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Original Research Article

Exploring Knowledge, Attitudes and Perceptions of Young Women, Community Members and Health Care Providers on Legal Abortion in Lusaka District, Zambia

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Abstract: ***Background*:** In 1972, Zambia made abortion lawful on a broad basis. However, safe abortion services are still limited, and the necessary standards and requirements for executing an abortion remain stringent. Due to a lack of knowledge and understanding of abortion law, many women and girls continue to seek unsafe abortion methods outside of health facilities. Healthcare providers play a key role in the provision of safe abortion care to eligible girls and women, but little is known about how they handle it. The aim of this study was to Assess and Explore the Knowledge, attitudes, and perceptions of adolescent girls and young women, and healthcare providers on abortion in the Lusaka district. Data was collected from Chawama, Chilenje, Chipata Kanyama, and Matero Level 1 Hospitals in Lusaka District. ***Method*:** To answer the research topic, the study used Exploratory mixed approaches. Statistical Package for Social Science, Versioni20.0 (SPSS) was used. The matic analysis was used to examine qualitative data by extracting themes from the responses. To see if there were any differences or correlations between the variables' knowledge, perceptions, and attitudes, cross-tabulations were used. This was demonstrated using Chi-square tests, which were all done at a 95ipercenticonfidenceiinterval with ai 0.05 significance level as the crucial level. For reporting, the SPSS frequencies were exported to Microsoft Word. ***Results*:** The study indicated that the knowledge levels on abortion among participants were high (93.25%). However, some participants on the other hand did not have sufficient information regarding the legality of abortion in Zambia. The theme analysis of reasons why they do not favor abortion revealed that one of them is religious, believing that abortion is comparable to murder. The findings also reveal that a person's religious affiliation influences their decision-making and thought process regarding abortion. ***Conclusion*:** The findings of this study suggest that there is a need to de-mystify abortion, particularly legal and safe abortion in the community, including availability, in order to increase the utility of this service among women and girls of childbearing age and reduce maternal mortality as a result of unsafe abortion procedures. Healthcare providers need heightened sensitization on the legal and policy framework on legal abortion as well as familiarization with the guidelines on the provision of the service.

Keywords: Legal Abortion, Perception, Knowledge and Attitude, Community Members.

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1.0 BACKGROUND

Abortion is a sensitive and frequently stigmatized topic, both politically and socially. The issue is frequently surrounded by secrecy, shame, and misconceptions, which can lead to negative health and social consequences. Women are more likely to attempt a clandestine, unsafe procedure if they are unaware that they could legally visit a trained health provider to obtain a safe abortion and may well attempt an abortion regardless of the law (Chanda, *et al.*, 2017). Several barriers exist that might prevent patients from seeking health care when it is needed such as little knowledge of the system and stigma both among people and in health institutions. Abortion is among the causes of maternal

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mortality in Zambia. (Chanda, *et al*., 2017). The direct causes of maternal mortality include post-partum hemorrhage (34%), Sepsis, (13%), Obstructed Labor (8%), pregnancy Hypertensive disorders – eclampsia (5%), and abortion complications (4%). Knowledge of the legal framework, in addition to community attitudes and stigma, can pose important barriers to accessing reproductive health services Creswell *et al*., (2016).

In today's world, views on abortion still remain unclear. Several articles have arisen from various studies around the world revealing the diverse perspectives of participants on abortion. Different world leaders have differing views on abortion. More countries are permitting legal abortions as a result of increased human rights, while others have entirely legalized abortions regardless of the reason. Other countries continue to restrict access to abortion, while others refuse to permit the procedure entirely. Abortion is legal in Zambia for health and socioeconomic reasons. However, a considerable number of unsafe abortions continue to be recorded in healthcare facilities, and little has been done to assess knowledge, attitudes, and perceptions about legal abortion (Banda, 2015). The aim of this study was to explore the knowledge, attitudes, and perceptions of young women, community members, and health care providers on legal abortion in Lusaka District.

1.1 Rationale

Despite the fact that Zambia's abortion regulations have been liberalized, the government still records abortion-related deaths. Despite several studies on abortion in Zambia, there is little research/information on Knowledge, attitudes, and Perceptions of Legal Abortion in Zambia. According to some studies, the main factors influencing the utilization of abortion services are knowledge, attitude, practices, as well as beliefs. It is for these reasons that this study aims investigate the knowledge, attitudes, and perspectives of young women, community members, and health care providers in the Lusaka District regarding legal abortion. The findings of this study will also contribute to the body of knowledge as well as serve as a reference for other researchers. In addition, the findings of this study will inform policy formulations and revisions were need be as the current law on abortion dates back to 1973, with an amendment in 1992. It was also assumed that the study would be helpful to researchers, students, and society.

1.2 General Objective

The objective of this study was to explore the knowledge, attitudes, and perceptions on abortion among young women, health care providers, and community members in the Lusaka district.

1.2.1 Specific Objectives

1. To determine the level of knowledge on abortion among adolescent girls, young women, health care providers, and community members in the Lusaka district.
2. To identify attitudes towards abortion among adolescent girls, young women, health care providers, and community members in the Lusaka district.
3. To establish the perceptions towards abortion among adolescent girls, young women, health care providers, and community members in the Lusaka district.

