare professions are relevant to the discussion on ensuring access to CAC for women in Zambia: the Health Professions Act[73] and the Nurses and Midwives Act.[74] These statutes provide for the registration and regulation of healthcare practitioners under their purview. The Health Professions Act also provides for the licensing of healthcare facilities, the accreditation of healthcare services they provide and recognition and approval of training programmes for healthcare practitioners.[75] The Nurses and Midwives Act primarily focuses on the regulation of education and training of nurses and midwives, their certification and regulation of their professional conduct.[76] The 2021 amendment to the Health Professions Act mandates the Zambia Qualification Authority to recognise a healthcare professional as a specialist based on assessment of their post-graduate qualification.[77] This may have the effect of reducing even further the number of specialists available to attend to women's abortion care as the applications for recognition as a specialist have to be dealt with by a body outside the medical profession whose functioning is out of their control. This strengthens the argument to relax the requirement for a specialist to be among medical practitioners required for an abortion procedure.

The Nurses and Midwives Act recognises nurses and midwifery agencies and centres as providers of human resources and services for nursing and midwifery in community settings.[78] The recognition of private services offered through nursing agencies, midwifery agencies, nursing care centres and midwifery care centres is cardinal for increasing access to CAC and could provide a basis for establishing rural-based maternity homes to provide abortion services to women in rural areas. The certification powers of the Nursing and Midwifery Council could also be extended to the certification of community health and care givers who are trained to offer CAC services. Both laws regulating healthcare professionals provide for codes of conduct and protocols for ensuring

73 Act 24 of 2009 as amended by Act 26 of 2021.
74 Act 10 of 2019.
75 Preamble.
76 Preamble.
77 Sec 4 of Act 26 of 2021.
78 Sec 2.

professional provision of healthcare services.[79] Women, particularly vulnerable women, however, must be empowered to use the codes and complaint procedures provided for under these laws to assert their rights.

3.2 Policies and protocols regulating women's access to abortion services in Zambia

3.2.1 National Gender Policy 2023

The National Gender Policy[80] is instrumental for driving the gender agenda in Zambia. Although the current policy recognises the fact that Zambia's MMR is high,[81] it does not expressly address the issue of unsafe abortion. One of the key objectives of the National Gender Policy is to 'facilitate access to cost-effective quality and gender responsive healthcare services for all'. Under this objective, the state seeks to implement two measures: (i) enhance equal access to quality health services for women and men; and (ii) strengthen provision of integrated sexual reproductive health services.[82]

The policy also sets as its objective the increase of women's participation in governance and decision making, requiring a measure that promotes women's participation in decision making in both public and private sectors.[83] These objectives allow for women's sexual and reproductive health issues to be considered and addressed through the national mechanisms for promoting gender equality. Although the policy does not specifically reference interventions for addressing abortion-related challenges for women, its provisions on promoting women's participation in governance can facilitate communication of women's experiences of abortion services. This information, in turn, can inform government decisions and interventions that are responsive to women's health needs.

The policy also recognises institutional and legal frameworks for realising these objectives. It mandates the ministry responsible for

79 Sec 60 of the Health Professions Act and sec 65 of the Nursing and Midwives Act.
80 Nation Gender Policy 2023 (n 36).
81 As above.
82 Nation Gender Policy 2023 (n 36) 29.
83 Nation Gender Policy 2023 (n 36) 28.

health to 'mainstream gender and foster equitable access to healthcare by addressing the concerns of ... girls and women'.[84] It also expects the ministry responsible for justice to 'mainstream gender and develop legislation relating to gender equity and equality which considering the provisions of regional and international instruments to which Zambia is a signatory'. It also mandates the Human Rights Commission to address laws, policies, customs and traditions that 'impair equal opportunities and gender equity and equality in enjoyment of human rights'.[85] By these provisions, laws and institutions for promoting women and girls' health rights can address laws, customs and practices that perpetuate women's low social standing and experiences of discrimination, thereby enhancing their access to CAC.

