



Community Perspectives on Unsafe Abortion and Postabortion Care

Bulawayo and Hwange Districts, Zimbabwe

By

Susan Settergren
Research Triangle Institute

Cont Mhlanga
Amakhosi Theatre Group

Joyce Mpofu
Amakhosi Theatre Group

Dennis Ncube
Amakhosi Theatre Group

Cynthia Woodsong
Research Triangle Institute

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Abbreviations

CBD	Community-based distribution
NGOs	Nongovernmental organizations
MP	Member of Parliament
PAC	Postabortion care
USAID	United States Agency for International Development



Notes

This project was implemented under the POLICY Project and funded by USAID through the Regional Initiative on Postabortion Care (PAC) for East and Southern Africa. The initiative, led by USAID's Regional Economic Development Support Office for East and Southern Africa (REDSO/ESA), USAID's Bureau for Africa, and the POLICY Project, aims to reduce the number and consequences of unsafe abortion by raising awareness and promoting dialogue about PAC and improving strategies for delivering PAC services.

The authors wish to thank the members of the communities in Zimbabwe who participated in this study and who are working together to address the problems of unsafe abortion. We also wish to thank the entire Amakhosi PAC Project team for its excellent work and dedication to the project: the cast and production crew of *Don't - Ungaqali*, the community presenters in Bulawayo and Hwange, the staff of Amakhosi Township Square Cultural Centre, and core project team members, Tula Dlamini, Styx Mhlanga, Nontokozo Mlotshwa, Andrew Moyo, Evelyn Muchirahondo, Godfrey Ncube, Ndumiso Ncube, Primrose Ncube, William Nyandoro, Fortune Ruzungunde, Pedzisayi Sithole, Mvuthu Cultural Group, and On The Road Performing Arts.

For additional information about this project or the Regional PAC Initiative, please contact:

Cont Mhlanga
Amakhosi Theatre Group
P.O. Box 7030
Mzilikazi
Bulawayo, Zimbabwe
Phone: 263-9-62652
Fax: 263-9-77412
Email: amakhosi@telconet.co.zw

Susan Settergren
Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC USA 27709
Phone: 1-919-541-6396
Fax: 1-919-541-6621
Email: sks@rti.org



Executive Summary

Postabortion care (PAC) is a widely accepted public health strategy to reduce maternal mortality and morbidity from unsafe abortion, and prevent repeat abortion, through three specific components of health care for women with abortion complications:

- emergency treatment services for complications of spontaneous or unsafely induced abortion;
- effective postabortion family planning counseling and services to prevent repeat abortion; and,
- links between postabortion emergency treatment services and comprehensive reproductive health care.

Most program efforts approach PAC from the service delivery perspective, with emphasis on operations research, training of service providers, and service delivery strategies. Little attention has been paid to the broader environment in which PAC services are offered. In particular, the role of the community in postabortion care has not been explored. Information on community perspectives, such as knowledge and attitudes about unsafe abortion and health-seeking behavior among those who experience complications of abortion, are sorely lacking. Yet, such information is critical for designing client-oriented services that will have maximum impact on reducing morbidity and mortality, and breaking the cycle of repeat abortion.

In this age of scarce health care resources, communities are being called upon to play a more active role in tackling health problems, including those arising from unsafe abortion. Yet, only limited information is available on how communities view that role and what they believe they can do.

Difficulty in collecting information on community perspectives on abortion is one of the reasons that research in this area has been overlooked. Traditional methods of data collection, such as surveys, have proved inadequate to gather valid data on this sensitive topic. The illegality of abortion and the social stigma attached to it contribute to peoples' reluctance to provide information to researchers.

However, in 1997, Amakhosi Theatre Group, a leading professional theatre company in Zimbabwe, produced a play on adolescent pregnancy and unsafe abortion that generated much audience participation. Audiences who previewed performances of the play commented freely on the issues presented in the play in discussions following the performances. They also recommended that the play be shown to others to promote dialogue.

Recognizing the potential of the play as a research and dialogue tool, the POLICY Project and Amakhosi Theatre Group undertook a collaborative study that uses the play and techniques of "Theatre for Community Action" to gather information from communities on unsafe abortion and postabortion care. This report describes the study and its findings.

Methodology

During November and December 1998, Amakhosi Theatre Group staged a series of performances of the drama, *Don't - Ungaqali*, in Matebeleland North Province. The 45-minute play, performed by a cast of 13 professional actors, uses a combination of drama, music and comedy to tell the story of a young teenage couple pressured by friends to engage in sex. The girl, who becomes pregnant, is abandoned by her boyfriend when he learns of her condition. Both are thrown out of their homes by their parents. With few alternatives, the boy runs away to South Africa and the girl takes up residence with a professional sex worker who advises and arranges for her to have an abortion. The abortion is performed by a *nyanga*, or traditional healer, who provides the girl with some *muti*, or herbal medicine. The girl aborts, but suffers serious complications. Her parents learn of the situation. Her mother arranges to take her to hospital, while her father concentrates on the arrest of the *nyanga*. The girl survives, but suffers irreparable damage, and will never be able to bear children. The play concludes with a statement to the audience by the mother, warning about the dangers of unsafe abortion. She also advises that if a woman experiences complications from an abortion, she should receive immediate medical attention and family planning counseling.

Performances were held in nine rural and urban locations in Hwange and Bulawayo Districts. Following each performance, the audience was invited to stay for a discussion of the issues raised by the play. The author of the play and a public health nurse led the discussions while two researchers documented what was said.

Altogether, approximately 2,500 people attended the performances. Post-performance discussions ranged in size from 18 to over 100 participants. Efforts to recruit members of specific stakeholder groups to the performances and discussions were successful. Participants included elected city officials, traditional chiefs, health care professionals, traditional healers, teachers and education administrators, clergy and religious leaders, police, court magistrates, business leaders, military officials, representatives of national- and community-level nongovernmental organizations (NGOs) and civil society organizations, and community members-at-large.

Researchers also conducted key informant interviews with representatives of these stakeholder groups before and after the performances. Fifty-three interviews were conducted with 61 informants. Most, but not all interviewees also attended a performance.

Results

The primary objective of the analysis was to document the full range of responses that were expressed. Highlights of the respondents' perspectives are summarized below.

- Abortion is a well-known problem, although most abortions are done secretly. It's often only when someone dies or gets sick that the problem becomes known. Sources of information about the size of the problem are both personal and public: through rumors, through personal observation, in health care and social services settings, and in the media. Infanticide is sometimes associated with abortion. Comments on specific infanticide incidents suggest these are publicized in the media and discussed throughout the community.
- Young girls are at highest risk of unwanted pregnancy and unsafe abortion. However, women of all ages induce abortions. Older women who induce abortions are often married women who have become pregnant from extramarital affairs.
- Causes of unwanted pregnancy are many. They include economic hardship that leads to sex for income, poor parenting, ignorance about sex and reproductive health, early physical maturity and experimentation with sex, promiscuity, unprotected sex, peer pressure to have sex, shift from traditional to modern societal values, inaccessibility of contraceptives, women's lack of control of their sexuality, inadequate family accommodation, boys and men cheating girls into having sex by promising marriage, and lack of respect between a man and woman.
- Men's denial of responsibility for the pregnancy and fear of family members finding out about the pregnancy are major causes for abortion.
- Abortions are obtained from a variety of sources, including traditional healers, community members (often female elders), and medical doctors. They also are self-induced with assistance from friends and other community members. Most abortionists are unskilled, although some are more qualified than others. Abortion methods used outside the formal health care system include oral administration of traditional medicine or herbs, overdoses of malaria tablets or contraceptive pills, and inserting knitting needles or roots into the vagina.
- Women who experience spontaneous abortion seek medical attention although they are sometimes unaware that they are aborting. They are treated respectfully by nurses and doctors, although difficulty in determining whether a client is suffering from complications of induced or spontaneous abortion may affect the quality of treatment that is given. Traditional healers also provide treatment for spontaneous abortion.

