Healthcare Providers' Ethical Navigation of Adolescent Abortion Care in Lusaka, Zambia

Hambweka S Munkombwe[*1], Joseph Mumba Zulu[2], Tizta Tilahun Degfie[1,3]

[1]Department of Public Health, School of Postgraduate Studies, University of Lusaka, Lusaka, Zambia

[2]School of Public Health, University of Zambia, Departments of Health Policy and Management, Health Promotion and Education

[3]Department of Reproductive Health and Population Studies, Bahir Dar University, Ethiopia

DOI: https://doi.org/10.47772/IJRISS.2026.100600898

Received: 20 June 2026; Accepted: 25 June 2026; Published: 08 July 2026

ABSTRACT

Background: Adolescent abortion care often poses ethical and practical challenges for healthcare providers. Debates commonly focus on adolescents' decision-making capacity, the role of parental involvement, and how to balance respect for autonomy with the implementation of policies and guidelines. This study investigated the ethical debates surrounding adolescent abortion care in Lusaka, Zambia, from healthcare providers' perspectives. Using an interpretive phenomenological approach, the study explored how providers understand adolescents' autonomy, parental involvement, and their ethical responsibilities in abortion care.

Methods: This qualitative study used an interpretive phenomenological design and Interpretative Phenomenological Analysis to explore healthcare providers' experiences supporting adolescents seeking abortion services in Lusaka, Zambia. The study was conducted in the Lusaka and Chongwe districts and involved mid-level providers engaged in abortion care. Semi-structured, face-to-face interviews were conducted with twelve healthcare providers. Data were analysed manually through iterative reading of transcripts, identification of exploratory comments, and development of subordinate and superordinate themes. Microsoft Word and Excel were used to organise analytic tables and emerging themes.

Results: Three interconnected themes emerged. First, providers viewed adolescents' abortion decisions as shaped by wider social factors, including educational goals, financial difficulties, stigma, and relationship instability. Second, providers described assessing adolescents' decision-making capacity through relational interactions, considering knowledge, communication, and educational background rather than age alone. Third, providers emphasised the balancing act between adolescent autonomy and parental involvement, often acting as mediators to reconcile legal obligations, parental authority, and adolescents' views.

Conclusion: Providers viewed adolescent abortion decision-making as a socially embedded, relational process rather than a purely individual choice. Policies and clinical guidance should better support providers in assessing adolescents' evolving capacities and in managing parental involvement while safeguarding adolescents' autonomy and access to care.

Keywords: adolescent abortion; decision-making capacity; autonomy; parental involvement; healthcare providers

INTRODUCTION

Unsafe abortion remains a major public health concern, particularly in sub-Saharan Africa, where a large share of abortions are unsafe (World Health Organisation, 2025; Haddad & Nour, 2009; Gebremedhin et al., 2018). Adolescents are especially vulnerable because pregnancy and childbirth complications remain leading causes of

death among girls ages 15–19 (World Health Organisation, 2024). Unsafe abortion can also cause serious complications, including infection, haemorrhage, and death, and places additional pressure on already strained health systems (Campbell et al., 2016; Likwa et al., 2009; Wall & Yemane, 2022). These risks make access to safe, timely, and ethically appropriate abortion care especially important for adolescents.

In Zambia, abortion is legally permitted under specified conditions. Yet, access to safe abortion remains uneven because of stigma, limited awareness, service-level constraints, and uncertainty around legal interpretation (Government of the Republic of Zambia, 1972; Campbell et al., 2016; Haaland et al., 2019; Fetters et al., 2017). Unsafe abortion continues to contribute substantially to maternal morbidity and mortality, and abortion-related complications account for a significant proportion of gynaecological admissions (Likwa et al., 2009; Lubeya et al., 2022). For adolescents, these access barriers intersect with concerns about confidentiality, parental involvement, and decision-making capacity, making abortion care both a clinical and ethical issue.