3.2.2 National Population Policy

Munalula describes a population policy as 'a vehicle through which government can channel its resources, in its quest to influence population dynamics'.[86] The National Population Policy[87] recognises that Zambia's population is mostly made up of adolescents who have a high fertility rate. It thus seeks to reduce the level of fertility especially among adolescents and improve access to quality family planning and other forms of sexual and reproductive health goods and services.[88] It offers greater detail on strategies for enhancing the sexual and reproductive health of women and adolescents compared to the National Gender Policy. The two policies, however, overlap in their pursuance of good-quality facilities and trained healthcare practitioners at a community level. However, unlike the National Gender Policy, the policy emphasises the need for integrated user-friendly sexual and reproductive health services that allows planners to programme services for different sub-groups of women (and men) taking into account their experiences. Munalula, however, argues that for the policy to be effective:

84 Nation Gender Policy 2023 (n 36) 34.
85 Nation Gender Policy 2023 (n 36) 36.
86 Munalula (n 19) 81.
87 Ministry of National Development and Planning 'National Population Policy' (2007) 14-15.
88 Munalula (n 19) 82.

> [T]he rights to privacy and reproductive autonomy have to be construed from the Constitution and other laws. There is no clear right to bodily integrity, especially for women. The jurisprudence on rights has not extended to issues of sexuality and reproduction ... It is therefore important to have constitutional amendments to clearly promulgate the said rights and thereafter to build jurisprudence that defines their content ... With the constitutional roots well established, it becomes easier to pursue legislative reforms.

Constitutional reforms for enhancing fundamental rights and freedoms are central to influencing a women-centred approach to CAC as it influences the necessary legal and policy frameworks that responds to women's experiences.

3.2.3 National Health Policy

The National Health Policy[89] attributes the high fertility of rural women to poverty. It also recognises that negative social, cultural and religious beliefs and practices contribute to poor health outcomes.[90] However, like the National Gender Policy, it does not expressly identify unsafe abortion as a problem and, thus, does not have any targeted interventions in this regard. It has provided progressive provisions regarding the recognition and regulation of traditional and alternative healthcare services which 80 per cent of the Zambian population uses, and the provision of services close to the community. It has also outlined in a progressive manner the role of laws in ensuring enjoyment of health rights, including the need to domesticate international and regional human rights instruments. However, without fully identifying the health challenges peculiar to women, such as unsafe abortion, there is a risk of not directly addressing barriers such as the criminalisation of abortion. This has the effect of maintaining the *status quo*, that is, the continued legalisation of women's vulnerability and inequality leading to unwanted pregnancies and exposing them to poor health and life-threatening conditions.

Women's experiences of accessing abortion procedures provide the evidence needed to assess the weaknesses in Zambia's regulatory framework and to advancing a paradigm shift to a women-centred approach to CAC, as demonstrated below.

89 Ministry of Health 'National Health Policy' (2012).
90 Ministry of Health (n 89) 6.

4 The impact of the regulatory framework on women most in need of abortion services in Zambia

Many factors are responsible for the high prevalence of unsafe abortions in Zambia. First, as shown above, the regulatory framework is not supportive for advancing access to CAC and ensuring the highest attainable standards of women's reproductive health rights, as discussed above. Second, many women suffer stigma and discrimination when they conceive an unwanted pregnancy or undergo an abortion.[91] Religious and cultural values are primarily responsible for the stigma and discrimination that women with unwanted pregnancies experience.[92] A research study attributed stigma and discrimination experienced by women to Zambia's failure to review the impact of its abortion law in years prior to 1990.[93] In 1990 attempts to review the law were frustrated by the President's declaration of the country as a Christian nation. Blystad and others found that this declaration had a chilling effect on access to abortion service, with one participant stating 'Zambia being a Christian nation, and (thus) the shame that goes with when you say "I have aborted" ... It's like you have no morals, you are a murderer.'[94]

The religious and cultural bases for stigma and discrimination affect other determinants of unsafe abortions such as access to condoms and contraceptives. In expert panel meetings conducted in Zambia by FHI 360 in 2017, sex workers narrated how they were discouraged from accessing family planning services.[95] Healthcare workers who knew them as sex workers would give them negative attitudes[96] or harass them,[97] or ask them to come with a spouse if they wanted to receive family planning or other reproductive healthcare services.[98] Stigma and discrimination in these instances occur when healthcare workers believe that one who has multiple sexual partners is promiscuous, or that one must not have sex