2.0 LITERATURE REVIEW

2.1 Knowledge, Attitude, and Perception Towards Abortion: Global Perspective

Abortion policy varies widely over the world, ranging from outright prohibition to unrestrictive access on a woman's request (abortion on demand). Abortion has been influenced by religion, culture, and traditions all across the world. Access to safe abortion is thus limited not just by law, but also by religious norms, customs, and politics, all of which play a role in many cases (Ireland, 2019). According to Human Rights Watch (2018), Donald Trump, the previous president of the United States of America (USA), expanded the Mexico City Policy, also known as the global gag rule in 2017 which restricted Non-Governmental Organizations (NGOs) from receiving grants the from the USA from l offering legal abortions. This was the president's position on abortion at the time yet the country's citizens required access to such services.

Colombia decriminalized abortion, contrary to the president's belief, but healthcare providers were resistant to providing the service due to a knowledge gap (lack of information) (Bearak J *et al*., 2020). When Colombia decriminalized abortion a few years ago, healthcare staffs were unaware that providing safe abortion care was part of their job, therefore girls and women encountered opposition when seeking abortion care in public facilities (Bearak J *et al*., 2020).

An article by (Stockton, 2001) examined students' perceptions on abortion, the findings of this study revealed that 86.7% of students believed that women have the right to have abortions if they so wish, whereas 13.3 % stated that abortion is unlawful and forbidden. Similar to Stockton's findings, (Dimoula *et al*., 2007) found that attitudes regarding abortion were still diverse, with some seeing it as murder and others who believe in God seeing it as a sin regardless of the reason for the abortion. (Ozmen *et al*. 2019) found that married women's attitudes towards induced abortion were similar to (Dimoula *et al*., 2007) findings that induced abortion is a sin and murder. A similar study was undertaken in Nairobi, with the findings being heterogeneous, with some seeing abortion-seekers as "black sheep" in society who face a lot of shame and discrimination, while others regard it as a common occurrence (Ushie BA *et al*., 2019).

Individuals hold differing perspectives on when life begins and whether abortion is morally acceptable and variances in cultural, traditional, and religious beliefs are the source of these differences (Dozier *et al*., 2020). The findings in the article by (Dozier *et al*., 2020) suggested that religious leaders have a double standard in that they vehemently refuse to condone abortion while still offering pastoral care to those congregants who have aborted, and the paper went on to say that most leaders who are pro-choice of abortion offer pastoral care but frequently misinform individuals during their pastoral care.

People's attitudes toward abortion are shaped by restrictive abortion regulations. Religious and traditional beliefs amplify these beliefs, yet this is thought to result in more illegal abortions and detrimental repercussions (United Nations, 2014). According to the United Nations (2014), countries around the world have increasingly extended their acceptance of abortion for all legal reasons, particularly when the mother's life is in danger. The publication further indicated that some developing countries continue to have restrictive abortion policies, whereas 82 percent of industrialized countries allow abortion for economic and social reasons. The number of countries that have come forward to take steps to expand access to safe abortion services has increased as perceptions of the need for increased access to abortion services have grown. Access to safe abortion services has been associated with a considerable decrease in maternal death rates (United Nations, 2014). (Espinoza *et al*., 2020) made a similar argument in a review study that adolescent programming should be adapted to address the unique requirements of adolescents by providing enough easily accessible and understandable information on abortion at a young age. While adolescent girls are aware of abortion, they lack full knowledge of where they can obtain these services, postponing care owing to stigma, a lack of resources, and provider prejudice (Espinoza, C *et al*., 2020).

2.1.1 Regional Perspective

Individuals' access to abortion-related information, attitudes toward abortion, and perceptions of abortion are all influenced by the legal structure of their country. Access to information has an impact on abortion knowledge.

Several African countries have taken a more permissive stance on abortion, with 10 of 54 countries in Africa strictly not permitting abortion of any nature (Guttmacher Institute, 2018). This paper recommended programs and policies that would improve knowledge in women and men on sexual reproductive health services and rights with the aim of preventing unwanted pregnancies thereby reducing the need of seeking abortion services. This study also made recommendations for providing quality post-abortion care to reduce complications and death from unsafe abortions; expanding the area where legal abortions should be allowed to improve access to safe abortion services; and, finally, increasing access to standard operating procedures on how to conduct safe abortions and passing laws that only allow trained staff to perform them to improve the safety of abortion procedures.

Legislature, professionalism, and individualism remain independent of each other as evidenced by the findings of the study in Ghana on attitudes toward abortion and the decision-making capacity of pregnant adolescents, (Bain *et al*., 2020) in which 89% of the students, the majority of whom were medical students, were opposed to making legislation to make abortion available on demand for pregnant adolescents. On the contrary, more than half of the midwives supported the idea of giving adolescents full decision-making power over the result of their pregnancy. If access to safe abortion services is to improve, this study's finding recommends that the law should be examined more closely. (Madziyire *et al*., 2019) found that healthcare providers and abortion experts in Zimbabwe had similar knowledge and views toward abortion, and that abortion regulations should be liberalized to prevent unsafe abortions. A South African study found that trained healthcare providers were more likely to regard abortion treatment as a human right, and that delivering abortions likely reduced maternal mortality due to unsafe abortion procedures. Several studies in Africa have indicated that healthcare personnel who provide abortion services are frequently stigmatized by family and colleagues, and that they face contradictory expectations regarding their professional duty to protect life vs providing abortion services (Chanda *et al*., 2017).