Adolescent abortion care raises ethical questions about decision-making capacity, autonomy, confidentiality, and parental involvement. Existing studies show differing views among providers and related professional groups. Some support parental involvement when adolescents seek abortion care, particularly when adolescents are perceived as needing guidance or lacking decision-making capacity (Engelbert Bain et al., 2020; Debuo Der & Ganle, 2026). Others emphasise that adolescents may be able to make informed pregnancy-related decisions, especially when they demonstrate understanding and receive appropriate counselling (McLean et al., 2019; Engelbert Bain et al., 2019; Lokubal et al., 2022). These debates highlight the practical difficulty of balancing adolescents' autonomy with welfare concerns, family expectations, and legal or institutional requirements.

Although previous studies have examined adolescents' access to abortion and healthcare providers' attitudes, less is known about how providers navigate ethical tensions in adolescent abortion care. Ethical issues are often discussed indirectly through attitudes, legal restrictions, or service barriers rather than through explicit attention to how providers balance autonomy, duty of care, confidentiality, and parental involvement in clinical practice. This gap is particularly important in sub-Saharan Africa, where cultural norms, legal interpretation, stigma, and health system constraints shape adolescents' reproductive choices. In Zambia, qualitative evidence on how healthcare providers interpret and manage these ethical responsibilities when adolescents request abortion services is limited.

This study aimed to explore healthcare providers' experiences of ethical decision-making in adolescent abortion care in Lusaka, Zambia. It focused on how providers understand adolescents' autonomy, parental involvement, and their professional responsibilities when supporting adolescents seeking abortion services.

MATERIALS and METHODS

Study Setting

The study was conducted in Lusaka Province, Zambia, where abortion is legally permitted under specified conditions but remains highly stigmatised, especially for adolescents. Abortion is regulated by the Termination of Pregnancy Act, although implementation remains shaped by legal interpretation, stigma, and service-level constraints (Government of the Republic of Zambia, 1972; Haaland et al., 2019; Fetters et al., 2017). Safe abortion and post-abortion care are provided mainly through public hospitals and primary health facilities, with trained mid-level providers, including midwives, nurses, and clinical officers, permitted to provide abortion-related services under national abortion guidelines (Campbell et al., 2016; Haaland et al., 2019).

Data were collected from seven public facilities in Lusaka and Chongwe districts: Mtendere Health Centre, Kalingalinga Health Centre, Chainda Health Centre, Ngwerere Health Centre, Matero Level 1 Hospital, Chawama Level 1 Hospital, and Chongwe District Hospital. Four were primary healthcare facilities, and three were level one hospitals. These sites were selected because they provide abortion-related services and have trained providers, making them suitable for exploring healthcare providers' experiences of ethical issues in adolescent abortion care.

Study Design

This qualitative study used interpretive phenomenology to explore healthcare providers' experiences with ethical issues in adolescent abortion care in Lusaka, Zambia. This approach was chosen because it supports an in-depth understanding of how providers make sense of adolescents' autonomy, parental involvement, and their professional responsibilities in abortion care. It was appropriate for examining how providers interpret and respond to these issues in routine clinical practice.

Participants and Recruitment

Participants were purposively recruited from the seven selected public health facilities. Eligible participants were mid-level healthcare providers trained in comprehensive abortion care, actively providing abortion-related services, including services for adolescents, and willing to participate. Purposive sampling was used to identify providers with direct experience of the study topic (Campbell et al., 2020). Twelve healthcare providers participated. Consistent with interpretive phenomenology, the sample size was considered appropriate for generating detailed accounts of providers' experiences rather than statistical representation (Eatough & Smith, 2006; Neale, 2020).

Data Collection

Data were obtained through face-to-face, semi-structured interviews with 12 purposefully selected healthcare providers. An interview guide featuring open-ended questions was used to examine the providers' experiences and perspectives on ethical issues in adolescent abortion care, with probes to clarify and deepen responses. Interviews took place in private areas within the selected health facilities and lasted 30 to 60 minutes. Data collection occurred from October 2025 to February 2026; the period was extended due to the topic's sensitivity and the limited number of trained providers available. With participants' consent, interviews were audio-recorded, transcribed, and then manually checked by the researcher against the recordings to ensure accuracy.

