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Economic and social dimensions influencing safety of induced abortions amongst young women who sell sex in Zimbabwe

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ABSTRACT: *Globally, women, experience inequities in access to safe abortion services and this is most acutely felt in country contexts where legal abortions are highly restricted. Data around abortion amongst young women who sell sex (YWSS) in sub-Saharan Africa are very limited. We conducted 30 focus group discussions and 42 in-depth interviews (IDIs) amongst YWSS (16–24 years) in urban and peri-urban areas of Zimbabwe, as well as IDIs amongst 16 peer educators, five health care providers and four key informants. Our findings indicate that abortions occur amongst YWSS in Zimbabwe but there remain questions over the extent of safety of abortions. The restrictive legal context around abortion and illegality of sex work in the country are key determinants underlying the clandestine nature of abortions. Socioeconomic concerns are key in decision-making around abortions. Youth, cost and lack of referral networks contribute towards unsafe abortions, even when safe abortion services are available. Many YWSS are not aware of the availability of post abortion care (PAC) services and resort to self-administered PAC. Being young and selling sex combine and interact on the economic and social levels to produce vulnerabilities greater than their sum to experiencing unsafe abortion.* DOI: 10.1080/26410397.2021.1881209

Keywords: young women who sell sex, sex workers, abortion, post-abortion care, Zimbabwe, social determinants of health

Introduction

Women across the world experience inequities in access to safe abortion services and this is most acutely felt in country contexts where legal abortions are highly restricted.[1] Despite the legal context, urban-based, well-resourced women at higher socioeconomic and educational levels will often have the choice to access abortion care from a private health provider or purchase misoprostol (medication widely used to soften the cervix and cause uterine contractions) to self-induce an abortion outside of the formal health care setting. However, those who lack these resources may face very constrained choices where services are not widely available, and as a result opt to terminate their pregnancy using dangerous and invasive methods, sometimes at the cost of their lives. For these reasons, in countries with restrictive abortion law contexts, poorer women, and those living in rural areas, are more likely to experience complications from unsafe abortion and less able to access the necessary care for these complications, including post abortion care (PAC), compared to urban-based, non-poor women.[1] Young age is another important determinant of vulnerability to unsafe abortions and concomitant access to care.[2] Young women and adolescents bear a considerable burden of least safe abortions in developing regions, with 41% of "least safe" (the term is discussed below) abortions occurring amongst young women aged 15–24 years.[3] Half of least safe abortions in Africa, a region widely characterised by restrictive abortion laws, occur amongst young women aged 15–24 years. Adolescents (15–19 years) in Africa are, by far, worse affected by least safe abortion compared to their peers in other developing regions.[3]

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While there have been a number of studies examining the safety of abortions amongst women in the general population in Africa, there are limited data on abortions amongst female sex workers. Studies in the sub-Saharan African region suggest relatively high rates of abortion amongst this group; in Côte d'Ivoire half of adult sex workers (18 years and older) reported ever terminating a pregnancy, with similar rates (47.7%) reported in Zambia.[4] Amongst young women who sell sex (YWSS) (15–24 years), who are a growing population with deepening levels of poverty in the region, 17.1% YWSS (15 years and above) reported ever undergoing an abortion in Ethiopia.[5] In Kenya, YWSS (16 years and above) reported abortion rates of 21-86%, with repeat abortions being common.[6,7] With the exception of the Kenyan study,[7] none of these studies distinguish between levels of safety in abortions amongst this group. Abortions can be induced in a variety of ways, with levels of safety ranging from safe abortions (with a trained provider using WHO recommended methods appropriate to pregnancy gestation), less safe abortions (trained provider not using recommended methods, or safe method used without the support of, or information from, a trained provider) and least safe abortions (untrained person using invasive and dangerous methods).[8] Less safe and least safe abortions make up all unsafe abortions.[8]

Abortion is highly restricted in Zimbabwe and only permitted on limited grounds, namely fetal abnormalities, incest, rape, or to save a woman's life (Termination of Pregnancy Act of 1977. No. 29). While a recent national estimate of induced abortion in Zimbabwe found that the country has one of the lowest abortion rates in sub-Saharan Africa,[9] Zimbabwean women in the general population also experience significant abortion-related morbidity and mortality due to complications from unsafe abortion methods.[9,10] A linked study found that young, single, rural and less educated women in Zimbabwe are significantly more likely to experience severe abortion-related complications, with adolescents (15–19 years) comprising at least 12% of PAC patients.[10] These vulnerabilities are compounded by critical gaps in the provision of PAC services in the country.[9–11] Questions also remain around differential access to PAC since women included in the study conducted by Madziyire and colleagues[10] were generally wealthier than the national average, with 37% classified in the highest wealth quintile, according to place of residence.