2.1.2 National Perspective

Zambia's abortion laws are the least restrictive in southern Africa, with the Termination of Pregnancy (TOP) act of 1972 allowing a pregnancy to be terminated due to "risk to the pregnant woman's life; risk of injury to the pregnant woman's physical or mental health; risk of injury to the physical or mental health of any existing child of the pregnant woman; or risk of physical or mental abnormalities to the unborn child," which was amended in 2005 and included “rape as a legal reason for seeking abortion and to exclude girls who have been raped from being prosecuted for attempting to self-abort” (Geary CW *et al*., 2012). Chanda *et al*., (2017) found that Christian beliefs influenced healthcare personnel’s decisions concerning abortion services in Zambia.

Even though Zambia has a liberal approach to abortion, there is still a knowledge gap about abortion services and access. Women's knowledge and views around abortion remain conservative, according to a study by Cresswell *et al*., (2016), despite the fact that women with complete awareness of Zambian abortion law have more liberal attitudes toward abortion and access to safe abortion services. They conclude that lacks of understanding and conservative views are substantial barriers to obtaining safe abortion services. Clients

seeking abortion services are still stigmatized due to varied beliefs about abortion. However, as provider attitudes improve, the number of persons seeking a safe abortion has increased significantly (Fetters T *et al*., 2017). Zambia has joined the Maputo Protocol, pledging to provide safe abortion services within its legal framework. The Republican Constitution, the Penal Code, the Termination of Pregnancy Act, the Health Professional Act, and the Gender Equity and Equality Act are the five main acts of parliament that constitute the legal framework for abortion (Ganatra *et al*., 2006).

2.2 Theoretical Framework

The Theory of Planned Behavior (TPB) started as the Theory of Reasoned Action in the 1980s. It is used to predict an individual's intention to engage in a behavior at a specific time and place. The theory was intended to explain all behaviors over which people can exert self-control. The key component of this model is behavioral intent. This theory argues that behavioral intentions are influenced by the attitude about the likelihood that the behavior will have the expected outcome and the subjective evaluation of the risks and benefits of that outcome (Vlassoff *et al.*, 2008).

The TPB has been used successfully to predict and explain a wide range of health behaviors and intentions. This includes but is not limited to smoking, drinking, health services utilization, breastfeeding, and substance use, among others. According to Corbett and Turner (2003), the TPB states that behavioral achievement depends on both motivation (intention) and ability (behavioral control). It distinguishes between three types of beliefs - behavioral, normative, and control. The TPB is composed of six constructs that collectively represent a person's actual control over the behavior. These are attitudes, behavioral intention, subjective norms, social norms, perceived power, and perceived behavioral control.

Attitudes refer to the degree to which a person has a favorable or unfavorable evaluation of the behavior of interest. This entails the person's consideration of the outcomes or benefits which will be attained by performing the said behavior. Behavioral intention refers to the motivating factors that influence a given behavior. The stronger the intention to perform the behavior, the more likely the behavior will be performed. Subjective norms are the belief about whether most people approve or disapprove of the behavior. It relates to a person's beliefs about whether peers and people of importance to the person think he or she should engage in the behavior (Vlassoff *et al.*, 2008). Social norms refer to the customary codes of behavior in a group of people or a larger cultural context. Perceived power implies the perceived presence of factors that may facilitate or impede the e performance of a behavior. Perceived power contributes to a person's perceived behavioral control over each of those factors. Last but not the least, is perceived behavioral control. This refers to a person's perception of the ease or difficulty of performing the behavior of interest. Perceived behavioral control varies across situations and actions. This results in a person having varying perceptions of behavioral control depending on the situation.