Data Analysis

Data were analysed using Interpretative Phenomenological Analysis (IPA), which examines how individuals make sense of lived experiences (Eatough & Smith, 2006; Smith & Osborn, 2015). Each transcript was first read repeatedly and analysed as an individual case. Exploratory comments were recorded alongside relevant quotations to capture initial interpretations. These comments were then developed into subordinate themes for each participant. Related subordinate themes were compared across transcripts and clustered into broader superordinate themes. Analysis was iterative, with earlier themes revisited as new patterns emerged across interviews. Microsoft Word and Excel were used to organise transcripts, analytic notes, and thematic tables, while interpretation and theme development were conducted manually.

Reflexivity

Reflexivity was incorporated during analysis through a reflexivity journal. The lead researcher documented personal reactions, assumptions, and emerging interpretations, particularly where professional experience in sexual and reproductive health and rights could influence the interpretation of participants' accounts. These reflections supported critical engagement with the transcripts and helped ensure that themes remained grounded in participants' narratives rather than the researcher's prior assumptions.

Ethical Considerations

Ethical approval was obtained from the UNILUS Research Ethics Committee, University of Lusaka (Ref No.: FWA00033228-00103/25), with additional authorisation from the National Health Research Authority, Provincial Health Office, and District Health Offices. Facility-level permission was granted by Medical Superintendents for hospitals and Facility-in-Charge officers for public healthcare clinics. Verbal informed consent was obtained from all participants after the study purpose, voluntary participation, confidentiality measures, and the right to withdraw were explained. To protect confidentiality, transcripts were anonymised by

removing participant and facility identifiers. Audio recordings and transcripts were stored securely on the researcher's password-protected computer (Saunders et al., 2015).

RESULTS

Twelve healthcare providers took part in the study. Their median age was 37 years (range: 30-58), with 7 males. The participants included midwives, clinical officers, medical licentiates, and registered nurses from hospitals and primary healthcare clinics. They had between two and ten years of experience delivering abortion or post-abortion care.

Three superordinate themes emerged from the analysis, each with related subordinate themes (Table 1). Together, these themes show how healthcare providers understood adolescents' abortion decision-making and how they navigated adolescent autonomy, parental involvement, and professional responsibilities in practice.

Table 1: Final themes: healthcare providers' experiences of adolescent abortion decision-making

Superordinate Theme	Subordinate Themes
1.0 Adolescents' decisions shaped by social realities	School continuation concerns Financial constraints Unplanned pregnancy Social stigma Relationship instability
2.0 Assessing adolescents' capacity for decision-making	Knowledge-based maturity assessment Communication-based maturity assessment Education-level assessment Recognition of adolescent autonomy
3.0 Negotiating autonomy and parental involvement	Parental consent requirements Mediation of parent-adolescent conflict Supportive parental involvement Protection of adolescent autonomy

Theme 1: Adolescents' decisions are shaped by social realities

Providers explained that adolescents' choices regarding abortion are influenced more by social and economic factors than by personal preference. They associated these decisions with worries about staying in school, financial instability, unplanned pregnancies, stigma, and unstable relationships.

School continuation concerns

Participants consistently linked adolescents' decisions to seek an abortion with the desire to stay in education and protect future opportunities. "...she knows that maybe she's in school or they are unable to provide, or maybe the person who impregnated her is a married man..." (P4). Providers described adolescents as weighing pregnancy against school continuation and longer-term plans.

Financial constraints

Financial insecurity was described as an important factor in adolescents' abortion decisions. Providers reported that some adolescents lacked the financial capacity to support a child, particularly when they remained dependent on parents or guardians. "...and she said, my mother is really struggling. She is a maid..." (P3). Providers associated these decisions with poverty, dependence, and limited support.

Unplanned pregnancy

An unplanned pregnancy was often cited as the immediate reason for seeking an abortion. Providers noted that adolescents frequently described their pregnancies as accidental or unexpected and said they were not ready for motherhood. “Many adolescents say it was not planned; it just happened.” (P2). Providers described this as a common reason adolescents gave for requesting abortion care.