- Girls and women who experience complications of induced abortion often delay or do not seek medical treatment. Fear of being reported to the police by clinic or hospital staff, fear of harsh treatment and exposure by nurses, and fear of parents' reactions are the primary reasons for avoiding medical attention. Other reasons include financial constraints, difficulty with transport, and "mild" symptoms.
- The law requires health care facilities to report abortion cases to the police. However, the practice of reporting appears to vary among service delivery sites and individuals. Parents and community members also report cases to authorities. Frequently, they file these reports because they are concerned with arresting the abortionist.
- Nurses' attitudes and behavior toward postabortion clients have an impact on client decisions to seek care. In particular, community members are concerned about gossip, harsh treatment, and unfriendliness to youth. On the other hand, nurses are often frustrated by the client's failure to explain the reason for her condition and delay in seeking treatment until complications are severe.
- Community dialogue and mobilization are needed to solve the problems of unwanted pregnancy and unsafe abortion. Recommended actions include: sensitize and educate on the dangers of unsafe abortion, the need for prompt medical attention for complications, and PAC; encourage church attendance and dialogue at church on unsafe abortion; establish and support programs for youth; facilitate networking among community organizations and families; engage elected officials and politicians; and, improve and expand PAC services.
- Better parenting would reduce the problems of unwanted pregnancy and unsafe abortion. Parents should provide more support to their children, improve parent-child communication, teach their children about sex, exercise more discipline over their children, and be better role models. Sex education, with a focus on abstinence, should be taught in schools.
- Legalization of abortion is a controversial issue. Some community members support legalization, believing it would reduce the incidence of unsafe abortion and its consequences. Others are opposed to legalization or support stricter penalties and law enforcement, believing that legalization would promote prostitution, encourage abortions, and increase mortality.

- Family planning helps to prevent unwanted pregnancy, but there are constraints. Since the government began selling contraceptives at higher prices, people can no longer afford them. Also, many people are concerned about side effects. Youth have limited access to family planning services, and opinions are mixed with regard to whether or not they should have better access.

Conclusions

Community members in Zimbabwe view the issue of unsafe abortion from a broad perspective that includes family, community, and societal dimensions. This perspective focuses on prevention of unwanted pregnancy and abortion. Although community members generally support the concept of PAC services, those in need of these services often do not seek them because of fears of legal prosecution, and harsh treatment and exposure by nurses.

In order to increase the use of PAC services among those who need them, quality of care needs to be improved and improvements need to be defined from a client perspective. This task, however, is not straightforward. Offering clients the confidentiality, support and counseling that they want, for example, could create for some service providers a dilemma arising from conflicts in their moral and professional values. Furthermore, improving the quality of services from a client perspective is not enough. Community perceptions of services also have to change in order to increase the use of PAC services. This, too, presents challenges because many members of the community think confidential and supportive treatment of clients would lead to an increase in the incidence of abortion.

Community perspectives also raise issues about the PAC strategy of providing family planning services at the time of emergency treatment for abortion complications. Many community members commented on family planning. These comments were both supportive and critical. Family planning was not necessarily considered the best approach to prevention of unwanted pregnancy and abortion. A particular challenge for postabortion family planning services is the legal restriction on, and community opposition to, provision of contraceptives to youth. In Zimbabwe, the family planning policy restricts provision of contraceptives to those 16 years of age and older. Thus, contraceptives are unavailable at the time of emergency treatment to those at highest risk of unsafe abortion.

Improving PAC services from the client perspective would go a long way toward strengthening the impact of PAC on morbidity, mortality, and repeat abortion. But, more than provision of high quality PAC services is needed to curb the problem of unsafe abortion. Community members are motivated to act and have specific ideas about what needs to be done. The health community can strengthen its role by improving its links with the community. Specifically, health managers need to listen to the community, educate the community, and partner with the community.



Background

The study described in this report was undertaken to enhance understanding of the role of communities in preventing unsafe abortion and in improving postabortion care (PAC) services.¹ PAC is a widely accepted public health strategy to reduce maternal mortality and morbidity from unsafe abortion, and prevent repeat abortion, through three specific components of health care for women with abortion complications:

- emergency treatment services for complications of spontaneous or unsafely induced abortion;
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Most program efforts approach PAC from the service delivery perspective, with emphasis on operations research, training of service providers, and service delivery strategies. Little attention has been paid to the broader environment in which PAC services are offered. In particular, the role of the community in postabortion care has not been explored. Information on community perspectives, such as knowledge and attitudes about unsafe abortion and health-seeking behavior among those who experience complications of abortion, are sorely lacking. Yet, such information is critical for designing client-oriented services that will have maximum impact on reducing morbidity and mortality, and breaking the cycle of repeat abortion.

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Difficulty in collecting information on community perspectives on abortion is one of the reasons that research in this area has been overlooked. Traditional methods of data collection, such as surveys, have proved inadequate to gather valid data on this

¹ This study was conducted by the POLICY Project, a 5-year project funded by USAID under Contract No. CCP-00-95-00023-04, beginning September 1, 1995. It is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and the Centre for Development and Population Activities (CEDPA).

sensitive topic. The illegality of abortion² and the social stigma attached to it contribute to peoples' reluctance to provide information to researchers. However, in 1997, Amakhosi Theatre Group, a leading professional theatre company in Zimbabwe, produced a play on adolescent pregnancy and unsafe abortion that generated much audience participation. Audiences who previewed performances of the play, titled, *Don't - Ungaqali*,^{3 4} commented freely on the issues presented in the play in discussions following the performances. They also recommended that the play be shown to others to promote dialogue.

Recognizing the potential of the play as a research and dialogue tool, the POLICY Project and Amakhosi Theatre Group undertook a collaborative study that uses the play and techniques of "Theatre for Community Action"⁵ to gather information from communities on unsafe abortion and postabortion care. This report describes the study and its findings.

² Abortion is illegal in most African countries. In Zimbabwe, abortion is permitted only to save the life of the mother, to preserve physical health, in cases of rape or incest, and in cases of fetal impairment.

³ The University of Zimbabwe Medical Library commissioned Cont Mhlanga, Artistic Director of Amakhosi Theatre Group, to write and produce the play. The Library, through support from the USAID-funded Support to Analysis and Research in Africa (SARA) Project, had established a Task Force on Unsafe Abortion and the play was one of its featured advocacy activities. It premiered in Harare in April 1997.

⁴ The play is based on Amakhosi's community research on unsafe abortion and the policy guidelines published by the Commonwealth Regional Health Community Secretariat in conjunction with the "Monograph on Complications of Unsafe Abortion in Africa," by Kinoti, S., L. Gaffikin, J. Benson and L. Nicholson. Arusha: Community Regional Health Secretariat, 1995.

⁵ "Theatre for Community Action" is term created by this project to describe an advocacy methodology that uses methods of social theatre to mobilize communities. This methodology was developed, applied, and tested in the project. A forthcoming report and videotape will document the impact of the methodology on community responses to unsafe abortion and PAC services. A forthcoming guide to "Theatre for Community Action" will describe in more detail the methodology and lessons learned.



Methodology



Overview of the Study Design

During November and December 1998, Amakhosi Theatre Group staged a series of performances of the drama, *Don't - Ungaqali*, in Matebeleland North Province. Some performances were by invitation and others were open to the general public. For each performance, the project team recruited a recognized leader within the local community to help promote the performance and present the play to the audience.

The 45-minute play, performed by a cast of 13 professional actors, uses a combination of drama, music and comedy to tell the story of a young teenage couple pressured by friends to engage in sex. The girl, who becomes pregnant, is abandoned by her boyfriend when he learns of her condition. Both are thrown out of their homes by their parents. With few alternatives, the boy runs away to South Africa and the girl takes up residence with a professional sex worker who advises and arranges for her to have an abortion. The abortion is performed by a *nyanga*, or traditional healer, who provides the girl with some *muti*, or herbal medicine. The girl aborts, but suffers serious complications. Her parents learn of the situation. Her mother arranges to take her to hospital, while her father concentrates on the arrest of the *nyanga*. The girl survives, but suffers irreparable damage, and will never be able to bear children. The play concludes with a statement to the audience by the mother, warning against the dangers of unsafe abortion. She also advises that if a woman does have an abortion and gets sick, she should receive immediate medical attention and family planning counseling.