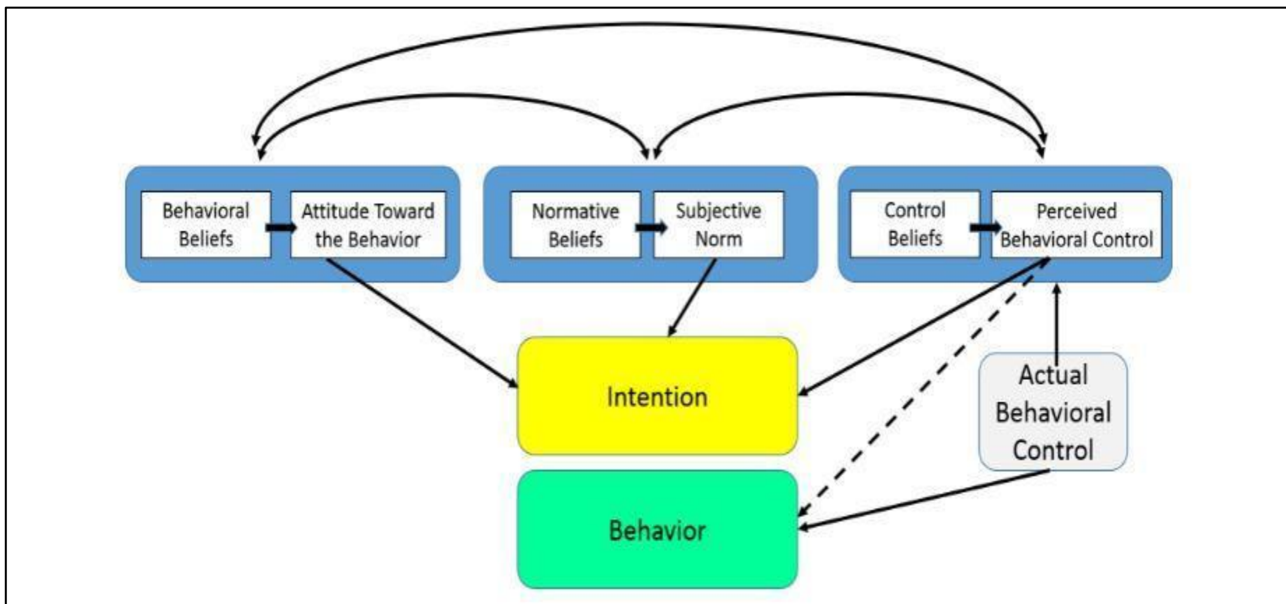

Figure 1: Theory of Planned Behavior

The figure was adapted from Ajzen (1991)

This construct of the theory created the shift from the Theory of Reasoned Action to the TPB. The TPB is applied for this study because attitudes practice and perception can be based on behavior. This model helps in the understanding of how the behavior of people can change. The model assumes that behavior is planned; hence, it predicts deliberate behavior (Ajzen, 1991).

Behavioral intentions represent an individual's commitment to act. Intentions are outcomes of a combination of several variables. According to the TPB, the factors that directly influence intentions to engage in a health behavior include the person's attitudes toward the behavior, the person's perception of subjective group norms concerning the behavior, and the extent to which the person perceives him- or herself to have control concerning the behavior (Say *et al*., 2014).

The TPB theory has some limitations. The theory assumes the person has acquired the opportunities and resources to successfully perform the desired behavior, regardless of the intention. It does not factor in other variables that can influence behavioral intention and motivation such as fear, mood, or past experiences. In as much as it does consider normative influences, it still does not consider environmental or economic factors which do have an influence on a person's intention to perform a certain behavior. It also does assume that behavior is the result of a linear decision-making process and does not consider that it can change over time (Ireland, 2019). Further, while the added construct of perceived behavioral control was an important addition to the theory, it does not say anything about actual control over behavior. Lastly, there is an argument that the theory does not address the time frame between "intent" and "behavioral action". According to Vlassoff *et al*., (2008), despite the above limitations, the TPB has shown more utility in public health. Over the past several years, researchers have used some constructs of the TPB and added other components from behavioral theory to make it a more integrated model. This has been in response to some of the limitations of the TPB in addressing public health problems.

Despite differences in culture, tradition, and religious beliefs, advocacy for safe abortion across the globe has similar trends which are to move from a more restrictive law to a liberal law concerning abortion. The rationale for this despite conflicting pieces of literature from countable studies is to increase, broaden or widen access to safe abortion services by increasing knowledge through access to information, and changing attitudes and perceptions towards abortion thereby reducing unsafe abortion and its complications.

3.0 METHODS

This chapter discusses the research, sampling techniques, data collection techniques, study design as well as the processing and analysis methods that were employed in this study. Furthermore, research design, study site and sample characteristics for qualitative and quantitative study designs.

3.1. Quantitative Study Design

3.1.1. Study Design

This was an exploratory mixed-method study design. An exploratory study is a process of investigating a problem that has not been studied or thoroughly investigated in the past. Exploratory type of research is usually conducted to have a better understanding of the existing problem but usually doesn't lead to a conclusive result.

3.1.2. Study Setting

The study was conducted in Lusaka District, Zambia at the first level hospitals namely; Chawama hospital which services an area of approximately 213514 females, Kanyama hospital servicing approximately 136,662 females and Matero hospital servicing about 241,653 females. The three areas have similar features such as; they are densely populated areas, and housing shanty compounds with a high incidence rate of pregnancies (Lusaka District Health Office, 2020). The other hospitals were Chelstone with approximately 260448 females, Chipata with approximately 249709 females, and Chilenje with 228229 females, housing non-densely populated areas and do not house shanty compounds (Lusaka District Health Office, 2020). However, all hospitals are in the capital city of the country Zambia. The study focused on the Obstetrics and Gynecology departments of the health facilities of interest.

3.1.3 Study Population

The study population was drawn from women aged 18-35years of age accessing Maternal and Child Health, Obstetrics, and Gynecology services at the facilities under study. This age of 18 and above was chosen because it is the consent age and also an age where one could have experienced a pregnancy or abortion.

3.1.4 Inclusion and Exclusion Criteria

3.1.4.1 Inclusion Criteria

1. Women aged 18-35 accessing MCH services.
2. Midwives, Medical Superintendents, and nurses.

3.1.4.2 Exclusion criteria

1. Women who are below 18 or above 35 years old.
2. Not willing to provide informed consent to participate in the study.

3.1.5 Study Sample and Sample Size

According to Lai (2019), a study sample is a group of individuals who participate in your study. These are the individuals that provide the data for your study. Non- probability Purposive sampling technique was employed to select the sample size for each hospital to ensure an even representation of the area that the hospital services.