Zimbabwe is home to a young population with nearly two-thirds under the age of 25 years.[12] High levels of unemployment and deepening poverty have pushed increasing numbers of young and adolescent women into selling sex for survival needs. Little is known about the sexual and reproductive health (SRH) of these highly vulnerable but hard to reach populations, including the need for, and access to, safe induced abortion services and PAC. Previous research in Zimbabwe has noted that YWSS are less likely to engage with targeted SRH services and/or are unaware of services or reluctant to use them.[13–15] One of the studies, piloting a comprehensive intervention aimed specifically at YWSS in Zimbabwe, reported that they failed to successfully link two of their YWSS participants to affordable abortion services.[13]

This paper is based on an ongoing study carried out by the Health Economics and HIV and AIDS Research Division (HEARD) as part of a joint four-year project in collaboration with the United Nations Development Programme (UNDP) and African Men for Sexual Health and Rights (AMSHeR), supported by funding from the Government of the Netherlands. The overall project aims to strengthen the legal and policy environment for reducing HIV risk and improving sexual and reproductive health and rights (SRHR) of young key populations in Angola, Madagascar, Mozambique, Zambia and Zimbabwe. The research conducted within the overall project aims to investigate the pathways of SRHR risk and vulnerability and the gaps in associated service provision, legislative and programmatic support for young key populations (16–24 years) in each of the five countries. In Zimbabwe, we explored the range of SRHR needs and challenges amongst YWSS (16–24 years) through in-depth interviews (IDIs) and focus group discussions (FGDs), and conducted IDIs with key informants and peer educators. This paper reports economic and social influences on abortion decision-making behaviour and abortion practices amongst a group of YWSS (16–24 years) in Zimbabwe.

Methods

Study setting

The study was carried out between February 2019 to September 2019 in urban and peri-urban areas (urban-rural transition zones) of Harare and

Table 1. Participant characteristics

	Total *N* = 198
Age (years)	
<18 years	37
18–19 years	62
20–24 years	99
Highest level of education	
None	2
Primary school	26
Some secondary	80
O level	83
A level	4
Missing	3
Ever been pregnant	
Yes	151
No	39
Missing	8
	n **= 151**
Age at first birth (years)	
11–15	30
16–17	51
18–19	29
20–24	12
Missing	29
Ever had an abortion	
Yes	44
No	102
Missing	5
Number of abortions	
1	26
2	11
3	5
>3	2
Ever had abortion-related complications	
Yes	10
No	34

Bulawayo in Zimbabwe. Harare is the capital and most populous city in north-eastern Zimbabwe and Bulawayo is the second largest city in the south-western part of Zimbabwe.

Study population

We conducted 30 FGDs ($n = 15$ Harare, $n = 15$ Bulawayo) and 42 IDIs ($n = 22$ Harare, $n = 20$ Bulawayo) with YWSS (16–24 year). Participants for the IDIs did not take part in the FGDs. FGDs consisted of, on average, 5–7 participants. As much as possible, FGDs were split between those aged 16–19 years and those aged 20–24 years as we were interested to understand how the burden of SRH issues differentially impacted older adolescents versus young adults. We found that when we held FGDs where ages were mixed, the older participants tended to dominate the conversation and thus perspectives on the issue being discussed. In total, 198 YWSS participated in the FGDs ($n = 99$ YWSS 16–19 years; $n = 99$ YWSS 20–24 years). For a description of the sample, please see Table 1. We conducted key informant interviews with individuals from the civil society organisation (CSO) sector ($n = 1$), a multilateral agency (n=1), government stakeholders ($n = 2$), health care providers ($n = 5$) and peer educators ($n = 16$).

Participant recruitment

Women aged 16–24 years who self-identified as being involved in selling sex were recruited from the study locations in Harare and Bulawayo. In Harare, YWSS were recruited from 14 different locations within the central business district and the outskirts and as far as 56 km outside the city, extending as far as Nyabira, Epworth, Chitungwiza, Hopely and Juru. In Bulawayo, YWSS were recruited from the city centre and the surrounding peri-urban areas up to 30 km from city centre, extending as far as eSipezeni and Nyamandhlovu areas.