91 Cresswell and others (n 38).
92 Standards and Guidelines for Comprehensive Abortion Care in Zambia (n 5).
93 Blystad and others (n 6).
94 As above.
95 FHI 360 'Understanding the legal barriers to accessing HIV/AIDS services by key populations: Findings from expert panel meetings in Zambia Final Report' (2017) 7.
96 FHI 360 (n 95) 15.
97 As above.
98 FHI 360 (n 95) 2.

if they are unmarried, or that a woman cannot solely decide on family planning without the consent of her husband. Providing healthcare services in a discriminatory manner has negative consequences for women. Sex workers stated that they are at risk of unsafe abortion even at the hands of government medical officers because they had no access to family planning: 'What can one do if they want to access family planning but are denied such access because they refuse to test for HIV? In Solwezi, family planning is dependent on HIV testing in government health institutions. If you refuse to test for HIV, they cannot give family planning. This is why people resort to abortions.'[99]

Another basis for abortion-related stigma and discrimination in Zambia is fear of criminal prosecution, with some women reporting to shun services for post-abortion complications for this reason.[100] The criminalisation of sexual activities such as sex work leads to sexual assault and other harmful practices that make sex workers vulnerable to unwanted pregnancies, and yet they are denied access to abortion services. Sex workers in the FHI 360 meetings recounted how they are often subjected to sexual exploitation by medical personnel and law enforcement under the threat of criminal action.[101] Unsafe abortions cannot be curtailed if such vices continue and if women are continuously subjected to harmful practices, including those done under the guise of criminal laws.

Similarly, women must be protected from vices such as gender-based violence and sexual assaults if they are to be effectively protected from unwanted pregnancies and unsafe abortions.[102] Narrating an experience of a gender-based violence survivor who had undergone several abortion attempts, Freeman and others write:[103]

> In the case of Bulongo, age 28, two feared men were absent yet present in her [abortion] decision-making –her abuser and her husband. Bulongo became pregnant after being raped at work. She explained that she might have continued the pregnancy and presented the child as belonging to her husband, but the perpetrator looked so different from him that she did not think she would be believed. Fearing that her account of rape would be doubted and that she would

99 FHI 360 (n 95) 40-41.
100 Moore and others (n 6) 145.
101 FHI 360 (n 95) 13-15.
102 E Dalhback and others 'Pregnancy loss: Spontaneous and induced abortions among young women in Lusaka' (2010) 12 *Culture, Health and Sexuality* 247.
103 Freeman and others (n 31) 94.

> be condemned for adultery by her husband and her faith community, she told no one about her ordeal. The actions of her attacker and the anticipated reaction of her husband determined Bulongo's initial need to seek abortion, the urgency and secrecy with which she pursued it, and the escalation of methods employed to obtain it; she tried unknown pharmacological abortifacients, then an unsuccessful medication abortion and finally a surgical abortion.

Adolescent girls are equally denied family planning services on account of their age and marital status. Given the high number of teenagers engaged in sexual activities, including through child marriage, access to family planning and other *sexual and reproductive health and rights* is cardinal to prevent unwanted pregnancies and resultant abortions.[104]

Third, and closely related to the issue of stigma and discrimination, is women's low socio-economic status. Women's fertility preference is influenced by cultural and financial factors, among others. Existing data shows that women in Zambia have more children than they prefer.[105] Their low socio-economic status fuels unsafe abortions in Zambia because many women cannot afford to access abortion services when they most need them. Cultural and financial factors negatively impact on women's ability to make decisions concerning their bodies and their health.[106] This is true of women in relationships dominated by inequality. For gender inequality, Freeman and others state that 'men's involvement in women's trajectories to safe or unsafe abortion mirrors inequitable power relations between genders'. Socially constructed gender roles influence men's involvement in abortion decision making at the individual level.[107] Their research finding was:[108]

> Six respondents reported that men had had a strong influence on their decision to abort. A few of these women reported that the suggestion to abort had been a man's but felt the decision was the right one; others reported that a partner or male family member had taken the decision away from them altogether. For example, when 15 year-old Precious became pregnant as a result of rape by her parents' tenant, her father beat her before telling her she must abort. 'I was told there was no way that I would take care of this child … I was asked how I would finish school … My father was very upset with me.'

