SOCIAL CONSEQUENCES

Attitudes toward abortion in Zambia

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A R T I C L E   I N F O

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A B S T R A C T

Despite Zambia’s relatively progressive abortion law, women continue to seek unsafe, illegal abortions. Four domains of abortion attitudes – support for legalization, immorality, rights, and access to services – were measured in 4 communities. A total of 668 people were interviewed. Associations among the 4 domains were inconsistent with expectations. The belief that abortion is immoral was widespread, but was not associated with lack of support for legalization. Instead, it was associated with belief that women need access to safe services. These findings suggest that increasing awareness about abortion law in Zambia may be important for encouraging more favorable attitudes.

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1. Introduction

Abortion is a controversial, even polarizing, topic. People within and among cultures differ widely in their views on the morality of and their support for legalization of abortion. Much of the debate surrounds the particular circumstances under which people believe it is acceptable, is moral, and/or should be legal. The results of opinion polls vary widely by region and country, and the questions asked to measure attitudes. In studies [1–3], typical questions have included “Do you think of abortion as a moral issue?” “Under what conditions do you think abortion should be allowed?” “Do you think that (in any situation) a woman always has (or should have) right to decide about her own pregnancy, including whether to have an abortion?” and “What is your personal feeling about abortion?”

Given the potential moral and legal complexities in any abortion decision, there are a number of dimensions of abortion attitudes that cannot be adequately addressed and are generally more nuanced than one single question can measure. Although arguments for and against legality are made on moral grounds, views on morality do not translate into views on legalization. In his work on a different, but equally emotionally charged topic, Herek [4] describes how attitudes toward homosexuality do not always extend to policy. In his research, he found that people uncomfortable with the idea of homosexuality did not necessarily support laws to restrict the rights of homosexual men and women.

Legalization of abortion does not remove all the barriers to safe abortion services. Strong societal moral judgment against abortion, even where laws are less restrictive, can create abortion-related stigma, and women who seek or have abortions experience discrimination and potentially make choices that endanger their health [5]. Kumar et al. [6] propose that stigma against women who have abortions causes shame, guilt, denial, and fear that may result in delay in care, choice of unsafe/illegal providers, or even self-induction that can result in serious negative health outcomes such as clinical complications or even death. Similar negative health consequences resulting from the effects of HIV stigma have been widely documented in the literature and have been the basis for recent theoretical conceptualizations of stigma [7,8].

Acknowledging the serious public health threat inherent in unsafe abortion that occurs in settings where abortion is stigmatized, it is important to understand people’s attitudes toward abortion that impact on restrictive laws and stigma experienced by women who find themselves in need of safe abortion services. The present study analyzed data from an operations research study in Zambia to examine 4 dimensions of abortion attitudes and beliefs, how they relate to one another, and how they may differ by community and personal characteristics.

1.1. The Zambia context

Zambia has one of the least restrictive abortion laws in Sub-Saharan Africa. Under the 1972 Termination of Pregnancy Act, pregnancy termination is permitted for the following reasons: risk to the life of the pregnant woman; risk of injury to the physical or mental health of the pregnant woman; risk of injury to the physical or mental health of any existing children of the pregnant woman; or risk of physical or mental abnormalities to the unborn child. This code was amended in 2005 to specifically include rape as a legal reason for seeking an abortion and to exclude girls who have been raped from being prosecuted for attempting to self-abort [9]. In spite of this fairly progressive law, the maternal mortality ratio continues to be high at 591 maternal deaths per 100,000 live births.
births [10]. Complications from unsafe abortion account for a large proportion of maternal deaths, perhaps as high as 30% [11]. Many more women are treated for complications due to unsafe abortion than undergo safe, legal abortions in Zambian hospitals [12].