For purposes of this study, a total of 100 quantitative questionnaires were administered at each study site giving a grand total sample of 500 participants who were randomly selected.

To participate in the study, on condition that they were females aged 18-35 of childbearing age accessing Maternal and Child Health services as well as Gynecology and Obstetrics services at the health facilities.

3.1.6 Data Collection

Data collection consisted of questionnaires programmed in kobo collect. An interview method was applied to solicit information from informants who were young women, healthcare providers, and community members from the selected health facilities and in the facility catchment areas in Lusaka District. The respondents were guided by the enumerator by interviewing them in an appropriate and convenient language.

3.1.6 Data Analysis

Quantitative data was analyzed using Statistical Package for Social Science (SPSS version 20.0). Cross tabulations were utilized to find out whether there are differences or relationships between the variable knowledge, perceptions, and attitudes. This was proven with the use of Chi-square tests and all tests were run at 95% confidence interval setting the critical level at 0.05 significance level. Frequencies run in SPSS were exported to Microsoft word for reporting.

3.1.7 Data Management & Quality

A total of 25 questionnaires were administered for a pilot study to ensure the validity and reliability of the results of the study. The pilot study was conducted at Chelstone Level 1 hospital. No alterations other than grammatical ones were made to the tools. Data collection tools were checked for completeness, consistency, correctness, and clarity.

3.1.8 Ethical Considerations

Ethics is a set of moral principles which is suggested by an individual or groups, which is subsequently widely accepted, and which offers rules and behavioral expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants, and students (De Vos, 1998: 24). Participants were issued with an information sheet with information about the study, which they read, or had read to them in the presence of a witness. After this, a consent form was given to each participant to sign. The information that was collected from the respondents was kept confidential and used for academic purposes only. The computer in which the research was kept was password protected so that no intruders could access it. Ethical clearance was sought from the Research Ethics Committee of Lusaka University, as well as from the Ministry of Health, the National Health Research Authority, and the District Health Office.

3.2. Qualitative Study Design

A cross-sectional study was undertaken using a phenomenological approach to enable a wide understanding of knowledge, attitudes, and perceptions of young women, community members, and health care providers on legal abortion in the Lusaka district. The design was more suited for this study since it aimed at collecting participants' responses as well as analyze and draw conclusions from the data.

3.2.1. Study Site

The study was conducted at Chipata, Kanyama, Chawama, Matero, and Chilenje General Hospitals. The study population that was considered for this study included adolescent and young women as well as health care providers and community members.

3.2.2. Sample Size

It has previously been recommended that a minimum sample size of 12 be employed in qualitative investigations to achieve data saturation (Clarke & Braun, 2013; Fugard & Potts, 2014; Guest, Bunce, & Johnson, 2006). For this study, the sample size was determined based on data saturation. A total of 500 participants were enrolled.

3.2.3. Sampling Strategy

To find possible participants for this study, a non-probability purposive sampling approach was utilized.

3.2.4. Data Collection

3.2.4.1. Data Collection Methods

3.2.4.2. In-depth interviews with key informants

The key informants and stakeholders were interviewed using an interview guide. Key informants included the facility in charge, the obstetrics and gynecology department in charge, or the nurse/midwife at these departments, while community stakeholders comprised of clergy of church and political leaders in the community were interviewed. A maximum of 500 participants took part in this study.

3.2.4.3. Focus Group Discussions (FDG)

A total of 3 focused group discussions comprising 5 participants in each group were conducted at 3 facilities, while 2 Stakeholder interviews with community leaders and clergy of Churches were conducted at 2 facilities.

3.2.5. Data Collection Tools

3.2.5.1. Unstructured interview guide

This data collection instrument was used as the method of inquiry for this study because it allowed for a natural flow of discussion and gathering of rich and detailed information from participants. This method also made it easier for individuals to share their viewpoints and thoughts without feeling constrained.

The use of interview guides also helped in facilitating follow-up questions to obtain deeper insight into issues that were raised by the participants during the interviews. Being a face-to-face interview, discussions are inevitable.

A voice recorder was used in the Focus Group Discussions and key informant interviews to ensure accurate data and to facilitate data analysis. A note-taker and study assistant were engaged to help in note-taking and monitoring the recorder.

3.2.6. Data Management

The data was kept under password protection on the computer and also routine checking was done all the time. Notes were kept under lock and key in a cabinet.

3.2.7. Data Analysis

Thematic analysis was used to analyze the data acquired in this study because it was qualitative in nature. According to Bergold and Thomas (2012), qualitative content analysis is the process by which a researcher can derive objective meanings and themes from obtained data that are either obvious or hidden. Interviews were recorded, and common themes were categorized and organized under each research question. The study employed inductive qualitative content analysis for this reason.

The data were analyzed using thematic analysis. Familiarization, Coding, Generating themes, reviewing themes, Defining and Naming themes, and Writing up are the steps of this study.

4.0 RESULTS

4.1 Respondents Social Demographic Distribution

Table 1. Gives a summary of the social demographic characteristics of the respondents. A total of 489 individuals took part in the study. Their age ranged from 18 years and above with a mean age of 24 years. Nearly half of the respondents (41.5%) were between the ages of 26 and 35 years and about (55%) were below 25 years. almost half (49.49%) of the respondents were unmarried, 41.10% were married, and 5.73% were divorced. (3.60%) and were widowed.