104 Standards and Guidelines for Comprehensive Abortion Care in Zambia (n 5).
105 GRZ & UNFPA 'Policy brief: Accelerating fertility decline in Zambia' (May 2015), www.zambia.unfpa.org/sites/default/files/pub (accessed 21 October 2021).
106 Standards and Guidelines for Comprehensive Abortion Care in Zambia (n 5).
107 Freeman and others (n 31) 95.
108 Freeman and others (n 31) 94.

Another study among adolescent girls in Lusaka demonstrates the effects of vulnerability and inequality that perpetuate women's low social standing and ultimately affects their access to CAC:[109]

> The impact of the parents in the abortion decision process was dual. Either the girls had an unsafe abortion done in secrecy because of fear of their parents' reaction or they were assisted by their parents to have an abortion to alleviate the social shame and the financial burden on the family. The greatest fear among 28 unmarried girls (82%) was the risk of being thrown out of the family or to increase poverty with one more unexpected family member and earning a bad reputation in the neighbourhood.

The high prevalence of unsafe abortions being conducted in secret does not only affect the women involved. It negatively impacts of public health interventions as it allows a parallel underground 'health system for abortions' to flourish at the expense of women's health rights. Women with a low socio-economic status are susceptible to unsafe abortion as they worry about their ability to provide for the unborn child. Some families facilitate the termination of pregnancy of women and adolescent girls on account of the expectant mother's age, physical or mental disability[110] or HIV status.[111] An unmarried woman may also not want to carry a pregnancy to term if the man responsible for the pregnancy is unwilling to marry her or provide support for it.[112] The pregnancy may be terminated, not because it is unwanted, but because the expectant mother does not want to raise the child as an unmarried single parent. Women thus may subject themselves to unsafe abortions to conform to financial situations and societal expectations. Dahlback and others write:[113]

> Partner-related factors play a decisive role in the final decision-making process to have an abortion. Five partners (15%) in the induced abortion group abandoned their girlfriends when they got to know she was pregnant and eleven partners (32%) denied paternity, claiming that the child was not his or blaming the girl

109 Dalhback and others (n 102).

110 'Zambia: Sexual, reproductive health rights for women with disabilities' *Times of Africa* 26 July 2021, https://allafrica.com/stories/202107260291.html (accessed 14 October 2021).

111 AM Moore and others 'Attitudes of women and men living with HIV and their healthcare providers towards pregnancy and abortion by HIV-positive women in Nigeria and Zambia' (2015) 14 *African Journal for AIDS Research* 29, http://www.pubmed.ncbi.nlm.nih.gov (accessed 14 October 2021).

112 Dahlback and others (n 102).

113 As above.

> for unfaithfulness and requesting that she should abort. They also refused both financial, emotional responsibility and support for the mother and child. Two partners and their families accused the pregnant girl of trying to 'trap' the man to force him to marry her and provide for her and the child's future. Seven (21%) of the partners made the decisions, made the arrangements, accompanied their girlfriends and paid to have the unsafe abortion procedure done.

In other cases, women may want to change their low socio-economic status or ensure that a high socio-economic status is not affected by an unexpected pregnancy. Evidence of this abounds of women aborting in order to pursue an education. An unexpected pregnancy interferes with one's educational plans and the majority of schoolgoing women resort to clandestine abortions.[114]

Fourth, the high cost of a safe abortion in both public and private hospitals is a barrier to access for many women.[115] Some public hospitals charge user fees for abortion services which they advertise as free. Moore and others in their research study found that a schoolgoing young woman borrowed an equivalent of US $23 for abortion-related expenses as she did not have disposable income.[116] They narrated another participant's experience as follows:[117]

> One low SES respondent who paid for the abortion herself related how costs impacted her choice. She originally went to a chemist to try to obtain an MA [medical abortion], but didn't have the money it cost so she went to a traditional healer to terminate the pregnancy. The traditional healer was willing to sell her medicine for less than the chemist, and performed a procedure with sticks and cotton balls, causing severe complications.