Social stigma

Participants emphasised the role of stigma in influencing adolescents’ choices, especially fear of judgement from family, community members, and peers. “They fear what people in the community will say if they continue with the pregnancy.” (P7). Another participant stated, “Some girls come because they are afraid their parents and neighbours will judge them.” (P8). Providers described stigma as a reason adolescents concealed pregnancies or delayed seeking support.

Relationship instability

Relationship dynamics, especially a lack of partner support, were also described as influencing abortion decisions. Providers reported situations where partners denied responsibility or withdrew support, leaving adolescents to manage the pregnancy alone. “Sometimes the boyfriend has refused responsibility, so the girl decides she cannot keep the pregnancy.” (P5). Providers identified partner abandonment and relationship uncertainty as common concerns raised by adolescents.

Across these accounts, providers understood adolescents’ abortion decisions as responses to pressures that could disrupt education, future opportunities, family support, and social acceptance. They therefore viewed these decisions as embedded in wider social realities rather than as isolated or impulsive choices.

Theme 2: Assessing adolescents’ capacity for decision-making

Providers described assessing adolescents’ decision-making capacity as a key part of abortion care. They considered adolescents’ knowledge of abortion, ability to explain their reasons and understand information, educational background, and demonstrated independence in decision-making.

Knowledge-based maturity assessment

Providers assessed adolescents’ decision-making ability by exploring their knowledge of abortion. This involved asking adolescents to explain what they understood about the procedure, risks, and possible implications. “Do they know much about abortion, or do they not know anything? If they do not know anything, you can start at that level… tell me what you know about this.” (P2). Providers described using these responses to determine the level of counselling and information needed.

Communication-based maturity assessment

Beyond knowledge, providers evaluated adolescents’ maturity through their ability to communicate clearly and coherently. “You look at how she explains her reasons and whether she is confident.” (P2). Adolescents who could articulate their reasons, respond to questions, and engage in dialogue were often considered more able to participate in decisions about their care.

Education-level assessment

Some participants considered adolescents’ educational backgrounds when assessing maturity and deciding how to provide information. “Some are grade 4s, some grade 9s, some grade 7s… when you understand that it becomes easier to know how to manage the client.” (P1). Providers explained that lower levels of education often required more explanation and support, while adolescents with higher levels of education were sometimes perceived as understanding information more quickly.

Recognition of adolescent autonomy

While acknowledging variation in maturity, providers recognised that some adolescents showed clear independence in decision-making. These adolescents were described as confident, informed, and decisive before reaching the facility. "Some adolescents know exactly what they want, and they explain clearly." (P9). Providers described such adolescents as able to express their preferences and participate actively in decisions about their care.

Together, these accounts show that providers did not assess capacity based solely on age. Instead, they relied on interactions during counselling to judge whether adolescents understood the procedure, could explain their reasoning, and could engage with the information provided. Capacity was therefore treated as context-specific and supported through dialogue rather than assumed or dismissed solely on the basis of age.

Theme 3: Negotiating autonomy and parental involvement

Providers characterised adolescent abortion decision-making as a negotiated process involving adolescents, parents or guardians, and healthcare providers. They acknowledged adolescents' capacity to voice their opinions but also noted the impact of parental consent laws, family expectations, and institutional policies. The subordinate themes included parental consent requirements, mediating parent-adolescent conflict, supportive parental engagement, and safeguarding adolescent autonomy.

Parental consent requirements

Participants frequently mentioned legal and institutional rules requiring parental or guardian consent for minors. "I believe that at 16, a person is capable of providing consent... However, based on the legal context, an 18-year-old is still considered a child, but if they can understand and give consent, we proceed with the process." (P6). Providers described these requirements as important but sometimes difficult to apply when adolescents were reluctant or unable to involve parents or guardians. "...the tricky part is when consent must be obtained... a child who is 18 seeking an abortion cannot give consent independently..." (P7). Providers reported that consent requirements could affect adolescents' access to care.

Mediation of parent-adolescent conflict

Providers often encountered situations where adolescents and parents held conflicting views about abortion decisions. In such cases, providers described facilitating discussion, allowing time for reflection, and encouraging families to return when they were ready. "If they cannot agree, I give them time and a later date... when they are ready, they can come back." (P5). Providers reported that this approach helped manage disagreements during care.

