

Self-Inflicted “Cesarean Section” in a 14-Year-Old Primigravida: A Case Report on the Consequences of Barriers to Safe Abortion Services

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Abstract

Introduction: Unsafe abortion remains a major challenge in Zambia despite a legal framework that permits termination of pregnancy. With a maternal mortality ratio (MMR) of 187 per 100,000 live births, it is estimated that up to 10% of these deaths are a result of unsafe abortion. Teenagers face unique financial, emotional, and physical barriers compared to adults, often leading to desperate attempts at unsafe abortion. **Patient and Observation:** This is a case of a 14-year-old Zambian primigravida at 15 weeks of gestation who presented to the emergency gynecology unit with a self-inflicted transverse abdominal incision. The patient had previously attempted to access termination services at a local clinic but was denied due to her age and inability to pay an unofficial fee. In a desperate attempt to extract the fetus, she used a razor blade to incise her abdomen down to the level of the rectus abdominis aponeurosis. The procedure was halted due to excessive blood loss. The wound was surgically repaired, and a medical termination of pregnancy was subsequently conducted. **Conclusion:** This case demonstrates how a lack of comprehensive abortion services can endanger lives. It emphasizes that a liberal abortion law does not necessarily translate to safe access, particularly for adolescents who face financial and consent-related issues.

Keywords

Unsafe Abortion, Teenage Pregnancy, Self-Harm, Case Report, Health Systems, Informal Payments

1. Introduction

Unsafe abortion remains a critical public health issue in Zambia. Despite the existence of the *Termination of Pregnancy Act*, which is considered favorable and liberal, barriers to access persist [1]. Current statistics indicate a maternal mortality ratio (MMR) of 187 per 100,000 live births, with unsafe abortions contributing significantly to this burden [2]. Adolescents are disproportionately affected; approximately 23% of unsafe abortions occur in women under 20 years of age, and 30% of these result in maternal deaths [2] [3]. The decision to terminate a pregnancy in adolescents is influenced by multiple interrelated factors ranging from personal, interpersonal, to societal. At the individual level, influences like the desire for self-realization and the experience of an unintended pregnancy. Interpersonal factors involve parental influence, partner reactions, peer and friend dynamics, the presence of existing children, and limited emotional or practical support. Broader social and structural circumstances also play a role, including experiences of sexual violence, financial constraints, restricted reproductive choices, and inadequate access to or utilization of healthcare services [4].

Even when they have a chance to access termination services, teenagers seeking termination of pregnancy encounter distinct challenges, including financial constraints, lack of information, consent-related barriers and provider bias. These barriers frequently force adolescents to seek unsafe methods [5] [6]. We present a “near-miss” case of a 14-year-old female who attempted a self-inflicted “cesarean section” after being denied care at a health facility due to financial and age-related barriers.

2. Patient and Observation

2.1. Patient Information

A 14-year-old primigravida at 15 weeks and 5 days’ gestation presented to the emergency gynaecology unit as a clinical referral for para-suicide. The primary reason for consultation was an abdominal injury following a self-inflicted attempt to terminate pregnancy. The patient was a grade nine pupil living with her parents and siblings.

Her psychosocial history was significant for severe family stressors. The patient reported that her father was strict and aggressive, and she feared disclosing the pregnancy to him. Two of her sisters had previously been forced into marriage with men who had impregnated them, further heightening her fear. She had initially sought termination of pregnancy at a local clinic but was denied services due to the requirement for an adult guardian, a condition not explicitly mandated by the Termination of Pregnancy Act but commonly imposed at facility level and an informal demand for payment, which she could not afford. She was HIV negative, had no history of sexually transmitted infections, and had no known chronic medical conditions. There was no documented history of prior medical or surgical interventions.

2.2. Clinical Findings

On admission, the patient was hemodynamically stable but slightly confused. Caregivers initially attributed her condition to spiritual causes. General examination revealed no pallor, jaundice, or cyanosis. Local abdominal examination showed a transverse suprapubic incision approximately 8 cm in length, located about three finger-breadths above the symphysis pubis. The wound extended through the subcutaneous tissue to the level of the rectus abdominis sheath, with hesitation cuts noted on the right side of the incision. Obstetric examination revealed a uterus consistent with approximately 16 weeks' gestation, with minimal vaginal bleeding on admission.

2.3. Timeline of Current Episode

- 1) Initial confirmation of pregnancy
- 2) Attempt to seek termination at a local clinic and denial of services
- 3) Mobilization of inadequate funds (equivalent to approximately \$2 USD)
- 4) Self-inflicted abdominal incision at home using a razor blade
- 5) Abandonment of the attempt due to pain and bleeding
- 6) Transportation to the health facility by a neighbour
- 7) Admission, stabilization, surgical repair, and subsequent medical termination of pregnancy

Note. Exact dates and intervals between the events listed above (including the time from initial clinic denial to self-injury, and from wound repair to initiation of medical termination) were not retrievable from the available record. This reflects the retrospective nature of the report and is acknowledged as a limitation in the limitations section below.

2.4. Diagnostic Assessment

Diagnosis was based primarily on clinical evaluation and physical examination. Vital signs on admission confirmed haemodynamic stability. Formal laboratory investigations (full blood count, blood grouping, and renal function) and ultrasound imaging were not documented in the available clinical record; this reflects a limitation of retrospective case retrieval rather than an intentional omission in clinical management. Diagnostic challenges included delayed access to safe abortion services due to legal, financial, and social barriers.

2.5. Diagnosis

Self-inflicted abdominal wall injury following an attempted unsafe abortion in a 14-year-old at 15 weeks' gestation. The prognosis was favourable following timely surgical and medical management.