Demonstrating another consequence of the lack of finances for an abortion procedure, one participant from the study by Moore and others al stated: 'But I have been looking for the money which has been so hard to find, which I just found. [The procedure] should [have been] last week. [I was only able to get the procedure] after it had already grown and everything.'[118]

The lack of finances negatively impacts on abortion choice and timely access to services, risking the woman's life and health. Women

114 As above.
115 Cresswell (n 38).
116 Moore and others (n 111).
117 As above.
118 As above.

who do not have a support system to help meet the financial costs are disproportionately affected:

> It was more common among women getting TOP [termination of pregnancy] (compared to those who had CUA) [care for unsafe abortions] for her, the husband, a relative, or a friend to borrow money or sell items to provide funds to pay for the abortion ... Some respondents reported borrowing money from someone who was wealthy enough to provide a loan. In some of these situations, the amount borrowed was beyond what the respondent felt she could ever pay back, leaving her and sometimes her family in a cycle of debt.

Women who cannot overcome the logistical, financial or social barriers to obtaining safe abortion may resort to illegal abortion, irrespective of the criminal sanction.[119] Desperation prompts many vulnerable women to consume detergents, or gasoline and other toxic substances to induce abortions and this carries a great risk of mortality and severe morbidity.[120]

Given all the experiences of women discussed in this part, a discussion on a women-centred paradigm for CAC in Zambia is necessary. The next part discusses events in Zambia that led to the enactment of the TOPA, how they failed to take a women-centred approach and what a women-centred approach can mitigate women's negative experiences of accessing abortion procedures.

5 A case for a women-centred approach to abortion services in Zambia

The motivation to enact a law on abortion in Zambia came at a time when the daughter of a prominent government minister died following an abortion procedure undertaken by a physician. This incident attracted public uproar and pressure for ensuring justice for the loss of life.[121] As there were no legal regulations for abortion at the time, the physician who performed the procedure was charged with and prosecuted for manslaughter.[122] In the same year, the Zambian Parliament was prompted to enact a law that regulated access to abortion services.

119 Kalifungwa (n 39).
120 MA Castle and others 'Observations on abortion in Zambia' (July-August 1990) 21 *Studies in Family Planning* 231.
121 Kangwa (n 2).
122 See the case of *The People v Bwanausi* (1976) ZR 103.

The approach taken by the TOPA, therefore, was not influenced by women's needs or human rights, but the need to curtail a repeat of loss of life at the hand of one physician.

5.1 Conceptualising a women-centred approach to abortion services

The experiences of women in Zambia discussed in the previous part reveal that many women with unintended pregnancies resort to safe and unsafe abortions depending on the woman's relationship with her sexual partner and family, her economic situation and access to resources, her desire to complete her education, her fertility preference, her health status and access to medical care. These experiences must be borne in mind when crafting, implementing, reviewing and evaluating regulations. It should be noted that Zambia has a hybrid regulatory framework that encompasses a stand-alone termination of pregnancy legislation and various laws and policies that may impact of women's access to CAC. As noted earlier, a women-centred approach requires that women's will and preferences are considered when responding to their individual abortion-related needs. Women's will and preferences are respected when they are able to make decisions concerning their bodies and health. A women-centred approach also requires that women have access to CAC and related services which is of high quality. Thus, to use the women-centred approach to examine laws, policies and protocols (referred to as regulation or regulations) the following considerations should be noted.[123]

With regard to the exercise of choice, regulations must be reviewed to ascertain if they create a conducive environment for women to exercise choice including their right and opportunity to select among options for abortion goods and services. Thus, restricting grounds upon which abortions could be undertaken limits women's choices. Grounds for limiting women's choices must be clearly stated in regulations, indicating who has the power to limit choice and a legitimate purpose in accordance with established constitutional principles for limitation of

123 Adapted from Hyman & Kumar (n 7).

rights.[124] Regulations must also be evaluated to determine the extent to which they criminalise women's abortion choices and bodily autonomy, with the view of decriminalisation. Considering that the majority of women in need of abortion services have different vulnerabilities that may negatively impact on their ability to exercise choice, regulations must promote and protect informed and supported decision making. Further, regulations must address exploitative and coercive practices that have the effect of limiting women's choices.