YWSS were initially recruited from the street where they were soliciting for clients in bars, and/or lodges. Following snowballing sampling techniques, we asked respondents who lived but did not work in other areas to assist with recruitment of YWSS who did work in these areas. In this way, we sought to avoid competition between participants and inclusion of friends. Participants who assisted with recruitment were compensated US$5 for their time and for transport to the study

site. All YWSS who participated in the IDIs or FGDs were compensated US$10 for transport and refreshments. Inclusion criteria for participation in the study were: being female, self-identifying as selling sex and being between the ages 16–24 years. Those who did not meet one or more of these criteria or who were less than 16 years of age were not recruited into the study.

Data collection

Interviews were conducted in the local languages (Shona in Harare and Ndebele in Bulawayo). The IDIs were guided by an interview guide consisting of semi-structured questions exploring life circumstances leading to entry into sex work, challenges faced related to SRH, knowledge of reproductive health and contraception, use of contraceptive methods, pregnancies and pregnancy outcomes, and access to SRH services. The FGDs followed an interview guide adapted from the Diagonal Interventions to Fast Forward Enhanced Reproductive Health (DIFFER) research project[16] which drew on a free listing and ranking approach. Free listing allowed the researcher to have as broad a discussion as possible on SRH challenges experienced by YWSS and ranking allowed participants to independently prioritise their challenges. The FGDs began with the question: What do you understand by the term "sexual and reproductive health"? A discussion over the definition of SRH ensued, and issues related to HIV, pregnancy, abortion, STIs, gender-based violence, and sexual risk were raised in some form in the discussion, so that there was common understanding amongst the group. Through a ranking exercise, participants were able to highlight their top SRH challenges. All the SRH challenges introduced at the beginning of the focus group were systematically discussed during the FGD to understand the nature of challenges experienced by YWSS.

Data analysis

All interviews were audio-recorded, transcribed, and translated into English and, through thematic analysis by all authors, collated and coded for themes and sub-themes. Data analysis was an ongoing and dynamic process throughout the data collection phase, so that the analysis guided and optimised the quality of information as it was being collected. Themes and sub-themes were inductively derived through a coding process as laid out by Corbin and Strauss.[17] Open coding permitted the inductive emergence of codes, which were organised into categories and themes. Axial coding allowed for the articulation of major categories and selective coding allowed for a picture to emerge on abortion practices. Relevant quotations were included in the memos to retain participants' own words and illustrative quotations were identified to support the propositions. Data were managed using Nvivo Software version 12.

Ethics

Ethics approval for the study was obtained from the Biomedical Research Ethics Committee, University of KwaZulu-Natal and the Medical Research Council of Zimbabwe. All participants provided written informed consent to participate in any component of the study and additional written consent to be audio-recorded. Written informed consent was also obtained from participants aged 16 and 17 years. Parental consent was waived for these young participants on the grounds that they were considered "emancipated minors". Such was the case for adolescents who were parents or expectant parents, married or living in a marital union, and/or are living separate or apart from their parents.

Results

In total, 198 YWSS (16–24 years) participated in one of 30 FGDs in either Harare or Bulawayo. The mean age of participants was 19.9 years. Out of the 190 participants who answered the question "Have you ever been pregnant?", 80% ($n = 151$) responded yes and 20% ($n = 39$) responded no. Mean age at first birth was 16.7 years. Forty-four (30%) respondents reported ever having an abortion, with 10 (23%) of these respondents reporting an abortion-related complication. Eighteen (41%) respondents who had undergone an abortion had done so more than once. We did not include missing responses in our percentage calculations.

Decision-making underlying obtaining an abortion

Participants voiced a number of reasons for undergoing or having undergone an abortion. Financial hardship or economic concerns were most commonly cited. At the time of the study, there were a number of currencies in circulation in Zimbabwe, including the Zimbabwean Bond

Dollar (Bond) and the US dollar (US$) which has consistently held the highest value in a greatly fluctuating currency exchange within the country. In February 2019, the official US$:Bond rate was 1US$:3.76 Bond and by September 2019 the rate was 1US$:12.4 Bond. The black market or "street" rate for US$ would have been much higher than the official rate in Zimbabwe. One participant shared her socioeconomic-related concerns over having a child:

"What will you do with the kid after delivery? A child is a burden. There are older women who can take care of your child. They need 5 Bond [approx. 0.5 -1 USD] per day [for babysitting]. You need food [for the child]. We don't cook every day. We buy food; a 5 Bond plate of sadza [staple maize meal diet]. There are no pots! You need clothes for the kid and for yourself, and rent is needed." (18 years old, FGD12H, Participant 5, Harare)

Other reasons included still being in school and using money earned through selling sex to pay for school fees, not knowing who the father of the child was or the father of the child being married or otherwise unavailable, lack of family support, and the need to keep sex work activities a secret from boyfriends and family members. The idea of the child being "fatherless" was another factor in the decision-making process:

"… because my pregnancy had five possible fathers. It would be difficult in the future if the child were to ask where her father is and she does not know him." (18 years old, FGD9H, Participant 4, Harare)

Given the socioeconomic context and occupational constraints that these young women often operated under, as well as being very young themselves, for the following 16-year-old, abortion was seen as her "only option":

"The only option is to abort. The challenge is no one will be responsible for the pregnancy and no one will be willing to step in and support the baby." (16 years old, FGD17B, Participant 7, Bulawayo)

Some participants recounted their experiences where their abortion attempts had been unsuccessful and they had been forced to bear the child without the financial or social support to do so:

"… some time ago I used to bring my child with me to the lodge [place of work]. But these days the lodges we are living in are not safe and there are reports of multiple cases of theft of blankets and other things. Hence due to fear that my child could be kidnapped or worse, I stopped bringing her with me … . the mother of my child's father died, and my mother is also not alive, and how my child survives is through temporary fostering with different people whenever I go to work." (20 years old, IDI, Participant ID10, Harare)

YWSS participants reported that abortion was not only common amongst sex workers but also amongst their peers who did not sell sex:

"The issue of abortion does not only affect sex workers but also other groups including the ghetto youths. I have a friend who is not into sex work but she was impregnated by her boyfriend who then convinced her to abort because he told her he was not ready to be a father. The boyfriend took her to someone who helped her abort without her mother's knowledge." (18 years old, FGD10H, Participant 4, Harare)

Social context shaping abortion practices

The restrictive legal context and the social stigma around abortions within the respective communities mean that any engagement with abortion care is conducted in secrecy and not freely discussed within communities or amongst YWSS themselves:

"Some will gain a bit of weight, their breasts also become bigger then all of a sudden they are back to normal." (16 years old, IDI, Participant ID20, Harare)

Fear of legal repercussions was a commonly reported reason for secrecy around abortions amongst our participants who expressed unwillingness to tell others about their experiences for fear that they would be reported to the authorities. In particular, it appeared that the circumstance of being young and involved in the illegal activity of selling sex greatly compounded fears of legal reprisal and heightened vulnerability for less and least safe abortions, as the following adolescent participant shared:

"Going to the clinic for abortion is not feasible, especially if you are a sex worker; you can get arrested. Here [in Zimbabwe] you can only abort if you have been raped. I end up going to the traditional healers and abort in the bushes, and bury the aborted baby there. Then they give me

concoctions to drink everyday as part of the womb cleansing process, then I can continue with my life." (16 years old, FGD17B, Participant 7, Bulawayo)

Despite the fears expressed by YWSS participants, the data suggested that the authorities only got involved when someone actually laid a complaint against the woman concerned and that the onus was on the complainant to provide proof of the event:

"I know because after I aborted, I went to the police, because my abortion had been reported by the person who claimed to be the father of the child. He had found out about the abortion and he reported to the police. I denied ever being pregnant recently and so I was asked to go the doctors for proof. I only survived from the accusations because I went to a religious church service of the [name] sect where I received prayers and when I then returned the alleged father no longer had money to take me to the clinic for required tests." (20 years old, FGD9H, Participant 3, Harare)

According to one key informant working at a CSO which provided legal services to key populations, the issue of abortion was rarely taken up as a formal legal matter. Rather, neonaticide or infant abandonment was identified as a more pressing and serious problem faced by the judiciary system:

"In fact, it's not abortion as such (in terms of legal cases being lodged), but it's actually baby dumping. There are a lot of cases that have gone through the courts where these young girls give birth to a child, and goes there and dumps the baby just like that. If they are asked: 'Why did you do this?', they do not even know the father, they can't feed the child, so the best way is to leave the baby. So, on the abortion side, there are no cases per se that have been recorded in [name of city]. Mostly it's actually related to baby dumping." (CSO KI)