Following each performance, the local presenter invited the audience to stay for a discussion of the issues raised by the play. The author of the play and a public health nurse led the discussions, following a semi-structured discussion guide that was developed from the research questions (see next section below). Two researchers trained in qualitative data collection methods documented the discussions by means of written notes and audiotape. Some of the performance discussions also were videotaped.

The researchers also conducted key informant interviews with selected community members before and after the performances. These interviews were conducted using a pre-tested interview protocol and guide that were constructed from the research questions.



Research Questions

The following research questions guided the data collection from post-performance discussions and key informant interviews. They also provide the framework for this analysis.

- What is the perception of the **magnitude of the problem** of unwanted pregnancy and abortion? Who is affected?
- What **causes** unwanted pregnancy and abortion?
- What does a woman do if she has an unwanted pregnancy or seeks an abortion? What **abortion methods** are practiced, and by whom?
- What do people do if **abortion complications** occur? Do they understand the urgency for treatment? What do communities know about PAC services?
- What services are available for treatment of complications? Are they adequate? How widely used are they? What are the constraints? What **PAC services** do communities want?
- What do communities think are appropriate **strategies** for addressing unwanted pregnancy and unsafe abortion? What actions can they (or are they willing to) take? How much of an impact can this have on reducing abortion rates, on reducing maternal mortality and morbidity, and on improving other aspects of the community?



Community Selection

Performances and data collection were undertaken at nine rural and urban locations in Hwange and Bulawayo Districts in Matebeleland North. These two districts were selected on the basis of (1) Amakhosi's geographic proximity to them, and (2) the socioeconomic diversity within the province that they represent. Bulawayo city is the provincial capital and urban center with a more developed health infrastructure. Hwange, some 300 km away, is an isolated, rural area with limited health facilities. Mpilo Hospital, the provincial hospital in Bulawayo, is an important referral hospital for emergency PAC cases from Hwange and surrounding areas.

The data collection made no attempt to represent the perspectives of all Zimbabweans. In fact, respondents are not necessarily representative of persons residing in the two districts. The results, therefore, represent only the viewpoints of those community members who participated in post-performance discussions and those key informants who were recruited for interviews.



Performance Attendance and Discussions

In total, nine performances were staged, as described in Table 1 below. Two types of audiences were recruited: community leaders (3 performances) and the general public (6 performances). Altogether, approximately 2,500 people attended at least one performance.⁶

Table 1. Summary of Performances

Audience	Attendance	Location	Date
District and city leaders seminar- by personal invitation (Bulawayo)	18 (6 men, 12 women)	Bulawayo City Hall	19 Nov 98
District leaders seminar- by personal invitation (Hwange)	60-70 (40% women)	Baobab Hotel, Hwange town	3 Dec 98
Provincial leaders seminar- by personal invitation (Bulawayo)	21 (14 men, 7 women)	Bulawayo City Hall	12 Dec 98
Luveve Township- general community (Bulawayo)	450-500	Luveve Hall	19 Nov 98
Pumula Township- general community (Bulawayo)	400-450 (50% young adults, 25% older adults, 25% children) Discussion: 70	Pumula Hall	20 Nov 98
Bulawayo city- general public (Bulawayo)	300-350 (20% adults, 30% youth, 50% children) Discussion: 100+	Amakhosi Township Square	22 Nov 98
Lwendulu community (Hwange)	600-700 (350 men, 150 women, 200+ youth and children) Discussion: 100 (20% women of all ages, 20% male adults, 60% male youth)	Lwendulu Compound Hall	4 Dec 98

⁶ Attendance at larger performances was estimated jointly by the researchers and local ushers who were assigned this task.

Audience	Attendance	Location	Date
Mpumalanga Township (Hwange)	500-600 (60% young adults, 20% adults, 20% children; 50% female) Note: only informal discussions were held following the performance.	Negasha Stadium	5 Dec 98
Ndlovu- Jambesi rural area (Hwange)	350-400	Chibombo Primary School	6 Dec 98

The three performances for community leaders were by personal invitation. Attendance ranged from 18 to 70 persons. Two of those performances were held for district leaders. These were scheduled prior to the public performances in the districts. Many leaders also attended a subsequent public performance. Almost all leaders in attendance stayed for the post-performance discussions.

A broad range of community leaders and members at large attended the public performances. Audience sizes ranged from 300 to 700 persons with representatives of all ages and a fairly balanced proportion of males and females. Unlike the leaders' performances, children and youth made up a significant proportion of these audiences. Post-performance discussion groups ranged in size from 50 to over 100 and comprised adults and youth.

In Zimbabwe, as in most African countries, two streams of influence bear on the decision-making process and health attitudes and behavior of communities: the traditional system and the official government system. Attempts were made to engage stakeholders from both systems in post-performance discussions and in key informant interviews. At the start of the project, researchers developed a contact list of important stakeholder groups from both traditional and official government spheres. With assistance from the local presenters, the project team then used the list to identify individuals within those groups who would be contacted, encouraged to attend performances and participate in post-performance discussions, and recruited for interviews.

Audience attendees included elected city officials (e.g., mayors, councilors), traditional chiefs, health care professionals, traditional healers, teachers and education administrators, clergy and religious leaders, police, magistrates, business leaders, military officials, representatives of national- and community-level NGOs and civil society organizations, and community members-at-large.

The researchers documented what the presenter said to the audience,⁷ questions and statements from the audience, and observations on audience behavior, including group size, composition, participation, and dynamics. Whether a comment was spontaneously raised or prompted was noted. Interviews and post-performance discussions were conducted in Ndebele or in English, depending on the language preferred by the respondents. The researchers, who were conversant in both languages, prepared notes in English. After each performance the research team debriefed with the presenter, discussion leaders, actors and videographer to document their reactions and comments about the performance and discussion.



Key Informant Interviews

Two researchers individually conducted a total of 53 interviews with 61 key informants: 28 in Bulawayo District and 25 in Hwange District. Seven of these interviews were conducted as small group interviews with 2 or 3 persons simultaneously. This situation typically arose when an interview was conducted just prior to a performance and the recruited interviewee was accompanied by one or two friends or relatives. The other 46 interviews were conducted one-on-one. Twenty-five interviewees were women and 36 were men.

Researchers began the interview process with individuals from the contact list that was developed at the start of the project. Once interviewing began within a community, researchers used a “snowball approach” to identify additional individuals; that is, interviewees were asked to suggest additional persons who should be interviewed. An attempt was made to interview representatives from all stakeholder groups that were included on the contact list. All of those who were approached agreed to an interview.

Most interviews were held at the performance venue prior to the performance. However, several were conducted either in the interviewee’s home or office several days prior to the performance, or immediately following the performance. Most, but not all interviewees also attended a performance. Interviews ranged in duration from 15 minutes to one hour. Interviewers followed a standardized, semi-structured interview protocol, but did not necessarily ask all questions of each informant. Topics that were of particular interest or relevance to an informant were explored in more depth. Some interviews were limited in time by the respondents’ availability. The types and numbers of key informants who were interviewed are summarized below in Table 2.

⁷ Not all research questions were addressed with every audience. Discussions were open-ended and were allowed to follow participants’ dialogue.

Table 2. Summary of Key Informants

Key informant	Bulawayo District	Hwange District
Clergy	1	2
Health care provider	8	7
Community member at large	3	3
Residents' association member	6	-
Army official	2	2
Traditional healer	2	2
Traditional chief	2	4
City official/civic leader	2	1
Teacher/principal	3	3
Social services worker: Government, NGO	2	2
Magistrate	-	1
Business owner	-	1
Police	1	-
Lawyer	1	-
Total number of persons	33	28



Data Analysis

Researchers keyed all post-performance discussion and interview notes into electronic word processing files so the data could be easily manipulated during analysis. The analysis team then coded and grouped the contents of the files according to the research questions. The full array of responses to each question was detailed and the number of occurrences was tallied. Although it was possible for an individual's response to get counted twice, through an interview and a comment in a post-performance discussion, an informal check revealed that this occurred rarely. Also, responses in the post-performance discussions were not made independently of one another. Audience members typically responded in terms of prior comments. The primary objective of the analysis was to document and summarize the full range of responses. Therefore, responses were only broadly quantified, such as when a particular point of view was widely held.