In Zambia, women continue to experience unsafe abortion even in contexts where abortion is legally accessible in part due to the requirement that abortions be performed by a physician and with the consent of two additional medical practitioners. Even with the caveat that only one physician need provide consent in emergency situations, this is a daunting requirement where there are fewer than two physicians for every 10,000 people [13]. A 2008 situational assessment in Zambia [14] based on in-depth interviews with stakeholders found that safe abortions by trained providers were available only at tertiary care facilities, making it difficult for most women to access safe services easily.

Another barrier to access reported in the situational assessment was lack of knowledge about abortion law in Zambia – many people believed it was illegal under any circumstances and completely unavailable to them in government hospitals or clinics. Many people also had very negative attitudes about abortion, believing it to be immoral, especially for young people.

These findings led to the design and implementation of an intervention by Ipas in collaboration with the Zambia Ministry of Health (MOH) to strengthen the current capacity to provide manual vacuum aspiration (MVA) in district and community health centers in 28 pilot sites in two provinces. Midlevel providers (nurses, midwives, and medical officers) were trained to perform MVAs, and MOH policy was revised to allow them to do so under the supervision of obstetrician/gynecologist trainers during the pilot phase. To further increase access, Medabon (Sun Pharmaceutical Industries Ltd, Mumbai, India), a combination mifepristone and misoprostol medical abortion product, was registered for use in Zambia with a prescription. Both health providers and pharmacists were trained in the appropriate use of Medabon for pregnancy termination.

To address the knowledge gap and negative attitudes toward abortion and women who have abortions, a community engagement process was incorporated into the intervention in catchment areas near 4 of the 28 intervention sites. The goals of this component were to increase awareness of the legal status of abortion and the dangers of unsafe abortion, change negative attitudes toward abortion, inform people of the consequences of stigma, and increase knowledge about the availability of safe services. Qualitative and quantitative baseline data were collected as part of the operations research project that described community members’ views on abortion before the intervention. This paper presents the results of an analysis of the quantitative data describing community members’ preintervention attitudes toward abortion, examining the relationships among different dimensions of these attitudes, and identifying variations in attitudes by individual characteristics.

2. Methods

2.1. Survey overview

Data from a baseline household survey conducted in January, 2010 focusing on respondents’ knowledge about laws and services and their attitudes about abortion were analyzed. The survey questions were informed by qualitative interviews with stakeholders from the same communities.

The population-based household survey was conducted in 4 communities – 2 in each of 2 provinces: Lusaka and the Copperbelt. Community engagement activities were pilot tested in the 4 communities, and the survey was conducted to obtain baseline measures for knowledge of abortion laws, perceived access to safe services, and attitudes toward abortion and women who have had abortion, as well as information on sources of health information and media use to inform intervention design.

2.2. Data collection

Interviewers conducted a census of all households in each community the week before initiation of the survey. From each enumeration area, interviewers randomly chose a starting point and selected households at specific intervals (every “nth” house), with the interval calculated to achieve a specific number of households per community, given the number of dwellings within a specific community. Each selected household completed a questionnaire listing all residents of the household older than 18 years, and from that list, the resident aged 18–49 years with the most recent birthday was chosen to be interviewed.

2.3. Data analysis

Several attitude domains based on questionnaire items were identified: morality, women’s rights, access to care, and support for legality. The first 3 variables were measured by level of agreement with 3 statements:

- Morality: Abortion is immoral.
- Women’s right to decide: A woman has the right to decide whether or not to continue a pregnancy.
- Access to care: Women should have access to safe abortion services.

These items had a 5-point response set from “strongly disagree” to “strongly agree”. Although there is some disagreement among researchers and statisticians about whether these items should be considered interval- or ordinal-level data, the present study treated them as interval-level data because they represent an underlying interval scale. Cohen and Cohen [15] support this position, saying, “In practice, ordinal scales as well as those that seek (not necessarily successfully) to yield interval or ratio level measurement, may be profitably employed [in multiple regression or correlation]” (p. 241).