About 48.47% of the respondents had attained secondary education and 10.22% had attained primary education.

Table 1: Demographic distribution of respondents

		Frequency	**Percentage %**
Age	18-25	269	55
	26-35	208	41.5
	36 and above	12	2.4
Marital Status	Married	201	41.10
	Unmarried	242	49.49
	Divorced	28	5.73
	Widowed	18	3.60
Level of Education	Sec. Sch	237	48.47
	Tertiary	159	32.52
	Primary	50	10.22
	No Ed.	43	5.79
Distribution of Respondents	Kanyama	99	20.25
	Chipata	99	20.25
	Chawama	98	20.04
	Matero	97	19.84
	Chilenje	96	19.63

4.2 Respondents' Level of Knowledge on Abortion

Figure 1 below shows the proportion of respondents who answered about abortion correctly against those who answered wrongly. As can be seen in the diagram majority of the respondents 456 (93.25%) had good levels of knowledge of abortion.

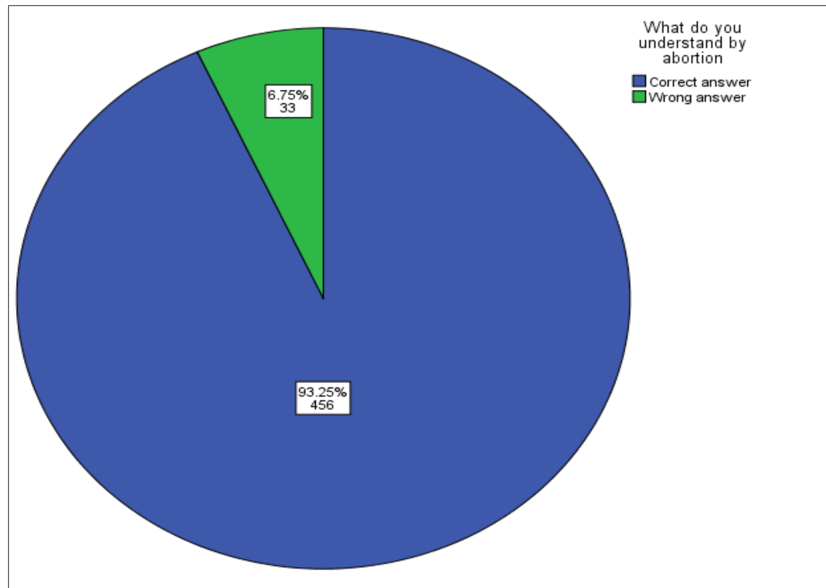

Figure 1: Respondents level of knowledge on abortion

4.3 Figure 2. Respondent's attitudes toward abortion

The majority of the respondents 71.17% displayed negative attitudes and were here not in favor of abortion while 0.41% withheld their opinion on the matter (figure 1).

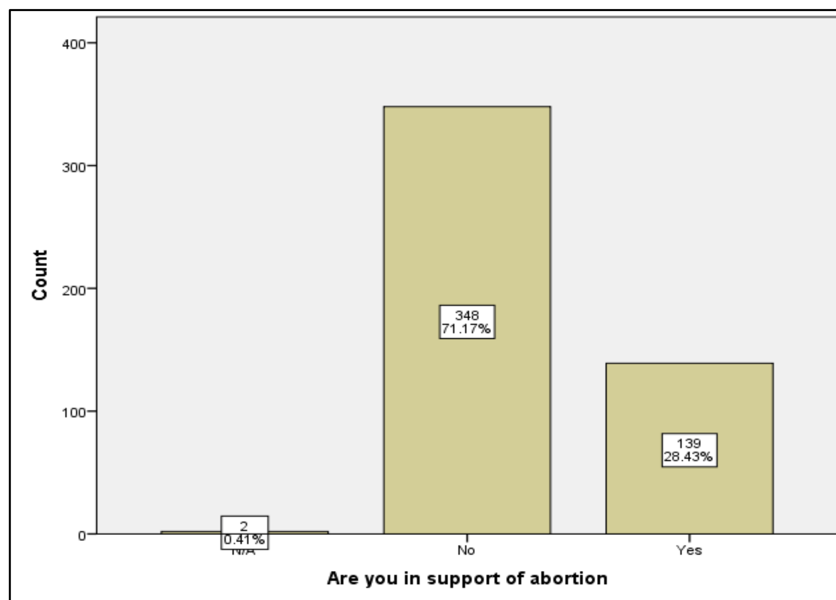

Figure 2: Respondent's attitude toward abortion

Table 2. The proportion of respondents by study site who had experienced abortion

Table 2 displays that Kanyama 15 had a high rate of respondents who had experienced an abortion. The most common reasons for abortion as shown in figure 4 included education 16 (6.72%) and fear of parents 12 (5.04%).