Responses for Bulawayo and Hwange data were analyzed separately, as were the interview and discussion data. When no differences between the locations and types of data were found, the data were summarized collectively.



Results

Results from the post-performance discussions and key informant interviews are presented below by research question. The views expressed are those of the respondents. They do not necessarily represent those of the authors or the funding agency.



Magnitude of the Problem

Knowledge of the incidence of abortion

"The problem of abortions is a well known fact in the communities, even if they're done in secrecy." - *Female residents' association member*

The majority of key informants (75%) referred to the magnitude of the problem of abortion. Among those, almost everyone acknowledged that it is a big problem in her/his community and cited examples to support this belief. All performance audiences confirmed this perspective. Specific references to the size of the problem included:

- 2 abortions per month, 2 deaths last year - *Male CBD manager*
- "One girl died in Victoria Falls in 1994 and there are many other cases." - *Male villager*
- 2-3 deaths annually; one death so far in 1998 - *Male district councilor*
- one abortion in Ndlovu in 1998, one in 1997 - *Male kraal head*
- 4 girls died between 1984 and 1987 - *Male chief*
- at least 3 or more cases annually - *Female nurse*
- 5 abortions in 1998, 3 of whom died - *Chairman of residents' association*
- "[in Pumula] abortion has left several dead bodies in the past few years." - *Female home-based care worker*
- "... came into contact with death related to abortion this very week." - *Female community member*

Sources of information

"It takes a lot of investigations to come up with the facts." - *Male vice-principal of a teachers' college*

All those who discussed the size of the problem of abortion referred to the difficulty in knowing its prevalence because it is done in secret. Many mentioned that it's only when someone dies or gets sick that the problem becomes known. The following comment demonstrates how the problem remains hidden:

"I am not aware of any abortions in the whole area under my chieftain and there is nothing I can say or do about it. There is no way I can know [of abortion]. All I know is what people report to me. They do not tell me of such matters. Since I am the chief, I am the eye of the government. So people believe if they report to me, I will tell the police. All I know and am aware of is what I am told by the people. Abortion is a new thing to me." - *Male traditional chief*

Several other informants shared the view that abortion is not a big problem. In Hwange, one informant said that it used to be a problem, but it has decreased. Three others said the problem in Hwange is not as big as in other areas of Zimbabwe or the world, but acknowledged that unwanted pregnancy is a significant problem. Another woman stated that abortion is not widely practiced because "children marry at a young age." A woman in Bulawayo said she couldn't say how big the problem is because she has "not seen much of it around her."

Sources of information about the size of the problem were both personal and public, and included the following:

- Through personal communication and rumors
- Through personal observation: "You can tell if one is pregnant, then you hear she is sick with a stomach problem. They say it's malaria. After a while you see her okay, but without the pregnancy." - *Male villager*
- In the health care and social services environment: "If you are working in health institutions you discover that there is a lot of unsafe abortion." - *Female nurse*
- Articles in newspapers and on radio programmes
- Community and professional forums on women's rights and reproductive health.

Infanticide

"Two girls in the villages 26 and 36 in 1997 gave birth and dumped their babies. The first girl just dumped the baby in the bush and ran to Vic Falls. The second girl at the age of 18 gave birth in the river and dug a hole under the sand. She buried the corpse and went to her home. On arrival, her parents saw her breasts producing milk and they were aware of what happened. They reported the girl to the police and she was arrested." - *Rural woman*

Several key informants in both Bulawayo and Hwange mentioned specific incidents of "baby dumping," or infanticide, in association with abortion. Baby dumping is described as the situation where a woman with an unwanted pregnancy delivers her baby in secret, usually "in the bush," and then abandons the baby. Key informant comments on specific incidents of baby dumping over the past several years suggest that such incidents are publicized in the media and discussed throughout the community.

Age groups at risk

"Mostly it's young girls who abort, but both young and old are affected."

- *Traditional midwife*

Consensus among key informants and performance audiences was that young girls are the ones most affected by unwanted pregnancy and unsafe abortion. There was little agreement, however, on the specific age groups at highest risk. Responses ranged from narrow (e.g., 13-14, 17-20, 16-18) to broad (e.g., under 21, 16-25, as early as 14 years) age groups.

Several respondents acknowledged (without prompting) that women of all ages are affected. Among audiences where the discussion leader asked directly about the prevalence of abortion among older women, there was strong agreement that it occurs. The most frequently cited situations were of married women who engaged in extramarital affairs. For example:

- "Older women too [get abortions]...they sleep around with other men while the husband is working in South Africa." - *Rural woman*
- "Husbands may only come home once a year and if a pregnancy occurs while they are away, the wife will abort." - *Female lawyer*

Other examples of older women who abort included sex workers and a specific case of a woman who died the previous week. She was a 30-year-old street vendor selling vegetables, a divorcee with three children who could not support the children she already had.

Several respondents acknowledged that although unwanted pregnancy and induced abortions occur among women of all ages, young unmarried women are the ones in greatest danger. One male teacher alluded to a situation where older, married women have an alternative to abortion: "the older women know [if] they are pregnant because of another man. They will make sure they sleep with their husbands and later in good time tell the man she is pregnant, and there is no way a man can know."



Causes of Unwanted Pregnancy and Abortion

Poverty and unwanted pregnancy

"Unwanted pregnancies are a result of poverty and hunger." - *Male family planning CBD worker*

In Hwange District, the most commonly cited reason (raised by one-third of key informants and in performance discussions) for unwanted pregnancy was economic hardships that lead to sex for income. Some blamed "sugar daddies"; others suggested it was the girl's or mother's fault. For example,

- "Sugar daddies cheat young children with money and then dump them when seeing that they are pregnant." - *Male social services worker*
- "Young girls roam the beer gardens looking for men to have sex with in return for money." - *Male magistrate*
- "Some, because of poverty, are sent to go and bring food to the home by mothers while young, and they get pregnant and the mother gets rid of the pregnancy, so as for her to continue to bring food." - *Man at post-performance discussion*

Other causes of unwanted pregnancy

Among Bulawayo respondents, "poverty and hunger" also was frequently cited as a reason for unwanted pregnancy, but not more frequently than some other reasons. Other causes of unwanted pregnancy cited by Hwange and Bulawayo respondents included:

(More than 10 references each)

- Lack of parental concern, teaching and guidance; poor parenting, e.g., "The parenting of today is not what it used to be. Kids are left to do whatever they choose." - *Female community member*
- Ignorance about sex and reproductive health, e.g., "[During a recent survey of Lukhosi Township] young girls said that they fall pregnant because no one talks to them about sex. They become pregnant because they do not have enough information about reproductive health." - *Female community nurse*
- Early physical maturity and experimentation with sex; indulging in sex at a young age, e.g., "Girls today are physically maturing before their time. They start experimenting with adult things like sex." - *Male church pastor*
- Promiscuity: "Unwanted pregnancies are caused by girls having many boyfriends and failing to tell who the owner of the pregnancy is." - *Female clinic nurse*

(5-10 references each)

- Carelessness, accidents, unprotected sex, e.g., "All these young girls that are walking around pregnant at 13, 14, 15 years; they are not victims of rape or incest. They are all victims of some kind of mistake." - *Beauty queen*
- Peer pressure to have sex, e.g., "It's the other girls and friends who make girls lose their way." - *Woman at post-performance discussion*
- Shift from traditional to modern societal values, e.g., "Children are no longer taught about their culture. Instead from TV they learn strange and foreign things

that have made them become wild. When an adult tries to caution them, they accuse the adult of being old fashioned." - *Male traditional healer*

(2-5 references each)

- Inaccessibility of contraceptives
- Women are not in control of their sexuality, e.g., "Family planning is left with the woman, but the decision-maker is the man. A woman has to be complacent to the man even if she has no contraception in place." - *Female social services worker*
- Inadequate family accommodation, e.g., "Long ago most married couples used to stay separate. A woman used to stay in the rural area for there were no rooms for both husband and wife in town. Therefore, men used to live in single quarters. After independence, a law allowing women and children to stay in these single quarters was set. In these single quarters, they divide the room with a curtain. So for kids to gain entry, they had to play outside till late to give space to mother and father. That is when things went wrong." - *Male social services worker*
- Boys and men cheating girls into having sex by promising marriage
- Lack of respect between a man and woman; lack of self-respect

(Single references)

- Late night parties
- Carelessness with contraceptives
- Contraceptive method failure
- Rape

Linkage between unwanted pregnancy and abortion

"First the pregnancy is unwanted and the fear of being discovered makes the girl abort." - *Male primary school teacher*

The causes given for abortion were highly linked with those cited for unwanted pregnancy. Many respondents spoke of unwanted pregnancy and abortion interchangeably, or spoke as if they assumed that unwanted pregnancy is the cause of abortion. Hence, the causes of unwanted pregnancy stated above also apply to causes of abortion. However, many made an explicit distinction between the two issues.