Supportive parental involvement

Although parental involvement can sometimes be restrictive, participants also noted occasions where it proved beneficial. Supportive parents were viewed as offering emotional reassurance, helping adolescents understand medical information, and supporting decision-making. "When parents understand the situation, they help the girl make a decision." (P6). Providers also considered parental support helpful when it facilitated more open discussions about options.

Protection of adolescent autonomy

While acknowledging parents' roles, providers highlighted the importance of including adolescents' voices in decision-making. Even with parental involvement, they prioritised listening to the adolescent's perspective and avoided imposing decisions. For example, a participant said, "Even if the parent is there, you still listen to the girl first." (P2). Another emphasised, "The adolescent must express her own decision." (P9). Providers described this as part of efforts to ensure that adolescents remained involved in decisions about their care.

In these accounts, providers acted as intermediaries among adolescents, parents or guardians, and institutional protocols. They aimed to meet consent standards while ensuring adolescents' voices were heard and included in their care decisions. This balancing act influenced how providers handled parental participation, all while safeguarding adolescent autonomy.

DISCUSSION

This study shows that healthcare providers understood adolescent abortion decision-making as socially embedded, relational, and shaped by institutional expectations. Rather than treating adolescents' choices as isolated individual preferences, providers interpreted them in relation to education, financial insecurity, stigma, relationship instability, parental involvement, and consent requirements.

These findings can be interpreted through principlism, which emphasises respect for autonomy, beneficence, non-maleficence, and justice in healthcare decision-making (Beauchamp, 2003; Beauchamp, 2016; Revon & Reiss, 2025). Providers' accounts show that adolescent abortion care rarely involves applying one ethical principle in isolation. Instead, providers balanced adolescents' emerging autonomy with their duty to support informed decisions, prevent harm, and comply with legal or institutional expectations. This reflects the practical use of specification and balancing when broad ethical principles must be adapted to complex clinical situations (Clarke, 2009; Revon & Reiss, 2025).

Respect for autonomy was therefore not understood as a purely individual act of choice, but as a process shaped by social conditions and counselling interactions (Beauchamp, 2003; Lindridge, 2017). Providers' attention to schooling, poverty, stigma, and relationship instability suggests that ethically responsive care requires more than asking whether an adolescent wants an abortion; it requires understanding the pressures that shape how that preference is formed and expressed.

Providers also balanced autonomy with beneficence and non-maleficence when assessing decision-making capacity. Their focus on adolescents' understanding, communication, and ability to explain their reasons reflects an interactional rather than age-based approach to capacity assessment (Beauchamp, 2003; McCarthy, 2003). This is important because rigid age-based assumptions risk either excluding capable adolescents from meaningful decision-making or exposing less-prepared adolescents to decisions without adequate support.

Parental involvement created the most visible ethical tension. Providers valued family support where it helped adolescents understand options and access care, but they also recognised that parental authority could constrain adolescents' autonomy. Their role as mediators illustrates how ethical decision-making in adolescent abortion care involves balancing competing duties: respecting adolescents' views, preventing harm, complying with legal or institutional requirements, and maintaining confidentiality where possible (Beauchamp, 2003; Revon & Reiss, 2025).

These findings align with studies showing that providers' responses to adolescent abortion care are shaped by concerns about maturity, parental involvement, legal interpretation, stigma, and adolescents' social vulnerability (Engelbert Bain et al., 2020; Debuo Der & Ganle, 2026; Lokubal et al., 2022; Dempsey et al., 2024). However, this study adds to the literature by showing how providers navigate between ethical principles in practice, using counselling encounters to interpret adolescents' capacities, social contexts, and family dynamics rather than applying fixed rules alone.

Regional evidence illustrates similar tensions. In Ghana, studies have reported ambivalence among providers and related professional groups about adolescents' decision-making capacity and parental involvement (Engelbert Bain et al., 2020; Debuo Der & Ganle, 2026). In Ethiopia, abortion providers have described ethical dilemmas when legal access is formally permitted but constrained by stigma and institutional uncertainty (McLean et al., 2019; Fekadu et al., 2022). Across low- and middle-income settings, adolescent abortion decisions are similarly influenced by partner support, family dynamics, schooling, poverty, and fear of social judgement (Lokubal et al., 2022). The present study is consistent with this broader body of evidence but adds a Zambian perspective by showing how providers translate these tensions into everyday counselling and consent practices.