Regarding access to CAC, regulations must mandate the availability of technically competent health providers, the availability of equipment and the use of appropriate clinical technologies.[125] Public and private healthcare providers must be targeted for training considering that many healthcare providers in rural Zambia are private providers. This will enhance women's access to services and advance the goals of the National Health Policy which are models of primary healthcare services as being provided close to communities. Regulations must, therefore, also facilitate partnerships between state and non-state actors and ensure effective coordination in the provision of CAC. Regulations must further provide for free CAC, including emergency services to encourage women's uptake of services. The free CAC could be attained through public funds reserved for vulnerable women under laws that promote their free access to healthcare services through the national health insurance scheme, mental health and gender-based violence. Alternatively, regulations could provide for a fund specifically for CAC. Regulations must also empower health administrators and policy makers to ensure long-term sustainability of abortion services by periodically engaging with users on their experience of services and devising home-grown community-based solutions to challenges they experience in service delivery. Health information management systems and policies must expressly identify barriers to CAC and community-based responses, ensuring that women are at the centre of community engagement programmes.

Regarding access to quality abolition services, regulations must be aware of women's intersectionalities and be inclusive in their programming. They must ensure that minority groups of women

124 In Zambia, *Christine Mulundika & 7 Others v The People* SCZ Judgment 25 of 1995 [1996] ZMSC 26 is instructive.

125 Brookman-Amissah (n 8).

also have access to appropriate information, counselling and other services that meet their needs. Regulations must also provide for the use of evolving medical technologies for abortion services and family planning. Further, regulations that provide for integration and linkages of abortion services to other family planning and healthcare services must not mandate women to access abortion or family planning services only if they undertake the other healthcare services. This limits their choices and imposes barriers to access to services. Healthcare providers in this case must be mandated to create a conducive environment for women to express their fears on available services and engage them on the importance on integration programmes in a non-discriminatory and respectful manner. Regulations must also provide for grievance procedures for health-related violations women experience when accessing *sexual and reproductive health and rights*.

This criterion may be adapted to the different regulations depending on the objectives of the individual regulation. For example, considerations on quality of service may not be relevant in examining the criminal provisions on abortion under the Zambian Penal Code and, therefore, may not be considered.

6 Conclusion

This chapter has illustrated that women's vulnerability and inequality expose them to unplanned pregnancies and abortions. The regulatory response in Zambia is inadequate to address women's situations and guarantee the enjoyment of sexual and reproductive health rights, including access to CAC. If anything, it contributes to women's vulnerability to human rights violations. Women's abortion experiences attest to violations of their rights to life, bodily autonomy, privacy, equality and freedom from inhuman, cruel and degrading treatment, among others. The criminal law paradigm for regulating abortion imported into Zambia by the British colonialists has long outlived its usefulness, especially in that it has driven Zambia's legislative approach to abortion for so many years and yet not had any positive impact for Zambia. The high numbers of abortions in the country coupled with the heavy financial, health and other social burdens of unsafe abortions prove the ineffectiveness of the criminal approach to abortion. It is a misnomer to classify Zambia's abortion laws as liberal when they stifle choice and legitimise barriers to CAC.

An examination of women's abortion experiences as well as the regulatory framework for abortion in Zambia indicate that women's access to CAC is suffocated by women's vulnerability, the inequality to which they are exposed and an ineffective legal approach to abortion services. While acknowledging that a multi-faceted and inclusive women-centred approach is necessary to holistically address the underlying problems, the need for addressing the law's ineffective approach and its role in choking women's access to CAC cannot be overstated. In this regard, the law's ineffective approach may be rectified by taking a women-centred regulatory approach that ensures that choice, access and quality CAC services replace vulnerability and inequality and become the three-strand cord that fosters the required paradigm shift.

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