While the data suggest a range of safety levels of abortion amongst participants, from safe, less safe to least safe method options, it was clear that the economic and social contexts greatly shaped vulnerability for least safe methods of abortion. In a restrictive legal context, younger participants often lacked access to the necessary referral networks that could link them to safer services, either through a private medical provider or through access to misoprostol, and feared reaching out for advice:

"Sometimes people die because they are not free to share with anyone. They abort secretly in fear of being reported to the police and yet they don't have enough information or experience so they end up dying." (17 years, FGD12H, Participant 4, Harare)

According to the key informant working at a CSO which provided legal services to key populations, many deaths due to complications arising from unsafe abortion occur outside of the hospital setting, and because of this they go underreported:

CSO KI: *And some they actually die, and those deaths they will go unreported.*
Interviewer: *And how are they being reported in those cases?*
CSOKI: *It's case closed. They will just say it's a sudden death.*

Prohibitive cost as a barrier to safe abortion

Given the restrictive legal context, safe abortion services are not publicly advertised in Zimbabwe. Misoprostol and clandestine abortion services are widely available but each poses out-of-pocket costs for women seeking to terminate their pregnancies. For young women already living on the margins, these costs strongly influenced choice of service and type of provider accessed and could result in delays in being able to access care within the first trimester of pregnancy – an accepted window period for abortions to occur which most participants expressed awareness about. Study participants were mostly paid in Bond notes by their clients which meant that accumulating many US dollars was often out of their reach, as the following young woman in Bulawayo shared:

"[Doctors who provide abortion care] are there … but they are expensive so you would see Mbuya ('grandmother' in the community with lay abortion care knowledge) as a better solution. You would find that Mbuya is cheaper because [the doctors] charge US$100. When will I get such an amount? Yet the pregnancy will be growing and days running out. Mbuya tells you that before three months, it is easier to abort but afterwards it is hard. So, we are targeting the days before three months. Sometimes you discover that you are pregnant when it is already two months off, so when will you be able to raise US$100? You will also be needing

money for food and rentals." (23 years old, IDI, Participant ID39)

The decision-making around safety versus cost was echoed by young participants in a FGD in Harare:

Speaker 1: *No, I don't think we can get services [at the doctor] because to seek services there you need money. If you want to terminate safely, it will cost you money. (17 years old, FGD5H, Participant 3, Harare)*

Interviewer: *Would you have an idea of how much it costs?*

Speaker 2: *When I wanted to abort mine, a man who works there [at a medical practice] told me to look for 50 Bond. He told me that they would remove everything. However, I did not have the money so I ended up getting 2 Bond services. (19 years old, FGD5H, Participant 1, Harare)*

Cost of services was a strong determinant for the safety of the abortion procedure:

"I started vomiting black substances because she also gave me herbs to take orally. You will be comparing prices of the doctor versus a layman so you choose the cheapest." (18 years old, FGD12H, Participant 5, Harare)

The data suggest that a key factor underlying decisions around which provider to approach, even amongst the pool of non-medically trained providers, was based on the provider's willingness to negotiate cost of service:

"Sometimes these old women will be feeling pity for us since we are young but you show gratitude by giving her whatever you have." (19 years old, FGD19B, Participant 3, Bulawayo)

Some participants shared their personal experiences with *Mbuya*'s who, they reported, would accept food in exchange for services or staggered payment terms:

"She charged me 80 Bond. So, I told her I only had 50 Bond and would pay the rest once I have worked a little more. Once a pregnancy is aborted you face some days of severe illness almost to the brink of death and this time your facial skin tone can change to a white-like colour. After the procedure she made me drink a lot of Mazoe [a sugary drink] in order to recover the blood I had lost. Eventually I did recover and within three months I had paid her back in full. Recently I had some friends of mine who also wanted to abort their pregnancies and I also took them to the same grandmother." (19 years old, FGD10H, Participant 3, Harare)

Participants also indicated that misoprostol could be purchased but that this was only accessible to those who had enough money to afford it. For those who could not, more rudimentary and unsafe methods of inducing abortion were often followed:

"Going to the clinic is not possible. But at the pharmacy there is a pill that is sold. This pill costs 300 Bond. So for me to go to the pharmacy and buy it I can't get the 300 Bond, where and what time am I going to get it? So, what I do when I get home, I buy (a Cola soft drink), and boil it with Tea leaves then I drink the mixture." (Age missing, FGD17B, Participant 9, Bulawayo)

