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# Unsafe Abortion in Tanzania: A Review of the Evidence

**Although pregnancy termination is restricted by law in Tanzania, it is widely practiced and almost always unsafe, and contributes to the country's high maternal morbidity and mortality. Yet the majority of abortion-related deaths are preventable, as are the unintended pregnancies associated with abortion. Better access to contraceptives, more comprehensive postabortion care and greater availability of safe abortion services within the current legal framework are critical to achieving the Millennium Development Goal 5 of reducing maternal mortality and ensuring universal access to reproductive health care by 2015.**

This report summarizes the current evidence on induced abortion in Tanzania, clarifies existing law on the provision of abortion, and identifies key areas where government and program planners can take action to decrease levels of unintended pregnancy and unsafe abortion.

### Current abortion law is restrictive, but its legal interpretation needs to be clarified.

In Tanzania, the penal code explicitly states that termination of pregnancy is legally permitted if it is performed to save a woman's life.[1] However, a recent report indicated that since Tanzania's legal system is based on English common law, the English case of *Rex v. Bourne* could be applied in the interpretation of Tanzania's abortion law to authorize abortion to preserve a woman's physical or mental health.[2] Furthermore, in 2007, Tanzania ratified the African Charter's Protocol on the Rights of Women in Africa (also referred to as the Maputo Protocol), which requires the government to "protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, [and] incest, and where the continued pregnancy endangers the mental and physical health of the [pregnant woman] or the life of the [pregnant woman] or the foetus."[3(p. 16)] Yet despite ratification, the Tanzanian government has not incorporated this provision into its national laws.

Contrary to widespread belief, a health care provider is not required to consult with other providers before performing an abortion.[2] In addition, the law does not specify what level of provider may perform a legal termination. Given the absence of interpretation by Tanzanian courts and the contradictory laws and policies, women and health care providers may lack a comprehensive understanding of the content and scope of the law on abortion.

### Unsafe abortion is common in Eastern Africa.

Given the legal restrictions associated with abortion, it is difficult to obtain reliable information on its prevalence and to assess the magnitude of the morbidity and mortality associated with it. No national abortion incidence data are available in Tanzania, however, estimates for regions of Africa indicate that unsafe abortion is common and represents the majority of induced abortions.[4] In Eastern Africa, which includes Tanzania, the estimated number of unsafe induced abortions was 2.4 million in 2008, or 36 unsafe abortions per 1,000 women of reproductive age (Table 1)[5]—the highest regional unsafe abortion rate in Africa.

### Unsafe abortion contributes to high levels of maternal mortality and morbidity.

Unsafe abortion represents one of the leading causes of maternal deaths in Tanzania. According to the Ministry of Health and Social Welfare, 16% of maternal deaths are due to complications from abortion;*[6] this is comparable to the proportion of maternal deaths from unsafe abortion in Eastern Africa (18%).[5] A higher proportion was reported in a small-scale review of 62 maternal deaths at a regional hospital in Tanzania, where a quarter of those deaths were due to abortion.[7] Similarly, an analysis of sentinel surveillance data for 110 maternal deaths in rural Hai District indicated that in 23% of the cases induced abortion was the cause of death.[8]

*The source for this figure is unclear in the Ministry report.

Table 1

## Abortion and Maternal Mortality

**Abortion incidence and consequences in Eastern Africa and Tanzania**

| | |
|---|---|
| **Abortion incidence** | |
| Eastern Africa (2008) | |
| No. of unsafe induced abortions | 2,430,000 |
| % of pregnancies ending in abortion | 14 |
| Abortion rate (per 1,000 women) | 38 |
| Unsafe abortion rate (per 1,000 women) | 36 |
| Unsafe abortion ratio (per 100 live births) | 20 |
| Tanzania | |
| No. of abortions | na |
| **Consequences of unsafe abortion** | |
| Eastern Africa | |
| No. of maternal deaths due to unsafe abortion complications, 2008 | 13,000 |
| % of maternal deaths due to unsafe abortion, 2008 | 18 |
| No. of women hospitalized for induced abortion complications, 2005 | 612,940 |
| Tanzania (2010) | |
| Maternal mortality ratio (per 100,000 live births) | 454 |
| No. of maternal deaths | 8,500 |
| % of maternal deaths due to abortion | 16 |

*Note:* na=not available. *Sources:* Eastern Africa—no. of abortions, unsafe abortion rate and ratio, and maternal death data: reference 5; pregnancies ending in abortion: Singh S et al., Unintended pregnancy: worldwide levels, trends, and outcomes, *Studies in Family Planning,* 2010, 41(4):241–250; abortion rate: reference 4; women hospitalized: reference 13. Tanzania—maternal mortality ratio: reference 11; maternal deaths: reference 12; maternal deaths due to abortion: reference 6.