Denial of responsibility

"The boys responsible for pregnancies deny responsibility, leaving the girl with only one thought: to abort." - *Female residents' association member*

The most frequently cited explicit reason for abortion among both Hwange and Bulawayo respondents was denial of responsibility for the pregnancy by the boy or man. One-third of all key informants gave this as a cause of abortion. Sometimes

the blame was placed on the boys, sometimes on the girls, sometimes on others. Examples of these viewpoints include:

- "The man may disown the pregnancy, leaving the girl in a dilemma. The next best thing is for the student to get rid of the pregnancy so that nobody knows about it." - *Male school vice-principal*
- "The boy denies responsibility because the girl is always in the company of many other boys." - *Residents' association chairman*
- "They [boys] are sometimes kids, too, and have their fears. It's the responsibility that they fear." - *Female home-based care provider*
- "The boys are afraid to accept responsibility because the father will breathe fire. The girls are left on their own." - *Female community nurse*

Fear of family reactions

"When they fall pregnant they don't know what to do. They choose to abort because at home parents won't tolerate it. She knows she will be a great disappointment and bring shame to the family." - *Male social services worker*

The second most frequently cited reason for abortion was fear of parents finding out about the pregnancy and lack of support at home when a pregnancy occurs. This reason was mentioned by 10% of key informants and also discussed in several post-performance discussions.

Other reasons for abortion

Other reasons that were given for abortion included:

(1-3 references each, by frequency of occurrence)

- "Sleeping around" with married men; committing adultery
- Peer pressure and social stigma against being young and/or unmarried and pregnant
- Unemployment or becoming pregnant by someone who is not working
- Fear/difficulty of being a parent when too young or not ready
- Fear of being dropped out of school
- Conflict with life plans
- Discovering one has AIDS when one is pregnant
- Fear of being dropped by the boyfriend
- Parting ways with a boyfriend after becoming pregnant



Abortion Methods

"All kinds of people come to the scene as far as the sources of abortions are concerned." - *Male school vice-principal*

Almost everyone interviewed provided some information on who performs abortions although many references were made again to its secrecy. Most informants identified several sources of abortions.

Izinyanga

"Of course, there are some izinyanga [traditional healers] who practice abortion."
- *Male army officer*

Over half the key informants and several performance discussion participants, including izinyanga themselves, identified izinyanga, or traditional healers, as those who perform abortions. The majority of those who commented on the quality of their services were critical. Example of such comments included:

- "All they want is money." - *Female home-based care provider* (8 related references)
- "...when the izinyanga poke things, they poke in areas that have nothing to do with abortion and their things end up in the intestines or uterus." - *Male medical doctor*
- "They lie to people that they know how to perform abortions...saying they are experts when they know nothing." - *Male church pastor*.

However, several respondents commented that "some do their duty well," while several others stated "some are skilled, some aren't." There also was general acknowledgment that not all traditional healers perform abortions. Members of Zinatha, the national association of traditional healers, were interviewed and asked about the practice of abortion. All commented that it is illegal and prohibited by Zinatha.

The most frequently mentioned abortion method provided by izinyanga was oral administration of herbs, or muti (7 references). Prescription of an "overdose" and "insertion of a crochet hook" were other methods identified. One nyanga described a method for a late-term abortion, which she said was less risky than one at early stages:

"For an eight- to nine-month-old pregnancy, the method is using a certain herbal root that has the power when inserted inside a woman, to pull outward, like in sucking. In this case it pulls out the fetus. It's easy because the head will have turned and is sitting on the cervix. The root pulls from the inkanda, breaking it open, so when the baby is out it's stillborn. The woman claims misfortune and the matter is laid to rest. It is risky or impossible to use this method during early months because the baby won't be in a position that's ready for delivery."

Self-induced abortions

"The girls and their friends perform these abortions. They know what to use."

- Female urban resident

One-third of key informants and several discussion participants identified self-induced abortions as an abortion method. Various methods of self-induced abortion that were identified included:

- "Drinking malaria (or Norolon) tablets" (13 references)
- Taking an overdose of contraceptive pills (4 references)
- Inserting knitting needles into the vagina (3 references)
- Inserting roots or herbs inside herself (3 references)
- Drinking tea leaves (1 reference)

Community members

"Community elders, especially women, help these girls to abort." - *Male church pastor*

Just as frequently, respondents cited various members of the community as assisting girls to perform abortions, including "grandmothers," "mothers," "older girls," "society members," "next-door neighbors," "older prostitutes," and "don't know exactly who, just know there are a lot out there." In all cases, these people are reported to give herbs or other medicines to induce abortion. A typical example of this scenario was provided by a local township woman:

"Another girl earlier in the year aborted as well. She went to a nyanga who refused to give her any help. Her friends were given some herbs by a community elder. The girl took the herbs. In addition she took some malaria tablets. She fell seriously sick and stayed at home, until the neighbors intervened and took her to hospital. She was staying alone as a lodger."

Formal health care system

"...cannot rule out that medical doctors are doing it, because otherwise why would these girls flock to them asking for an abortion... It may be a bit safer with a doctor than a nyanga, but they are still vulnerable to infection since it's done in surgeries instead of a proper theatre setting." - *Male private medical doctor*

Many references were made by key informants and discussion participants to private doctors performing abortions. General consensus was that this method was only an option for "those who have the money to pay for it." Two respondents quoted doctors' prices for such services as Z\$600 and Z\$2,000. Most mentioned that

it is safer to go to a doctor than to a nyanga, but many noted that "even doctors are not safe."

Abortion-seeking behavior

Respondents described various scenarios about how a girl or woman goes about seeking or inducing an abortion. Several of these scenarios are presented below.

- "The girls connive to abort without the knowledge of anyone. They are normally alone when they conspire to abort. When she falls sick is the time the parents come to know of it, but they always pretend to be sick of this and that. In case the mother discovers that she is bleeding, when questioned she says she is having her periods. At this point, the mother has no reasons to suspect anything, so she lets it pass at that." - *Female villager*
- "Last year a schoolgirl came [to a traditional midwife] and asked for an abortion. It was a Monday. An arrangement was made for the girl to return on Friday. During the course of the week, her teachers were alerted and her parents were summoned. They promised to come on Friday when they were told the story of their daughter. Fortunately, the abortion was not carried out and the girl went on to give birth to a healthy baby." - *Female traditional midwife*
- "Girls may tell the izinyanga that they are only a few months pregnant, when they are actually in the fifth or sixth month. The izinyanga would perhaps not do the abortion if they knew the girl was so advanced in her pregnancy, but the girls lie to them. It is more dangerous to do an abortion at the later stages." - *Male councilor*
- "Both the boy and girl are the ones responsible [for abortion], because for the girl to abort she is [most of the times] given money by the boyfriend." - *Male police sergeant*
- "In some cases the mothers do seek nyanga services for their daughters, but this is rare. In most cases it's the girls themselves who seek these abortions without the knowledge of the parents." - *Female traditional healer*
- "Izinyanga say that AIDS may influence a nyanga to perform an abortion, since they are trying their best to help people deal with this disease. They know that a woman's health may suffer if she has AIDS and is pregnant, and there is the chance that the baby will get AIDS. Better to have an abortion and play it safe." - *Male councilor*



Health-Seeking Behavior for Abortion Complications

Spontaneous abortion

“Women who have had spontaneous abortion [or miscarriage] do urgently seek medical attention. They come complaining of bleeding, not knowing what is happening.” – *Female community health nurse*

Some key informants were asked specifically about spontaneous abortion, or miscarriage. Those who provided comments all agreed that when a woman experiences serious complications such as bleeding during pregnancy, she seeks medical attention from a clinic or hospital. Many of the health professionals who were interviewed commented, however, that many women when they arrive at the health facility are not aware that they are aborting.