Table 2: Proportion of respondents who had experienced abortion

		Interview site					Total
		Chilenje	Kanyama	Chipata	Chawama	Matero	
Have you ever had an abortion?	No	56	33	71	59	71	290
	Yes	4	15	11	8	4	42
	N/A	36	51	17	31	22	157
Total		**96**	**99**	**99**	**98**	**97**	**489**

Figure 3. Reason for abortion

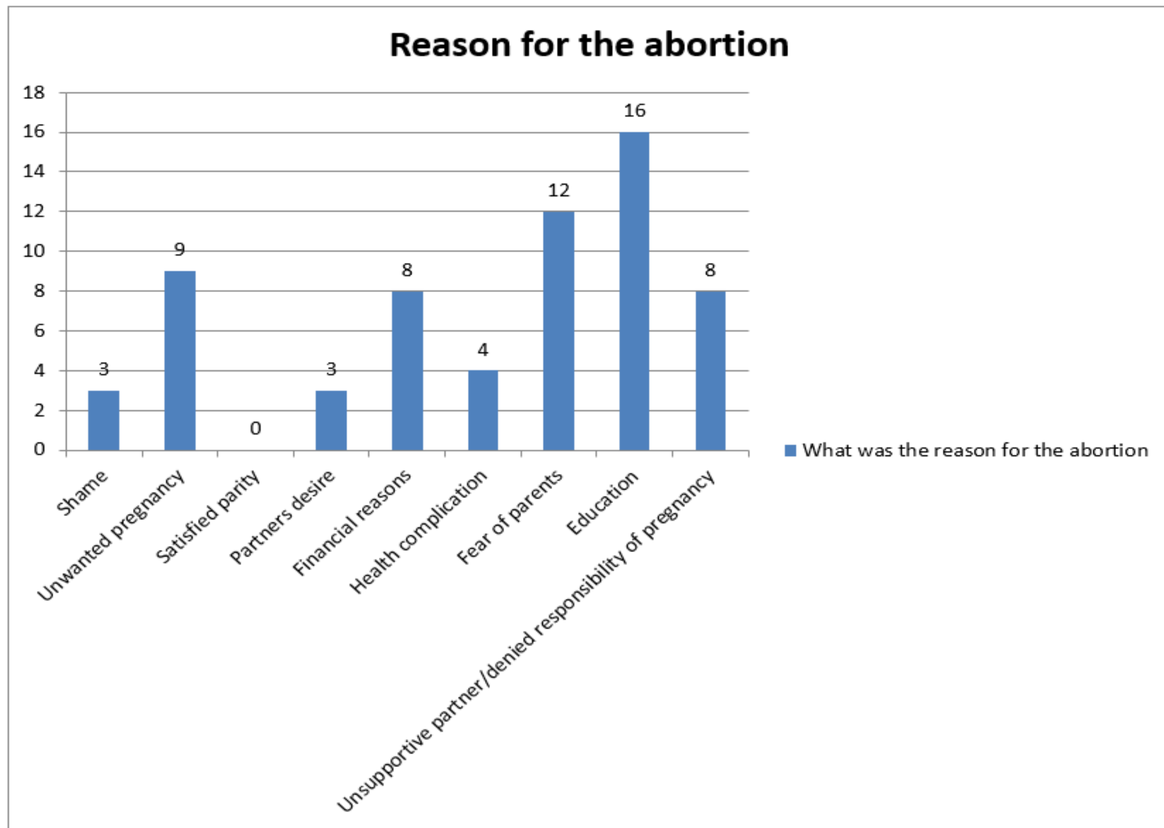

Figure 3: Respondent's reasons for abortion

Figure 3. About 9% of the respondents reported that unwanted pregnancy was a reason for abortion while the majority 16% highlighted that lack of education was the main reason for abortion. 12% of the respondents stated that the main reason for abortion was fear of parents while 8% stated that the main reason for abortion was financial reasons.

4.4 Figure 4. Respondents' perceptions on legalizing abortion

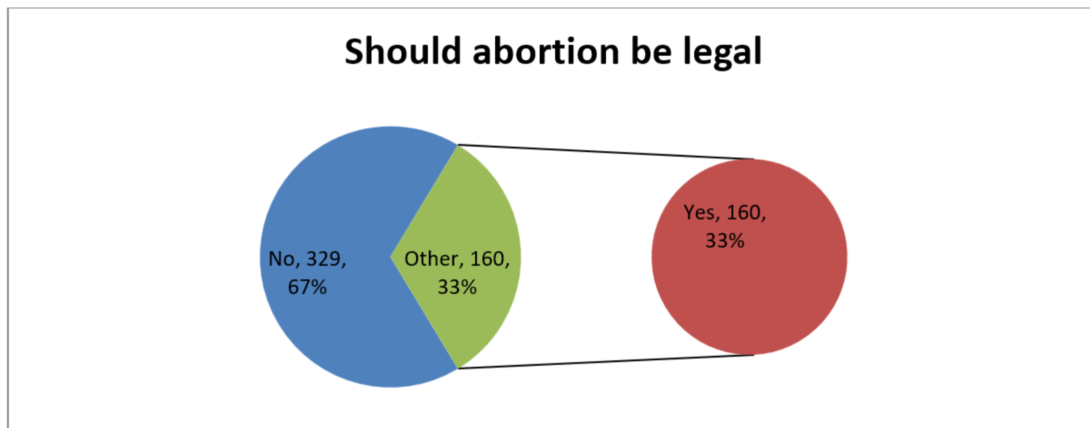

Figure 4: Respondents' perceptions on legalizing abortion

Respondents' perceptions on legalizing were heterogeneous as 67% (329) were against it while 33% (160) were for the idea (figure 4).