These findings have three practical implications. First, adolescent abortion decisions should be interpreted within the social realities that shape choice. Second, decision-making capacity should be assessed through structured dialogue rather than age alone. Third, parental involvement should be managed in ways that support, rather than replace, adolescents' own participation in decisions about their care.

To translate these findings into practice, clinical guidance should include three elements. First, providers need structured but flexible criteria for assessing decision-making capacity, including adolescents' understanding of the procedure, ability to explain their reasons, appreciation of risks and alternatives, and consistency of choice.

Second, counselling guidance should require providers to explore the social context shaping adolescents' decisions, including schooling, financial dependency, stigma, relationship instability, and safety concerns, without using these factors to override adolescents' expressed preferences.

Third, guidance should clarify how parents or guardians may be involved in ways that support, rather than replace, adolescent decision-making. This should include procedures for protecting confidentiality, managing disagreement, and ensuring that the adolescent's own views are documented and prioritised during counselling.

Strengths and Limitations

This study offers a detailed overview of healthcare providers' experiences across seven public health facilities in Lusaka and Chongwe districts. Using Interpretative Phenomenological Analysis allowed for in-depth engagement with participants' accounts and yielded context-specific insights into ethical decision-making in adolescent abortion care. However, the study involved only 12 providers from selected facilities, which may limit the generalisability of the results to other settings. This study reports the healthcare provider component of a larger study that also included adolescents' perspectives and service data. Therefore, while the present findings provide an in-depth understanding of providers' ethical decision-making, they do not represent adolescents' own experiences of abortion decision-making and care. These perspectives will be examined in complementary analyses to provide a more balanced and comprehensive understanding of ethical decision-making.

CONCLUSION

This study shows that healthcare providers understood adolescent abortion decision-making as socially embedded, relational, and shaped by institutional expectations. Providers described adolescents' decisions as influenced by education, financial insecurity, stigma, and relationship instability. They assessed adolescents' decision-making capacity through counselling interactions rather than age alone and often mediated between adolescents, parents or guardians, and legal or facility requirements. These findings suggest that ethical decision-making in adolescent abortion care requires attention to adolescents' social contexts, evolving capacities, and family dynamics.

Policies and clinical guidance should therefore provide clearer guidance on assessing adolescents' decision-making capacity, managing parental involvement, and safeguarding adolescents' autonomy, confidentiality, and access to care. Strengthening provider guidance and support systems may promote more consistent, rights-based, and ethically grounded care for adolescents seeking abortion.

RECOMMENDATIONS

Based on these findings, policy guidance for adolescent abortion care should provide structured but flexible criteria for assessing adolescents' decision-making capacity, recognising that capacity may be demonstrated through knowledge, communication, understanding, and counselling interaction rather than age alone. Guidance should also acknowledge the social conditions that shape adolescents' abortion decisions, including education, economic insecurity, stigma, relationship dynamics, and family circumstances.

Practice guidance should clarify how providers can balance parental involvement with safeguarding adolescents' autonomy, confidentiality, and right to be heard. Training should enhance providers' skills in adolescent-centred counselling, ethical decision-making, and effective communication with adolescents and their parents or

guardians. Future analyses should integrate adolescents' perspectives with healthcare providers' accounts and service data to provide a more comprehensive understanding of ethical decision-making in adolescent abortion care.

Declaration by Authors

Ethical approval: Ethical approval was obtained from the UNILUS Research Ethics Committee, University of Lusaka (Ref No.: FWA00033228-00103/25), with additional authorisation from the National Health Research Authority, Provincial Health Office, District Health Offices, and participating facilities.

Acknowledgements: The authors acknowledge the healthcare providers who participated in the study and the health facility managers who supported data collection.

Funding: This research received no external funding.

Data availability: The qualitative interview data are not publicly available due to confidentiality and ethical restrictions. De-identified data may be available from the corresponding author upon reasonable request and subject to ethical approval.