Delaying or not seeking treatment for complications

“It is quite clear why young girls do not seek emergency treatment [for abortion complications]. ...When they find they can no longer hide it [the pregnancy], they decide to abort and still keep on hiding and hope that things will be all right. As a result they come late for help, when they can no longer cope.” – *Male private medical doctor*

Most (80%, 23 out of 28) of the key informants who commented on the issue of postabortion complications, stated that girls/women do not seek, or are not taken for, prompt medical care when abortion complications occur. Discussion participants shared this view. Only four respondents stated that some do go for prompt treatment, and two others said they were not aware of the problem of failure to seek prompt care. Several independent stories were told of how this situation arises:

- “They conceal the pregnancy to find ways to get rid of it before their parents discover it. That’s the reason they don’t let the truth of the matter be known to the parents when they fall sick. The parents might discover late that she is sick due to abortion, when they are told in hospital.” – *Male health care provider*
- “When the girl gets sick and the mother asks her what’s wrong she will tell you this and that. When she is taken to the doctor, you will be shocked to learn that she had aborted. Sometimes they claim to be in their periods. They don’t tell the truth until it’s late.” – *Female home-based care worker*
- “Some girls hide the truth that they are pregnant and tell their parents that they are suffering from period pains and it becomes difficult for them to know. It

takes parents a long time to react. Instead they buy painkillers for their children.”
- *Female health care manager*

- “Last month of October, a young girl of 19 years in the neighborhood aborted. Her parents knew nothing of the pregnancy. It was only later when she fell seriously sick that her friends notified the mother of the fact that she had aborted. The parents took her to hospital. She is alive. For two weeks she was at home, without any one noticing anything. She went to the clinic and complained of a headache. Her friends provided her with the herbs to abort, and it’s the same friends who told the parents when things got out of hand.” - *Chairwoman of a women’s NGO*

Fear of legal consequences

“People are afraid to seek treatment because it’s an offense to abort. They will be prosecuted.” - *Male Magistrate of the Courts*

“Girls and women fear to go for medical attention because they might end up behind bars – along with the person who might have performed the abortion.”
- *Female home-based care provider*

Fear of being reported to the police was the most commonly cited reason for not seeking prompt medical treatment for abortion complications. This issue was raised by over half of the key informants and was widely discussed in performance discussions. Many stated that it is common knowledge that abortion is illegal in Zimbabwe. Various perspectives, however, were given regarding legal reporting practices when a girl or woman does seek medical attention for abortion complications. Comments on this topic are provided below.

- “Within my area, when a girl has aborted and is reported to the police, I am called to come and see what happened. I ask questions of both the nyanga and the girl on why they did it. After that, I write a letter to hospital attendants to help the girl. But then both the nyanga and the girl are arrested.” - *Male traditional chief*
- “No one is reported for seeking medical attention. Abortion [complication] cases are treated as any other sickness.” - *Male community relations officer, police station*
- “Most people will shy away from going to a hospital because the doctors are supposed to report. There is even a police post at the hospital. Whether the doctors do report or not is another question. It depends on the discretion and judgment of the doctor.... People will have to make decisions themselves whether to go to hospital or not.” - *Female lawyer*

- "I have never heard of anyone reported to the police by clinic or hospital staff. But most people believe that nurses do." - *Male councilor*
- "There is no way that the police can know about an abortion from the clinic. ... It is perhaps one member of the family has been to the police before the case [is seen at the clinic] and there is nothing the clinic can do to reverse the situation." - *Female community health nurse*
- "Nurses do not report to the police, but they tell the truth when asked. Our concern is to provide medical care." - *Female clinic nurse*
- "Abortions are done in secrecy and such cases rarely come before the courts. It's in some extreme cases where someone has died and the parents come to know of the fact of the abortion that they make a report to the police and the case is brought before the courts... By law, the nyanga is charged with assisting to procure an abortion and is liable for prosecution. The judgment and sentence for one who has aborted depend on mitigating factors. For a 13-year-old, they look at the background and other factors. Normally the sentence is not custodial. Someone above the age of 18 is an adult and responsible for her actions, so the sentence could be custodial, varying from 1 to 5 years." - *Male Magistrate of the Courts*
- "Doctors don't care when tending to someone who has aborted. They only write 'abortion' and treat it as any other sickness. They don't report such cases. Neighbors report cases because they will be wondering about what has happened." - *Male traditional healer*
- "It's true abortions are illegal in this country, except in cases of incest, rape and pregnancy that has complications that threaten the health of the mother or child. Even in such cases you don't go to a doctor. You apply to the courts. They will issue a court order to the effect of an abortion." - *Policewoman*

Fear of harsh treatment and exposure

"They fear being reported to the police by the doctors and rough treatment by the nurses. Nurses are not secretive of the facts in cases of those who have aborted. They go around telling the community of the abortion." - *Male CBD manager*

"Girls hide these pregnancies and abortions until it's late – the reasons for this being fear of the parents and fear that they will be laughed and ridiculed by their peers when they discover they have aborted." - *Residents' association chairman*

Fear of harsh treatment by nurses and fear of being exposed to parents or the community were two other reasons commonly cited for not seeking, or delaying treatment for, complications. Among Bulawayo respondents, harsh treatment by

nurses was mentioned almost as frequently as fear of arrest (14 references). Hwange respondents mentioned nurses' treatment less frequently (4 references). Often the two reasons were linked, as in the above quote.

Other reasons for delaying or not seeking treatment

Other reasons that were cited less frequently included:

- Financial constraints (3 references)
- Health facility is far away and transport is difficult (Single reference)
- Complications aren't serious enough (Single reference)

Treatment sought from the formal health care system

"Izinyanga perform most abortions. Thereafter, people come to the surgery to seek medical attention." – Female nurse at a private surgery

Few references were made to girls seeking treatment for abortion complications from izinyanga. Based on this limited discussion, it appears that those with complications who seek services usually go to the formal health care system, perhaps because they wait until complications are severe. Two female izinyanga presented these two different scenarios:

- "[If someone is bleeding severely and comes to me], I advise her to go to hospital as the first option..."
- "The problem with traditional healers is that they don't have traditional methods to stop the bleeding. In cases where things get out of hand, it's rare for them to refer the patient to hospital. They fear the law since abortions are illegal. There are some cases where one has no choice but tell the girl to go to hospital or clinic. In most cases, one way or the other they all end up in hospital."

Although it is possible that girls go to izinyanga with mild complications and are told to stay away from the clinic or hospital, no one cited this as a reason for avoiding or delaying care.



Postabortion Care Services

Spontaneous abortion

"Miscarriage is treated normal and fairly." – Female nurse at a private surgery

Postabortion care services for women with spontaneous abortion were discussed with just a few key informants and only rarely during performance discussions.

Those few who commented indicated that service providers treat these cases as any other medical case. However, several references were made to the difficulty in determining whether a client is suffering from complications of induced or spontaneous abortion. This, in turn, may affect the treatment that is given. Comments on treatment of miscarriage also came from *izinyanga*, which indicates that they provide such services as well. References to this issue included:

- “Miscarriages are treated normally depending on the behavior of the person affected.” – *Male traditional chief*
- “It is difficult to rule on miscarriage so this results in nurses mistrusting patients when they come to the clinic saying they have miscarried.” – *Female clinic nurse*
- “If someone miscarries, you can tell by her behavior. There are some special herbs that are given to the patient for cleansing.... [If someone is bleeding severely and comes to me] I advise her to go to hospital as the first option, unless it is someone who miscarried and had received some treatment before. She is acceptable. Serious measures are taken to stop the bleeding.” – *Female traditional midwife and healer*
- “How you treat miscarriage depends on the behavior of the person. Sometimes it is difficult to understand until you get to know that it is miscarriage and not [induced] abortion.” – *Male traditional healer*

Physical access to services

“[We] have only three clinics and they have no machines [for example, x-ray machines] and we walk distances [about 12 km] to reach the clinic. One might be dead before reaching there if seriously ill, or having a miscarriage. There are no ambulances except in Victoria Falls. The only means of transport one can use is a scotch cart.” – *Woman at post-performance discussion*

Limited physical access to services was mentioned only once, and that was at a performance discussion in a rural area.