The Tanzanian government has shown, through various policies —including the implementation of the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015—that it is committed to reducing maternal mortality. In 2007, misoprostol was registered by the Tanzanian Food and Drugs Authority (TFDA) for use in the prevention and treatment of postpartum hemorrhage, the leading cause of maternal death worldwide.[9,10] In 2011, the TFDA approved the use of misoprostol for the treatment of incomplete abortion.[9] Overall, progress in reducing maternal mortality has been made over the last two decades; however, the maternal mortality ratio in Tanzania is still one of the highest in the world at 454 per 100,000 live births.[11] For comparison, the ratio for all developing countries is 240 per 100,000 live births, and that for all developed countries is 16 per 100,000.[12]

Unsafe abortion is also associated with high levels of morbidity. In Eastern Africa, more than 600,000 women were estimated to be hospitalized for induced abortion complications in 2005, corresponding to a rate of 10 per 1,000 women aged 15–44.[13] The prevalence of unsafe abortions in hospital-based settings in both urban and rural areas in Tanzania has been documented in a number of studies,[14–16] which have shown that up to 60% of women admitted with an alleged miscarriage had in fact had an induced abortion. The actual proportion of Tanzanian women who have an unsafe abortion and who need medical care may be even higher given that some women who attempt an abortion may experience complications for which they do not seek care. Worldwide, an estimated one-third of the 8.5 million women who have complications from unsafe abortion do not seek care in health facilities.[13]

### Abortion methods, providers and costs vary in Tanzania.

For women who cannot access safe abortion services, many will try to abort the pregnancy themselves or turn to unskilled providers. In a study of women who were admitted to a hospital with complications from an induced abortion, 46% of those in rural areas and 60% of those in urban areas reported that the abortion had been performed by an unskilled provider.[16] Preliminary results from a qualitative study in mainland Arusha and Town West, Zanzibar, found that providers in nonclinical settings—such as traditional birth attendants and pharmaceutical retailers—were preferred because they ensure greater privacy and lower costs than physicians.[17]

Methods used for self-inducing an abortion vary and include herbs, high doses of chloroquine and the detergent "Blue."[16–19] Other known methods are wood ashes in solution, cassava stems, twigs and contraceptive pills.[17–20] Participants in a small qualitative study mentioned a drug purchased from retail pharmacies and shops, most likely misoprostol.[17]

Few studies have collected information on the cost of the abortion procedure itself. In one study, young people aged 15–27 estimated that an abortion performed at a health facility cost 10,000–15,000 Tanzanian shillings (US$12–18),* while they thought the cost for herbs or other reputed abortifacients was only 10–50 shillings (US$0.01–0.06).[19] A recent study estimated that the cost of the procedure in two urban areas was US$32–44.[17] Given the generally prohibitive cost of obtaining a safe abortion, it is not surprising that women will attempt to self-induce or seek a cheaper alternative, including procedures from untrained providers.

### The cost of unsafe abortion for women and the health system is high.

Although no recent costing studies have been conducted, it is clear that the proportion of hospital admissions for abortion-related complications accounts for a disproportionate share of hospital expenditures. According to an exploratory study in the late 1990s, the cost of a one-day hospital stay for the treatment of abortion complications was more than seven times the Ministry of Health's budget per person per year.[21]

In addition to the immediate economic and health costs associated with unsafe abortion, there are also a number of indirect costs, such as loss of income and productivity in the short term and from long-term morbidity.[22] These latter losses are more difficult to quantify and have not been measured.

### Postabortion care is essential for reducing maternal mortality.

Since 2000, the Tanzanian government—through its National Package of Essential Health Interventions and Postabortion Care Clinical Skills Curriculum—has committed to providing postabortion care (PAC) as an essential service, recognizing that limited access to such services in rural areas has left many women suffering from the consequences of unsafe abortion. The provision of PAC services, including contraceptive counseling, is an important

*All amounts reflect the cost at the time of data collection.

strategy for preventing future unintended pregnancy and mitigating the effects of unsafe abortion, and can greatly reduce maternal mortality.