Support for legalization of abortion was measured using an index created from responses to questions about all abortion indications the respondent believed should be legal. These were summed with a possible total of 11 indications for abortion (shown in Fig. 1). Higher numbers represent greater support for abortion. Survey data were analyzed using SPSS Statistics, version 17.0 (IBM, Armonk, New York, USA).

Ethical review and approval was obtained from the Allendale Institutional Review Board in the USA and the University of Lusaka Research Ethics Committee. Documented informed consent was obtained from every research participant. No information that could link the identity of individual participants with responses was collected.

3. Results

From the 718 households selected using the described sampling technique, 668 people were interviewed. Two of these were omitted from the final sample because they did not fall within the eligible age range of 18–49 years. Sixty-two percent of residents interviewed were female. The mean age was 33.6 years. Sixty percent were married. Three-fourths of the respondents could read and write. Most were Protestant, and about a quarter identified as Catholic. Approximately 60% reported that they watched television and listened to the radio, and about one third read the newspaper.

Figure 1 shows the percentages of household survey respondents who endorsed each of the 11 indications (e.g., rape, incest, threatens the life of the mother) for which they “think abortion is legal” compared with similar set of questions about the indications for
which they “think should be legal”. Only a minority of people thought it was legal or believed it should be legal for any one of these indications. Thirty-two percent believed it was legal for at least 1 named indication, and 41% supported legalization for at least 1 of the named indications, indicating slightly more liberal desire for legalization than what people believe the law really is. Risks to the health or life of the mother or the child garnered the most support for legalization, but support was still weak for all indications.

Support for legalization was measured by assessing the number of indications for which respondents believed abortion should be legal. This index was used for subsequent analyses. Scores for this index ranged from 0 to 11 with a mean score of 1.6 and a median and mode of 0, indicating an extremely strong skew toward a lack of support for legalization.

With regard to other attitudinal domains (measured on a scale of 1 to 5 with 1 = strongly disagree and 5 = strongly agree), when survey respondents were asked about their own attitudes and opinions related to abortion, overall, 88% strongly agreed that abortion is immoral (mean, 4.65). Forty-one percent strongly believed that women should have access to safe abortion services (mean, 3.35) and 35% strongly believed that a woman has the right to decide whether to continue a pregnancy (mean, 3.09) (Table 1). These results indicate that some respondents who believe abortion is immoral also support access to safe abortion services and a woman’s right to decide.

Bivariate correlation coefficients were calculated for all possible combinations of these 4 attitudinal items (Table 2). Contrary to expectations, belief in the immorality of abortion was not negatively correlated with support for legalization. Also unexpectedly, belief in the immorality of abortion was positively associated with the belief that women should have access to safe abortion services ($r = 0.131; P = 0.001$). As anticipated, however, support for legalization was positively related to belief in women’s right to decide ($r = 0.118; P = 0.002$) and access to safe services ($r = 0.121; P < 0.001$). Beliefs in right to decide and access to safe services were also positively correlated ($r = 0.411; P < 0.001$).

Finally, attitude measures were examined by personal characteristics that could potentially be used to identify target groups for attitude change interventions, such as sex, age, marital status, literacy, television viewing, religion, community, and schooling. The mean values of the 4 attitude measures for the variables found to be significantly related are shown in Table 3. Female respondents were more likely to support a woman’s right to decide than male respondents ($3.24 \text{ vs } 2.83; P = 0.003$). Those with a secondary school education supported legal abortion for more indications than did those who had less than a secondary education ($1.83 \text{ vs } 1.41; P = 0.006$). Support for legal abortion was stronger in Lusaka province communities than in those in the more conservative Copperbelt. Mufalira, a rural Copperbelt community, had the most conservative attitudes in the remaining 3 attitudinal items. Those who watched television had stronger beliefs that abortion is immoral than those who did not ($4.74 \text{ vs } 4.51; P = 0.006$), but television viewers also were more likely to believe that a woman had a right to choose to continue a pregnancy than nonviewers ($3.22 \text{ vs } 2.28; P = 0.012$).