Harsh treatment from nurses

“...the treatment [a girl] gets from nurses is bad. They discuss you with other patients. They beat you up. When cleansing the womb, they cause severe pain.” – *Female schoolteacher*

Nurses' attitudes and behavior toward postabortion clients was the only aspect of quality of clinical care that was mentioned by any key informants or discussion participants. However, this issue was raised frequently (27 references). Most (70%) of these responses were critical of nurses' treatment to clients. As mentioned above,

this was also a primary reason for delaying treatment or avoiding it altogether. Below are examples of some of the comments.

- "Nurses have a bad attitude. They start having meetings and discuss about you and come back only to shout at you, 'Why did you do it?' That's why girls choose to be attended by a nyanga, who will lend a listening ear and keep it quiet." – *Female AIDS worker at a performance discussion*
- "The bulk of nurses are hostile... As health workers [we] are not youth-friendly." – *Female community health nurse*
- "If they do go to a clinic the nurses will gossip." – *Female lawyer*
- "Nurses have no sympathy and they shout for everyone to hear..." – *Young girl at performance discussion*

The other 30% who commented on nurses' attitudes and behavior said that they were either variable or good. Examples included:

- "Nurses judge by the look. People with money get better treatment than the poor." – *Older woman at post-performance discussion*
- "Nurses have a fair attitude and they treat patients equally. They do accept people who have aborted." – *Female church administrator*
- "Abortion [complications] are an emergency. Attitudes are there with different people, but...there is no room for attitudes. It is an emergency and we treat it as such." – *Female community health nurse*

Reasons for nurses' behavior

"People neglect going to hospitals saying they get bad treatments, which is not true. All this happens because people lack information. Why nurses get angry is because someone would be smelling and that they don't tell the truth." – *Female health department peer educator*

Several respondents provided explanations for nurses' negative attitudes and behavior. Almost all of them referred to either the client's failure to explain the reason for her condition or frustration because the client waited until she was severely ill before seeking treatment.

Only limited information on actual service provision was obtained because the data collection effort focused on community perspectives, rather than on assessment of services. However, several service providers were included as key informants and they were asked to describe their services. Their comments are provided below.

- “The clinic provides postabortion care services. Normally young girls do not reveal abortions, spontaneous or otherwise. After some examinations you will find that the person has gone through unsafe abortion. We treat to avoid further damage, and then we refer her to the family planning corner. We have a family planning corner with people trained for this cause... There is no specific training for postabortion care.” – *Female nurse at an urban clinic*
- “If people come to hospital they don’t tell the truth. One might be in a state of severe bleeding so the nurse’s duty is to attend and find out if everything is out and complete. Thereafter, she can be taken to the doctor for more checkups.” – *Female clinic nurse*



Strategies for Addressing Unwanted Pregnancy and Unsafe Abortion

Key informants and discussion participants were asked explicitly what they thought should be done about the problems of unwanted pregnancy and unsafe abortion, and what they could do personally.

Effects on the community

“There is no point in blaming this and that. Abortion is a community problem.”
– *Woman at a performance discussion*

In general, discussion participants and key informants alike acknowledged that abortion and unwanted pregnancy, while directly affecting a few, have far-reaching effects on the community. Specific effects that were cited include:

- On young girls: death; inability to bear children in the future; inability to marry; legal arrest and prison.
- On parents: To see this happening to their children; humiliation and embarrassment to the family when a daughter aborts or dumps a baby; confrontation between mother and father regarding how to handle an unwanted pregnancy.
- On development efforts: loss of educated schoolgirls.
- Tension and quarrelling within the community over taking a girl to hospital after an abortion. [In a specific case mentioned, villagers urged parents to take the girl to hospital. They refused. Later they did take her, but she died.]

Community dialogue and mobilization

“People from communities, sports clubs, burial societies, etc., must stand together and fight the abortion problem.” – *Male employment development officer*

Community dialogue and mobilization was the most frequently proposed solution to the problems of unwanted pregnancy and unsafe abortion. Over 75% of all key informants and many discussion participants mentioned the need to approach the problem from all sectors of the community. Specific recommendations that were cited most frequently included:

(8 references each)

- Encourage church attendance and dialogue on unsafe abortion at church, e.g., "One way to resolve the issue is through the churches because a lot of people go to churches every weekend." - *Female lawyer*
- Establish and support programs for youth, e.g., "Have places where youth can meet to discuss their problems and develop in creating jobs for themselves." - *Residents' association chairman*; "Establish centres where young people could drop in for advice on reproductive health and counseling." - *Male teacher*

(More than 3 references each)

- Facilitate networking among community organizations and families in communities
- Engage elected officials and politicians

Sensitization and education

"There is need for sensitization to the communities, starting from the community leaders down to women of the village." - *Female community health nurse*

"People are asleep on the abortion issue. They take it as something light just as they did with AIDS. So they need to be educated." - *Male traditional chief*

"The solution is in all communities coming together to put an effort to teach children about abortions and its repercussions." - *Member of a women's NGO*

Sensitization and education were the most commonly recommended actions. Over 30% of key informants made this recommendation and it was raised often in post-performance discussions. Specific approaches that were recommended included:

- "The village community workers and the home-based care groups, working with people at the village level, should round up people and teach them about unsafe abortion and postabortion care." - *Male kraal head*
- "Nurse aides, home-based care providers, and CBDs should come together and discuss PAC door to door." - *Male family planning CBD manager*
- "It should be put on the radio so people are made aware of it, like AIDS and family planning." - *Male traditional chief*

- "Sensitize the izinyanga about the dangers of unsafe abortion, try to teach them that they should not perform what they do not know." – *Male traditional chief*
- "Parents should organise a meeting for young and old and try to create awareness on the issue of abortions." – *Female church administrator*
- "More dramas [on the subject] should be brought to this area." – *Female traditional midwife*
- "Create workshops and plays for children." – *Male residents' association member*
- "What can be done is to launch an educational and information campaign on the dangers of seeking late medical attention... But it has to be done carefully to avoid opening the floodgates [for abortion]." – *Male church pastor*

Prompt medical attention for complications

"People who have aborted should seek medical attention before their inner parts are spoiled." – *Male traditional healer*

In conjunction with education, many respondents also noted that those who experience abortion complications should seek prompt medical attention. Parents, other family members, and neighbors were encouraged to take young girls to clinic or hospital if they become sick after aborting. One respondent voiced this recommendation, but noted, "But in this regard, there is need for approval of medical and legal authorities to get help, if need be."

Improvements in PAC services

Nine respondents recommended improving PAC services. Specific recommendations included:

- Improve service provider attitudes and counseling skills; provide more counseling
- Educate on dangers of abortion and need for prompt treatment of complications
- Provide free medical attention
- Offer PAC services through home-based care programs

Better parenting

"In September two young girls died within a space of two weeks of each other, and within that same period of time a newborn baby was found abandoned. Both funerals were attended by the MP and the councilor. They later called a meeting with the community to address the issue. In that meeting the parents were found

to be the culprits in the problem of unwanted pregnancies that lead to abortions and baby dumping. Parents were urged to have more control over their children. They were said to be the ones responsible for good upbringing of their children."