Conflicts of interest: The authors declare no conflicts of interest.

REFERENCES

1. Allen, L. R., Adams, N., Ashley, F., Dodd, C., Ehrensaft, D., Fraser, L., Garcia, M., Giordano, S., Green, J., Johnson, T., Penny, J., Rachlin, K., & Veale, J. F. (2025). Principlism and contemporary ethical considerations for providers of transgender health care. International Journal of Transgender Health, 26(3), 611-629. https://doi.org/10.1080/26895269.2024.2303462
2. Beauchamp, T. L. (2003). Methods and principles in biomedical ethics. Journal of Medical Ethics, 29(5), 269-274. https://doi.org/10.1136/jme.29.5.269
3. Beauchamp, T. L. (2016). Principlism in bioethics. In Bioethical decision making and argumentation (pp. 1-16). Springer International Publishing. https://doi.org/10.1007/978-3-319-43419-3_1
4. Campbell, O. M., Aquino, E. M., Vwalika, B., & Gabrysch, S. (2016). Signal functions for measuring the ability of health facilities to provide abortion services: An illustrative analysis using a health facility census in Zambia. BMC Pregnancy and Childbirth, 16(1), 105. https://doi.org/10.1186/s12884-016-0872-5
5. Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: Complex or simple? Research case examples. Journal of Research in Nursing, 25(8), 652-661. https://doi.org/10.1177/1744987120927206
6. Clarke, D. L. (2009). Moral principlism alone is insufficient, and traditional moral theories remain important for practical ethics. South African Journal of Bioethics and Law, 2(2), 54-58.
7. Debuo Der, A., & Ganle, J. K. (2026). Ethical issues in providing comprehensive abortion care to adolescents: A qualitative study of healthcare providers in the Eastern Region of Ghana. BMC Medical Ethics, 27, 13. https://doi.org/10.1186/s12910-026-01398-3
8. Dempsey, B., Callaghan, S., & Higgins, M. F. (2024). Providers' experiences with abortion care: A scoping review. PLoS One, 19(7), e0303601. https://doi.org/10.1371/journal.pone.0303601
9. Eatough, V., & Smith, J. A. (2006). I feel like a scrambled egg in my head: An idiographic case study of meaning making and anger using interpretative phenomenological analysis. Psychology and Psychotherapy, 79(1), 115-135. https://doi.org/10.1348/147608305X41100
10. Engelbert Bain, L., Amoakoh-Coleman, M., Tiendrebeogo, K. S., Zweekhorst, M. B., de Cock Buning, T., & Becquet, R. (2020). Attitudes towards abortion and decision-making capacity of pregnant adolescents: Perspectives of medicine, midwifery and law students in Accra, Ghana. European Journal of Contraception and Reproductive Health Care, 25(2), 151-158. https://doi.org/10.1080/13625187.2020.1730792
11. Engelbert Bain, L., Zweekhorst, M. B. M., Amoakoh-Coleman, M., Muftugil-Yalcin, S., Omolade, A. I.-O., Becquet, R., & de Cock Buning, T. (2019). To keep or not to keep? Decision-making in adolescent

pregnancies in Jamestown, Ghana. PLoS One, 14(9), e0221789. https://doi.org/10.1371/journal.pone.0221789