In 2007, EngenderHealth, through its ACQUIRE Project Tanzania, began working with the Ministry of Health and Social Welfare to decentralize PAC services to lower-level health facilities in an effort to increase the availability of services throughout the country. An assessment study found that implementation of the program was weakened by difficulties in obtaining essential supplies, such as manual vacuum aspiration kits, and by lack of sufficient trained staff.[23] Indeed, the problem of inadequate medical supplies continues to be a barrier to services. A study of health facilities in three districts of Tanzania found that on the day of the survey, only 24% of facilities had manual vacuum aspiration kits in stock, and only one of the five hospitals surveyed had both misoprostol and the kits, which can be used for the treatment of incomplete abortion.[24]

A small-scale study of 62 cases of maternal death found that the standards of care for those who died from abortion complications were alarmingly low.[7] Notably, substandard care—defined as whether death could have been prevented without the delay in proper care—was identified in all cases. Staff interviews revealed that the causes of substandard care were most frequently attributed to a lack of training and limited staff availability.

PAC is not only important as a means to reduce maternal mortality, but is also critical to addressing the unmet need for contraception among women who have resorted to an unsafe abortion. Studies have shown that women who receive PAC are likely to accept contraceptive counseling services and leave the facility with a contraceptive method.[23,25,26]

## High levels of unmet need for family planning persist.

The difference between Tanzanian women's total fertility rate (5.4 children) and their wanted fertility rate (4.7 children) indicates the difficulty of achieving fertility desires (Table 2).[11] Women with an unintended pregnancy will either have an unplanned birth or seek an abortion.* According to the 2010 Tanzania Demographic and Health Survey, 26% of recent births were unplanned, and the proportion has increased slightly since the 2004–2005 survey.[11]

Although the contraceptive prevalence rate has risen over the past decade, it is still very low. However, between 2004 and 2010, the use of a modern contraceptive method has increased among both married women (from 20% to 26%) and sexually active unmarried women (from 36% to 44%).[11] Nonetheless, the demand for family planning remains high in Tanzania.

Women who face an unintended pregnancy represent an important group with unmet need for contraception; they want to delay or stop having children, but are not using contraceptives. One in four married women and one in three unmarried women of reproductive age have an unmet need for contraception, and this proportion has changed little since 1999.[11] In 2010, the level of unmet need was even higher among women who had low economic status, were less educated or resided in rural areas.

A report on the benefits of investing in family planning and maternal health found that, if the need for family planning was fully met in Sub-Saharan Africa, the number of women who die from pregnancy- and birth-related causes would decrease by 29% and the number of unintended pregnancies would drop by 78%, from 19 million to 4 million.[27] Not only would this kind of investment save money in overall health care costs, but it would also help achieve economic and social development goals—including the Millennium Development Goals—and more importantly, it would save lives.

## More can be done to address unsafe abortion.

The Tanzanian government must continue to address the issue of unsafe abortion to prevent maternal deaths and improve women's health. Other key domestic and international stakeholders can take action now to support the following measures:

• *Reduce unmet need for contraception.* Increasing access to family planning, intensifying family planning education and offering a wide range of methods and counseling can reduce the incidence of unsafe abortion and its consequences by preventing unintended pregnancies.

• *Increase access to comprehensive PAC.* Abortion-related mortality and the severity of related morbidity can be reduced by offering comprehensive PAC services. These must include use of modern and less invasive technology and ideally a choice of treatment methods, as well as postabortion contraceptive counseling and provision of a method of the woman's choice. The expansion of PAC services in the country as a whole should also continue, through training of midlevel providers, offering services at lower-level health facilities and ensuring that facilities are adequately stocked with drugs and supplies.

• *Improve providers' ability to offer abortion services within the current legal context.* It is critical to raise health care providers' awareness of the content and scope of the Tanzanian abortion law and to equip them

*A small proportion of women have miscarriages.

Table 2

**Fertility, Contraceptive Use and Unmet Need**

**Characteristics of Tanzanian women aged 15–49, 2004–2005 and 2010**

| | 2004–2005 | 2010 |
|---|---|---|
| **Fertility** | | |
| Total fertility rate | 5.7 | 5.4 |
| Wanted fertility rate | 4.9 | 4.7 |
| **Contraceptive use and unmet need** | | |
| Married women | | |
| % using any method | 26.4 | 34.4 |
| % using a modern method | 19.5 | 26.1 |
| % with unmet need for contraception | 24.4 | 25.4 |
| Sexually active unmarried women* | | |
| % using any method | 40.5 | 50.6 |
| % using a modern method | 35.7 | 44.0 |
| % with unmet need for contraception | 31.7 | 31.2 |

*Among those who had had sexual intercourse within 30 days preceding the survey. *Source:* reference 11.

with appropriate training to provide safe abortion services within legally permitted circumstances.

• *Conduct more research.* National-level data on abortion incidence and abortion-related complications, and assessments of the cost of unsafe abortion to the Tanzanian health system, would help raise awareness of the issue and give policymakers a better understanding of the magnitude of the problem.

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## CREDITS


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