- Chairwoman of a women's NGO

In addition to community-based actions, better parenting was frequently cited as a solution to unwanted pregnancy and abortion. Over 40% of Bulawayo and Hwange key informants offered this strategy and the comment was raised by over 20 discussion participants. A variety of opinions, however, were offered with regard to what comprises better parenting. Opinions about parenting generally fell into the following categories:

- Parents should provide more support to their children; improve parent-child communication, e.g., "Families should understand problems that arise. If a girl is pregnant they have to sit and discuss and try to comfort her even if as parents it's something [we] find difficult to do." - *Male residents' association member*
- Parents should teach their children about sex, e.g., "For parents its difficult for them to talk to their children about sex. It's one of the most difficult things to do, but somehow parents have to brace themselves and do it." - *Chairwoman of a women's NGO*; "Mothers should stand up and teach their children about the facts of life." - *Female health care provider*; "But also the father should be responsible for the boy child and talk to the sons." - *Female lawyer*; "Sex is a subject that has always been taboo in our culture and this has to change. Parents have to talk to their children about sex and its dangers so when these kids get pregnant and find themselves in this unfortunate situation, they can easily relate to it without fear." - *Male church pastor*
- Parents should exercise more discipline over their children, e.g., "Parents should come down hard on the girls who fall pregnant because if they do not, it will send wrong signals to other girls in the family." - *Young girl at post-performance discussion*
- Parents should be better role models for their children, e.g., "Parents should be exemplary to their children and try not to fight in front of them." - *Male traditional healer*; "These kids abort because of the aggressiveness of us fathers. We should stop this." - *Father at a post-performance discussion*

Sex education in schools

"Sex education should be incorporated into the school curriculum." - *Male CBD manager*

Linked to better parenting, 35% of key informants recommended sex education in the schools as a strategy and it frequently was raised in post-performance

discussions. One discussion participant announced that beginning in 1999 sex education would be taught in schools at the primary level. Others mentioned that it is being taught in the schools now. While there was general support for sex education in the schools, little consensus existed regarding what should be taught, by whom, and at what age. However, most respondents who expressed an opinion on sex education in schools recommended teaching abstinence from sex. A few respondents expressed the opinion that sex education should come only from the parents. Some specific comments on sex education included:

- "Parents and teachers should teach children not to indulge in sex before marriage." – *Female high school teacher*
- "Teachers should discourage sex." – *Female traditional midwife*
- "Peer educators should go to schools to give lectures to children and advise them not to indulge in sex before marriage." – *Female home-based care provider*
- "Children at grade 5 upwards should have full sex education as these kids already know so much." – *Man at post-performance discussion*
- "At schools they have sex education, but some teachers are closed for discussion on the subject. We need better dialogue between teachers and students." – *Man at post-performance discussion*
- "As parents we should advocate that it be taught at school, but we should complement this teaching at home." – *Female community health nurse*
- "Teachers should work with parents." – *Male primary school teacher*
- "[The school system] should take more responsibility in teaching kids about sex and reproductive health." – *Young man at post-performance discussion*
- "Government should take on the responsibility and introduce sex education at schools, especially at secondary level. The kids at primary school have no need for it." – *Chairwoman of a women's NGO*

Legalization of abortion

"Legalization of abortion needs deep thinking before action is taken." – *Male community services worker*

The issue of legalization of abortion was discussed by a third of the key informants and raised during discussions by seven participants. Two opposing viewpoints were presented. About half (14 respondents) expressed support for liberalization of the abortion law, as represented by the following comment by a male councilor: "As

long as the law does not allow people to abort unwanted pregnancies, the cases of unsafe abortion will continue. We should legalize abortion."

Opposition to legalization of abortion, recommendations that the penalty be made stricter, or a call for better enforcement of the current law was voiced by 11 respondents. For example, a male community relations officer in a police department commented, "Legalization of abortion is not recommended for it will promote prostitution, encourage abortions, and death cases will increase."

Family planning

"Of course, even though they have serious side effects, contraceptives do reduce unwanted pregnancies." - *Female clinic nurse*

Family planning was a frequently discussed topic among key informants and during post-performance discussions. While most informants commented that family planning is effective in preventing unwanted pregnancies, many expressed concern about the side effects of contraceptives or other factors. For example,

- "Family planning is not safe. Better one dies of AIDS than taking tablets."
- *Female home-based care provider*
- "For men, condoms are not comfortable as they sometimes get torn or come off, making sex unenjoyable for men. Therefore men are not happy with the idea of putting on condoms." - *Male army lieutenant*
- "Women are willing to use contraceptives, but there are problems with men's attitudes. They say they do not want their women to use them because of this and that. Some of the women go to the extent of hiding them from their men."
- *Female community health nurse*

Contraceptive use by young, unmarried women was widely debated. Over one third of key informants expressed an opinion on this issue. Among those, 65% opposed family planning services for youth. Almost all of them voiced the belief that use of family planning by young girls would promote promiscuity. For example,

- "Family planning tablets influence children to have sex with men. If only they will be banned, the better." - *Male traditional chief*

The other 35% of key informants who addressed this issue expressed their support for family planning services to youth and many expressed concerns about youths' limited access to family planning services. For example,

- "For those at 13 and 14 years, it's a pity. They should abstain from sex. But, then given the circumstances, it's better to afford them access to family planning. We

should wake up to reality and afford them family planning." – *Male college vice-principal*

- "The girls might be aware of contraceptives, but in the rural areas there is one contact person who distributes and she or he knows the girl. That person might get moral and start asking, 'Why contraceptives?' In the health centres, contraceptives are not accessible to young girls. They have to get them from their friends and relatives." – *Female community health nurse*

During one post-performance discussion, a participant asked for clarification of the government policy. A public health nurse responded by saying that government policy does not allow health service providers to give contraceptives to anyone below the age of 16 years.

Six key informants voiced concern over the recent change in government policy that requires clients to pay for contraceptives, and commented on people's inability to pay. For example,

- "Long ago, back in the 1980s, coming into the 1990s, people had no problem in taking some [FP] tablets-- even though at first it was free and later they had to be bought for a small amount. Unlike these days-- people can't afford them. They are too expensive. Instead of buying them one chooses to buy a loaf of bread." – *Male social services worker*
- "Since September 1998 contraceptives are being sold and people have no money. There will be an increase in unwanted pregnancies and abortions." – *Male CBD manager*



Conclusions

Community members in Zimbabwe view the issue of unsafe abortion from a broad perspective that includes family, community, and societal dimensions. This perspective focuses on prevention of unwanted pregnancy and abortion. Although community members generally support the concept of PAC services, those in need of these services often do not seek them because of fears of legal prosecution, and harsh treatment and exposure by nurses.

In order to increase the use of PAC services among those who need them, quality of care needs to be improved and improvements need to be defined from a client perspective. This task, however, is not straightforward. Offering clients the confidentiality, support and counseling that they want, for example, could create for some service providers a dilemma arising from conflicts in their moral and professional values. Furthermore, improving the quality of services from a client perspective is not enough. Community perceptions of services also have to change in order to increase the use of PAC services. This, too, presents challenges because many members of the community think confidential and supportive treatment of clients would lead to an increase in the incidence of abortion.

Community perspectives also raise issues about the PAC strategy of providing family planning services at the time of emergency treatment for abortion complications. Many community members commented on family planning. These comments were both supportive and critical. Family planning was not necessarily considered the best approach to prevention of unwanted pregnancy and abortion. A particular challenge for postabortion family planning services is the legal restriction on, and community opposition to, provision of contraceptives to youth. In Zimbabwe, the family planning policy restricts provision of contraceptives to those 16 years of age and older. Thus, contraceptives are unavailable at the time of emergency treatment to those at highest risk of unsafe abortion.

Improving PAC services from the client perspective would go a long way toward strengthening the impact of PAC on morbidity, mortality, and repeat abortion. But, more than provision of high quality PAC services is needed to curb the problem of unsafe abortion. Community members are motivated to act and have specific ideas about what needs to be done. The health community can strengthen its role by improving its links with the community. Specifically, health managers need to:

- Listen to the community. Community members have information that service delivery managers need in order to design and provide services that will better meet clients' needs. This is important because, as this study shows, many clients in need are not seeking services. Community members are eager to provide their perspectives if they feel they are being listened to and respected.

- Educate the community. Many people, particularly young people, do not understand the seriousness of abortion complications. More broadly, there is a serious lack of knowledge about sex and reproductive health. Members of the health community must reach out to the larger community to provide this education. The community looks to them to do this. Outreach education should be a cornerstone of PAC service delivery.
- Partner with the community. The problem of unsafe abortion is not going to be solved by better PAC services alone. Unwanted pregnancy and unsafe abortion are multidimensional problems deeply embedded in societal and cultural norms and practices. The health community cannot and should not operate alone. As PAC services are expanded and improved, health managers must seek opportunities to create linkages and synergies with other community services and organizations.