12. Fekadu, A., Berhe, A., Belgu, B., Yimer, I., Tesfaye, Y., Holcombe, S. J., & Burrowes, S. (2022). Professionalism, stigma, and willingness to provide patient-centred safe abortion counselling and care: A mixed methods study of Ethiopian midwives. Reproductive Health, 19(Suppl 1), 197. https://doi.org/10.1186/s12978-021-01238-0
13. Fetters, T., Samandari, G., Djemo, P., Vwallika, B., & Mupeta, S. (2017). Moving from legality to reality: How medical abortion methods were introduced with implementation science in Zambia. Reproductive Health, 14(1), 26. https://doi.org/10.1186/s12978-017-0289-2
14. Gebremedhin, M., Semahegn, A., Usmael, T., & Tesfaye, G. (2018). Unsafe abortion and associated factors among reproductive aged women in Sub-Saharan Africa: A protocol for a systematic review and meta-analysis. Systematic Reviews, 7(1), 130. https://doi.org/10.1186/s13643-018-0775-9
15. Government of the Republic of Zambia. (1972). The Termination of Pregnancy Act. https://www.parliament.gov.zm/sites/default/files/documents/acts/Termination%20of%20Pregnancy%20Act.pdf
16. Haaland, M. E. S., Haukanes, H., Zulu, J. M., Moland, K. M., Michelo, C., Munakampe, M. N., & Blystad, A. (2019). Shaping the abortion policy-competing discourses on the Zambian Termination of Pregnancy Act. International Journal for Equity in Health, 18(1), 20. https://doi.org/10.1186/s12939-018-0908-8
17. Haddad, L. B., & Nour, N. M. (2009). Unsafe abortion: Unnecessary maternal mortality. Reviews in Obstetrics & Gynecology, 2(2), 122.
18. Likwa, R. N., Biddlecom, A., & Ball, H. (2009). Unsafe abortion in Zambia. Issues Brief, (3), 1-4.
19. Lindridge, J. (2017). Principlism: When values conflict. Journal of Paramedic Practice, 9(4), 158-163. https://doi.org/10.12968/jpar.2017.9.4.158
20. Lokubal, P., Corcuera, I., Balil, J. M., Frischer, S. R., Kayemba, C. N., Kurinczuk, J. J., Opondo, C., & Nair, M. (2022). Abortion decision-making process trajectories and determinants in low- and middle-income countries: A mixed-methods systematic review and meta-analysis. EClinicalMedicine, 54, 101762. https://doi.org/10.1016/j.eclinm.2022.101762
21. Lubeya, M. K., Mukosha, M., Jacobs, C., Chanda, K., Phiri, C. C., Munakampe, M. N., Sichone, V., Makasa, M., Mangala, B., Vwalika, B., & Kaonga, P. (2022). Magnitude and determinants of unsafe abortion among Zambian women presenting for abortion care services: A multilevel analysis. International Journal of Gynecology & Obstetrics, 159(3), 979. https://doi.org/10.1002/ijgo.14351
22. McCarthy, J. (2003). Principlism or narrative ethics: Must we choose between them? Medical Humanities, 29(2), 65-71. https://doi.org/10.1136/mh.29.2.65
23. McLean, E., Desalegn, D. N., Blystad, A., & Miljeteig, I. (2019). When the law makes doors slightly open: Ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia. BMC Medical Ethics, 20(1), 60. https://doi.org/10.1186/s12910-019-0396-4
24. McReynolds-Pérez, J. (2017). Abortion as empowerment: Reproductive rights activism in a legally restricted context. BMC Pregnancy and Childbirth, 17(Suppl 2), 350. https://doi.org/10.1186/s12884-017-1498-y
25. Neale, J. (2020). Research methods for health and social care. Bloomsbury Publishing.
26. Revon, G., & Reiss, J. (2025). Principlism in bioethics: How to consolidate autonomy? A scoping review. Bioethics Open Research, 3, 1. https://doi.org/10.12688/bioethopenres.17704.1
27. Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: Challenges and compromise in practice. Qualitative Research, 15(5), 616-632. https://doi.org/10.1177/1468794114550439
28. Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. British Journal of Pain, 9(1), 41-42. https://doi.org/10.1177/2049463714541642
29. Tatum, C., Rueda, M., Bain, J., Clyde, J., & Carino, G. (2012). Decision making regarding unwanted pregnancy among adolescents in Mexico City: A qualitative study. Studies in Family Planning, 43(1), 43-56. https://doi.org/10.1111/j.1728-4465.2012.00301.x
30. Wall, L. L., & Yemane, A. (2022). Infectious complications of abortion. Open Forum Infectious Diseases, 9(11), ofac553. https://doi.org/10.1093/ofid/ofac553

31. World Health Organisation. (2024, April 10). Adolescent pregnancy. https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy
32. World Health Organisation. (2025). Abortion: Key facts. https://www.who.int/news-room/fact-sheets/detail/abortion