2.6. Therapeutic Interventions

Management included psychosocial counselling and education on comprehensive abortion care. Pharmacologic interventions consisted of analgesics and intrave-

nous antibiotics. Surgical intervention involved repair of the rectus sheath and suturing of the skin. After stabilization, medical termination of pregnancy was performed using mifepristone followed by misoprostol. Medical termination was selected because the self-inflicted wound did not penetrate the uterine wall, making uterine evacuation prior to wound closure unsafe. Surgical termination of pregnancy before wound repair would have required entering a contaminated operative field; medical management with uterotonic agents after wound repair was therefore the appropriate and safer sequence. A formal mental health assessment was not arranged following discharge, representing a gap in the patient's care that is noted in the limitations below. The treatment course was completed without modification.

2.7. Follow-Up and Outcome of Interventions

Forty-eight hours after administration of misoprostol, the patient expelled a foetus weighing 0.2 kg. She remained clinically stable throughout admission, tolerated treatment well, and experienced no documented complications. She completed five days of intravenous antibiotics and received contraceptive and psychosocial counselling prior to discharge.

2.8. Informed Consent

Informed consent for management and procedures was obtained in accordance with institutional protocols, with consideration of the patient's age and clinical condition. Given that this case involves a minor and a sensitive reproductive health event, a separate consent-to-publish was sought from the patient's legal guardian in addition to treatment consent. Patient identifiers have been removed or sufficiently anonymised to protect confidentiality. Publication of this case was considered appropriate on the grounds of significant public interest in documenting access failures in adolescent reproductive healthcare. The authors confirm that all ethical obligations in reporting this case have been fulfilled in accordance with the institutional guidelines of Levy Mwanawasa University Teaching Hospital and the principles of the Declaration of Helsinki. A waiver of review for case reports was obtained in accordance with institutional policy.

3. Discussion

This case highlights the severe challenges faced in the provision of comprehensive abortion care (CAC) in Zambia, specifically regarding adolescents. Challenges can be categorized into community-related factors, financial barriers, and structural healthcare failures.

3.1. The Financial Barrier: "Fee for Service" in a Free System

A critical finding in this case was the demand for an informal payment. Although abortion services in Zambian public facilities are theoretically free or low-cost, "out-of-pocket" expenditure remains a significant barrier. Research by Leone *et*

al. has established that unofficial provider payments represent a major cost to women seeking abortion services in Zambia [7]. These informal fees disproportionately affect adolescents and the poor, who lack the financial autonomy to pay. For this patient, the inability to meet financial demand may have contributed to her self-inflicted surgery.

3.2. The Disparity of Consequence

It is critical to contextualize this case within the global landscape. While the moral and ethical controversy surrounding abortion is a universal phenomenon, present even in high-income nations, the clinical sequelae of this controversy differ starkly by region [8]. In well-resourced settings, societal debate rarely precludes access to the extent that a minor would resort to self-inflicted laparotomy. This case exposes a painful reality specific to our setting: in the African context, stigma does not merely create social friction; it drives life-threatening morbidity that is rarely documented in settings with accessible and integrated reproductive health services [6] [7].

3.3. Healthcare System Failures: Inconsistent Access in Mixed-Use Facilities

Although abortion is legal in Zambia, access is often hindered by provider attitudes and requirements for parental consent [1]. This patient was denied care at a primary level due to her age. However, the failure is systemic rather than individual. The absence of dedicated abortion clinics in the public sector necessitates the integration of termination services into general outpatient departments.

This integration creates an inconsistent access environment for patients. Because providers with conscientious objections work alongside those who offer services, a patient's access often depends entirely on which specific health worker is on shift [8]. In a dedicated clinic, the patient is guaranteed a willing provider; in our mixed-use facilities, the lack of spatial separation between objecting and non-objecting staff acts as a functional blockade, effectively vetoing the patient's legal right to care based on the moral stance of the first person she encounters [1] [9].

3.4. Community and Social Barriers

Stigma remains a primary barrier. In many Zambian communities, abortion is considered taboo and a moral issue, leading to fear of judgment [9]. For teenagers, this is compounded by the fear of rejection, loss of educational sponsorship, or forced marriage, as seen in this patient's history. The interpretation of her distress as "demon possession" by caregivers further illustrates the lack of community understanding regarding reproductive health crises [9].

4. Limitations

This report has several limitations that should be considered when interpreting its findings. First, the account of access barriers—including the requirement for an

adult guardian and the informal payment demand—is based solely on the patient's self-report and could not be independently verified. Second, due to the retrospective nature of case retrieval, complete clinical data, including vital signs on admission, laboratory investigations, imaging results, and the precise intervals between key events were not available from the institutional record. Third, no formal psychiatric or psychological assessment was arranged at discharge, limiting conclusions about the patient's mental health trajectory. Fourth, as a single case report, the findings cannot be generalised beyond illustrating the potential consequences of structural barriers to adolescent abortion care. These limitations are acknowledged; the report's value lies in raising attention to a serious access failure rather than making definitive epidemiological claims.

5. Conclusion

This near-miss case emphasizes the urgent need to enhance abortion services through community sensitization and the establishment of youth-friendly corners. Furthermore, health systems must address the structural issues of conscientious objection and informal payments to ensure that a patient's access to legal care is not determined by their ability to pay. There should be enough safety nets in the system to protect minors.

Declarations

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Authors' Contributions

Aubrey Shanzi, Reward Sibanda, David Kadisha, Chifuka Phiri, Chanda Nkaka, and Mabvuto Zulu contributed to patient management, data collection, and manuscript writing. All authors have read and agreed to the final manuscript.

Conflicts of Interest

The authors declare no competing interests.

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