4. Discussion

The results of the present study indicate that although people in the Zambian communities studied had strong beliefs about the immorality of abortion as a general principle, they were also concerned about women’s health and safety, and these attitudes could potentially take precedent over other attitudes, depending on the situation. Although people might not support pregnancy termination in the abstract, they may change their opinion in particular circumstances. The associations found among the different dimensions of attitudes toward abortion seem inconsistent. These seemingly incongruent positions are in line with a social norm to report believing that abortion is immoral even if it does not reflect a more nuanced belief about the need for women to have access to appropriate care. The present study did not find a significant negative association between believing abortion is immoral and support for legalization. This is consistent with the study mentioned above regarding attitudes toward homosexuality [4].

Age was not associated with these attitudinal indicators. Youth is generally associated with more progressive ideas, but the cor-

<table>
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<tr>
<th>Table 1</th>
<th>Mean scores and percentage who strongly agree with 3 abortion-related attitudes ($n = 666$)</th>
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<tr>
<td>Attitude</td>
<td>Mean score</td>
</tr>
<tr>
<td>Abortion is immoral</td>
<td>4.65</td>
</tr>
<tr>
<td>A woman has the right to decide whether or not to continue a pregnancy</td>
<td>3.09</td>
</tr>
<tr>
<td>Women should have access to safe abortion services</td>
<td>3.35</td>
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<tr>
<th>Table 2</th>
<th>Correlations among indices of abortion-related attitudes ($n = 666$)*</th>
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<tbody>
<tr>
<td></td>
<td>Immorality</td>
</tr>
<tr>
<td>Support for legalization</td>
<td>0.042</td>
</tr>
<tr>
<td>Immorality</td>
<td>-</td>
</tr>
<tr>
<td>Right to decide</td>
<td>-</td>
</tr>
</tbody>
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* Values are given as $r$ value ($P$ value).
relation was not significant in the present analysis. Perhaps this might have been different if respondents younger than age 18 had been included. Women were more likely than men to support a woman’s right to decide whether to continue a pregnancy. Residence in Lusaka, considered to be a more progressive area than the Copperbelt, was associated both with a stronger belief in the immorality of abortion and yet stronger support for legalization, a disparity that requires further qualitative investigation.

There are additional questions that might help us understand these results, and there are some ways in which certain questions asked in a different way may have yielded different results. Unpacking what “immorality” means to community members might be useful. What are the perceived consequences of immoral acts? What about abortion is immoral? Do people believe that morality is different for different indications? Do the circumstances of the pregnancy matter? Do characteristics of the woman matter? How is this related to religious beliefs? Whose rights are more important? What are the perceptions of the consequences an abortion has on the community?

One limitation in this study was the item, “A woman has the right to decide whether or not to continue a pregnancy”. The question was possibly open to interpretation in a way that it was not originally intended. It is possible that both women who support and women who do not support abortion could agree that women have the right to continue a pregnancy. However, from the pattern of results, the question seems to have been interpreted as was intended. An additional item should be added in the endline survey – “Women have a right to terminate a pregnancy” – to make the meaning clear.

These findings raise questions about how people reconcile strong community norms against abortion with a perceived need for safe abortion services within their communities. Additional multivariate analyses of these data may reveal interactions with some of the predictive factors. Furthermore, qualitative data may explain how these seemingly disparate findings are reconciled by the respondents. Further research should ascertain whether awareness of abortion law in Zambia influences how respondents view the morality of abortion and whether the perception that abortion is illegal is in line with the view that it is immoral. Researchers may also investigate whether social stigma toward abortion leads people to believe that it is illegal in the absence of effective communication.

Taken together, these findings suggest that community interventions to increase awareness about abortion law in Zambia may be important for encouraging more favorable attitudes.

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Conflict of interest

The authors declare that they have no conflicts of interest.

References