Common abortion methods included inserting the sharp end of a tail comb, crochet hook or a sharpened stick into the uterus. Herbal methods were widely used and reported to be inserted vaginally or ingested. Plants included the *ingotsha* (Pencil Cactus), *mufuta* or *umhlafutho* (Castor oil plant), the *mupfuti* tree (Brachystegia boehmii) and the *muremberembe* (long-tailed cassia), as the following participant explains:

"There is an old lady we know of who does the procedure. When we go to the old lady's place, she sharpens a root of castor beans tree and then inserts it in your privates. You then pull it out the following morning and you start bleeding, then it comes out." (24 years old, FGD22B, Participant 3, Bulawayo)

Other ingested substances commonly reported, any combination of which were believed to induce an abortion, were clothing detergents, bicarbonate of soda, a cola soft drink, vinegar and aloe vera, and chillies.

In general, there was high awareness amongst study participants around the levels of safety and health risks associated with the different abortion methods and providers, but youth and inexperience, desperation, lack of money and fear of being found out often pushed young women to resort to the methods available to them regardless of safety, thereby deepening their levels of vulnerability to poor SRH outcomes:

"Those who are not Doctors, they just start the process and send you away; you finish the process on your own. They don't care about what happens to you. I have a friend who was given herbs to abort and some residues remained in the uterus. Her body became swollen and she died, so it's risky. We witness others going to herbalists where they are not given anything to clean the uterus after the abortion. Sometimes the stick can remain in the uterus, sometimes you cannot afford to purchase pills to clean up at the pharmacy because you need USD. Sometimes you also go back to work quickly before you are totally healed." (18 years old, FGD12H, Participant 5, Harare)

Awareness of and access to PAC

In light of these less safe and least safe methods, it was concerning that many YWSS participants were unaware of the availability of PAC services should they have experienced abortion-related complications. For those who were aware of PAC services, several barriers prevented them from seeking out such care; in particular fears around being arrested for having undergone an abortion in a country with restrictive abortion law:

"No one will ever go to the local clinic after having complications as a result of an abortion because they know it's illegal and they could be arrested." (23 years old, FGD6H, Participant 3, Harare)

"We never get there [to the clinic] because of fear of being sued. You just think I will end up tied with chains on the hospital bed [laugh]." (18 years old, FGD12H, Participant 3, Harare)

While the research did not explore the PAC experiences of YWSS who had accessed this care, the CSO key informant was able to talk to the issue based on his work within his organisation:

"They go to a hospital but they face a hard time there … they will get a nasty experience there. They can leave you for hours and hours, knowing that they are not attending to you. They just leave you there, just because you don't know your rights. You can't stand up and claim that right, to say: 'Look I need my legal right on the health issues. I need to be treated as soon as possible; as soon as I get here I need to be treated'. That person (YWSS) will be saying 'Since I committed … . I did an illegal abortion, so I need to get help (to obtain PAC)'. You don't need to get help for a service! The service has to be provided at your need!" (CSO KI, IDI)

Given these fears and concerns, and lack of knowledge around formal PAC services, participants often resorted to self-administered PAC, emphasising the need to "clean the uterus". Participants distinguished clearly between vaginal douching as an everyday practice versus the need to orally ingest a pill or herbal remedy to "clean the uterus" following an abortion. It seemed that cleaning the uterus either referred to resolving incomplete abortions or treating infections following an abortion, with participants reporting a range of herbs or medications that they ingested as treatment:

"If your uterus is not cleaned once you have aborted, the consequences are excessive and long menstrual bleeding, excretion of wastes which are hard to place. So, the best thing is to get tablets which can clean your uterus soon after abortion. After I aborted my pregnancy, I used Doxycycline [tetracycline antibiotic]." (20 years old, FGD9H, Participant 3, Harare)

"You may bleed non-stop but if you go to the clinic, they will accuse you of aborting. They will ask a lot of questions. In the end, we will just buy herbs to cleanse the uterus. There are people who move around in our neighbourhoods selling the herbs. They will have a variety of herbs and pills, from those which treat STIs, to those which cleanse the uterus and those which prevent pregnancies." (19 years old, FGD5H, Participant 1, Harare)

Discussion

Our findings highlight that even if punitive legal consequences for seeking an abortion did not materialise in practice, the fear of legal repercussions due to the restrictive legal context greatly influenced decision-making around seeking induced abortion and PAC amongst our study participants. Another study about PAC in Zimbabwe reported fear of authorities around obtaining an abortion in the general female population.[18] Selling sex in a country where sex work is illegal will further compound these anxieties.

There are indications that abortion has long been practised within the respective communities in Zimbabwe, but the social stigma and marked silences around abortion, and lack of question over pregnancies that suddenly end, endure.[19,20] In this context, women who don't have strong social networks, as is generally the case for

adolescents, may not know where to go to obtain a safe abortion and may be understandably cautious about asking for information, leading to less and least safe practices. Indeed, many study participants were initially very guarded about sharing information over their own abortion experiences in the FGDs and some chose not to answer the question as to whether they had undergone an abortion in the brief structured questionnaire administered after each FGD. The restrictive abortion law, illegality of sex work and the social stigma attached to being a young woman selling sex and to undergoing an abortion in Zimbabwe undoubtedly contribute to the highly clandestine abortion practices amongst these young women and will discourage the sharing of information on where to obtain safe abortions, where available, potentially leading to least safe practices. Research has found that even in a liberalised country context, where abortion is obtainable on request, the stigma associated with being a sex worker negatively impacts seeking abortion care,[21] highlighting the need for tailored approaches to safe abortion services for sex workers – and particularly young women who sell sex.

Our findings around financial hardship and inability to identify who fathered the child, as amongst the key factors underlying decision-making to undergo an abortion, have been found in other country contexts in the region.[22] In the Zimbabwean context, where lineage is strongly patriarchal, a child takes the father's family name and is viewed as belonging to the father's family.[19] While not negating the economic dimension of acknowledged paternity, our findings also suggest that not being able to identify the father of a child, for the child's sake, was also an important consideration in the abortion decision-making process. Socioeconomic concerns related to decision-making around an abortion are one of the most commonly cited reasons in other country contexts.[1] Interestingly, in three countries in SSA, women were more likely to cite factors associated with youth (e.g. still in school, not yet prepared to have a child, and fear of parent's reactions to the pregnancy) as reasons for wanting to obtain an abortion.[1] We have previously highlighted that YWSS will go to some length to distance themselves from a sex worker identity and keep their involvement in selling sex secret from family members,[23] pointing to the need to consider different strategies targeting younger versus older women who sell sex, in relation to safe abortion care. Even where safe abortion services are available, they may have limited reach amongst younger women who sell sex who are not part of safe abortion referral networks.

While some young women did experience abortion-related complications, as reported in our descriptive and qualitative data, there remains a question over the extent of least safe abortion amongst this population. Our data suggesting that deaths due to complications from abortion which occur outside health facilities may not be reported as such means that least safe abortions may be underestimated in national surveys.[24] A recent study evaluating the quality and coverage of PAC in Zimbabwe found critical gaps in availability.[11] This study reported stock-outs of misoprostol, and lack of intravenous antibiotics and blood for transfusions in Zimbabwe's central hospitals, which deal with the most serious abortion-related complications.[11] Of key concern were the study findings reporting delays in women accessing PAC due to lack of ability to pay for services before receiving care, with one-fifth of public facilities requiring up-front payment.[10] Given our study findings that cost is a key determinant to least safe abortion, the health of young women who suffer complications due to abortion will be further compromised due to prohibitive cost barriers in accessing the necessary, life-saving, PAC services. Low capacity to provide PAC at health facility level, combined with negative provider attitudes and fears around being arrested, will act as a strong deterrent to these young women accessing PAC. A recent review of PAC in the east and southern Africa region has highlighted a gap in adequate PAC for adolescent populations and the need to address adolescent-specific needs in PAC services.[25] Compared to older women, adolescents generally have less knowledge of health services and this will negatively influence their healthcare-seeking behaviour.[2] Greater effort should be made in creating awareness around the availability of PAC services and ensuring that facilities do not charge for what, according to Zimbabwean national policy, should be freely provided.[10]

Limitations

There were several limitations to the study. Given the fears of reprisal if found to have undergone an abortion, it is possible that experiences of abortions were under-reported by our study

participants. However, this was a qualitative study and the descriptive findings presented here are not intended to be generalised or regarded as representative of the YWSS population in Zimbabwe. In addition, this study focused on the basket of SRHR issues amongst YWSS in Zimbabwe. For this reason, our analysis could not determine the extent of unsafe abortions and the level of need for safe abortion care and PAC amongst this population. For this, a stand-alone, in-depth study is required in order to further inform policy and programming.

Conclusions

Unsafe abortions represent a key site where health inequities manifest most visibly. For young women living on the margins, an undesired pregnancy can deepen pre-existing vulnerabilities and increase their SRH risk as a result of survival needs. Living in already precarious circumstances and unable or not yet ready to accommodate the needs of a child, some of these young women may choose to exercise their reproductive right to terminate their pregnancies. However, in restricted legal contexts, safe abortion services are often limited to private providers, meaning that those that need them most are often the least likely to be able to afford them. These young women are also more likely to experience the most barriers to accessing care, through the compounded stigma of being young, in the first instance, and involved in selling sex in the second. For these reasons, even where safe abortion services are available, young women may opt for the services of informal providers who may not stigmatise their clients but whose methods may pose a serious risk to their health. Greater efforts need to be made at the national level to offer services that are not only safe in terms of quality of care but also that are viewed as safe to access for young women already experiencing high levels of stigma and discrimination and who are disproportionately burdened by poor SRH outcomes.

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Résumé

Dans le monde, les femmes se heurtent à des inégalités dans l'accès aux services d'avortement sûr et elles le ressentent de manière particulièrement aiguë dans les pays où les avortements sont extrêmement restreints. Les données relatives à l'avortement parmi les jeunes femmes qui vendent des faveurs sexuelles en Afrique subsaharienne sont très limitées. Nous avons mené 30 discussions par groupe d'intérêt et 42 entretiens approfondis auprès de jeunes femmes âgées de 16 à 24 ans qui vendent leurs faveurs sexuelles dans des zones urbaines et périurbaines du Zimbabwe, ainsi

Resumen

Mundialmente, las mujeres enfrentan inequidades en el acceso a los servicios de aborto seguro; esto sucede con mayor intensidad en contextos nacionales donde la interrupción legal del embarazo es sumamente restringida. Existen datos muy limitados en torno al aborto entre mujeres jóvenes que venden sexo (MJVS) en África subsahariana. Realizamos 30 discusiones en grupos focales y 42 entrevistas a profundidad (EAP) entre MJVS (de 16 a 24 años) en zonas urbanas y periurbanas de Zimbabue, así como EAP entre 16 educadores de pares, cinco profesionales de

que des entretiens approfondis avec 16 éducateurs de pairs, cinq prestataires de soins de santé et quatre informateurs clés. Nos résultats indiquent que l'avortement est fréquent chez ces jeunes femmes au Zimbabwe, mais que des questions demeurent sur la sécurité des avortements. Le contexte juridique restrictif autour de l'avortement et l'illégalité du travail du sexe dans le pays sont des déterminants majeurs sous-tendant la nature clandestine des avortements. Les préoccupations socioéconomiques influent profondément sur les décisions relatives à l'avortement. La jeunesse des femmes, le coût de l'intervention et le manque de réseaux d'aiguillage contribuent aux avortements à risque, même lorsque des services d'avortement sûr sont disponibles. Beaucoup de ces jeunes femmes ne connaissent pas la possibilité de services de soins postavortement et ont recours à des soins auto-administrés. Le jeune âge et la pratique du commerce du sexe s'associent et interagissent aux niveaux politique, économique et social pour produire des vulnérabilités à un avortement à risque qui sont plus grandes que la somme de ces facteurs.

salud y cuatro informantes clave. Nuestros hallazgos indican que el aborto es común entre las MJVS en Zimbabue, pero aún existen preguntas sobre la seguridad del aborto. El contexto legislativo restrictivo en torno al aborto y la ilegalidad del trabajo sexual en el país son determinantes clave implícitos en la naturaleza clandestina del aborto. Las preocupaciones socioeconómicas son de importancia fundamental en la toma de decisiones sobre el aborto. La juventud, el costo y la falta de redes de referencia contribuyen a los abortos inseguros, aun cuando hay servicios de aborto seguro disponibles. Muchas MJVS no son conscientes de la disponibilidad de servicios de atención postaborto (APA) y recurren a APA autoadministrada. Ser joven y vender sexo se combinan e interactúan a nivel político, económico y social para producir vulnerabilidades mayores que su suma y experimentar un aborto inseguro.