4.5 CROSS-TABULATIONS

4.5.1 Relationship between having an abortion and denomination for Christian

As can be seen in table 3 the relationship between denomination and having an abortion was not statistically significant at a p-value of 0.704.

Table 3: Relationship between having an abortion and denomination for Christian

		If Christian, choose a denomination				
		other	**SDA**	**Roman Catholic**	**Pentecost**	**Jehovah Witness**
Have you ever had an abortion?	No	57	52	58	105	18
	Yes	9	8	6	17	2
	N/A	38	30	34	51	4
	Total	**104**	**90**	**98**	**173**	**24**

P-value =0.704

Table 3 shows that of all the respondents that had an abortion, about 17 of the respondent's stay was Pentecost, 9 of the respondents were from other denominations and 8 of the respondents were SDA. The majority of the respondents have never had an abortion. The statistical findings indicate that there was no association between denomination and having an abortion. This is strongly supported by a statistical test of chi-square with a p-value of 0.704 which is greater than the normal p-value (0.05).

4.5.2 Relationship between having an abortion and Marital Status

Table 4: Relationship between having an abortion and Marital Status

		Marital status				Total
		Never married	**married**	**divorced**	**widowed**	
Have you ever had an abortion?	No	79	175	21	15	290
	Yes	22	12	5	3	42
	N/A	141	14	2	0	157
	Total	**242**	**201**	**28**	**18**	**489**

P-value = 0.000

The relationship between abortion and marital status was statistically significant with a p-value of 0.000 (table 4).

4.5.3 Relationship between having an abortion and Education Level

As can be seen in table 5 there was a significant relationship between education level and abortion at a p-value of 0.000.

Table 5: Relationship between having an abortion and Education Level

		Education level				Total
		Non	**primary**	**secondary**	**tertiary**	
Have you ever had an abortion?	No	26	40	159	65	290
	Yes	8	1	17	16	42
	N/A	9	9	61	78	157
	Total	**43**	**50**	**237**	**159**	**489**

4.5.4 Relationship between having an abortion and the number of live births

There was a statistically significant relationship between the number of live births and abortions at a p-value of 0.000 (table 6).

Table 6: Relationship between having an abortion and the number of live births

		How many live births have you ever had					
		0	1	2	3	4	5
Have you ever had an abortion?	No	37	110	62	51	21	8
	Yes	16	7	4	9	3	2
	N/A	150	0	2	4	0	0
	Total	**203**	**117**	**68**	**64**	**24**	**10**

		How many live births have you ever had		Total
		6	**16**	
Have you ever had an abortion?	No	1	0	290
	Yes	0	1	42
	N/A	1	0	157
	Total	**2**	**1**	**489**

4.5.5 Relationship between having an abortion and employment status

Employment status and abortion had a relationship with a p-value of 0.000 as displayed in table 7.

Table 7: Relationship between having an abortion and employment status

		Employment status/ source of income		Total
		employed	not employed	
Have you ever had an abortion?	No	124	166	290
	Yes	18	24	42
	N/A	32	125	157
Total		**174**	**315**	**489**

4.5.6 Relationship between having an abortion and knowledge of the legality of abortion in Zambia

At a p-value of 0.000, the relationship between having an abortion and knowledge of the legality of abortion in Zambia was statistically significant (table 8).

Table 8: Relationship between having an abortion and knowledge of the legality of abortion in Zambia

		Is abortion legal in Zambia			Total
		No	Yes	N/A	
Have you ever had an abortion?	No	217	73	0	290
	Yes	20	22	0	42
	N/A	84	71	2	157
Total		**321**	**166**	**2**	**489**

4.6 QUALITATIVE THEMATIC ANALYSIS

Table 9 is a presentation of themes from respondents who took part in the focused Group Discussions as well as in-depth interviews as Key Informants (Health care providers, community and religious leaders). Some of the major themes were; methods of abortion; reasons for abortion and understanding of legal abortion.

Table 9: Thematic Analysis

Theme: What is abortion **Codes:**	**Theme: Methods of abortion** **Codes:**	**Theme: Reasons you had for having an abortion**
• Termination of pregnancy before 28 weeks gestation • Do not know anything • Getting rid of unwanted pregnancy • Removing the baby by killing it	• Do not know anything about methods of abortion • Medical abortion at the hospital by trained personnel (including MVA) • Traditional abortion using herbs by untrained people • Self-abortion using a sharp tool or stick • Self-using off-the-counter drugs	• Health complication • Unwanted pregnancy • Fear of parents • Education • Financial reasons • Unsupportive partner/denied responsibility for pregnancy • Shame
Theme: Understanding of legal and **Codes:** • Do not know • Legal abortion is the type of abortion that is allowed by the law • When you have signed a document and it is done from a medical facility • Legal abortion is an abortion that is done with the consent of the medical personnel or rather it is an abortion done in a country where abortion is allowed. • Aborting with doctors' consent • You're of the legal age to abort and you have the right to do it • Abortion is done in the open • Abortion is done in a safe environment • Abortion that is permitted	**Theme: Understanding of illegal abortion** **Codes:** • Do not know • **This one is done without the consent of the pregnant woman** • Not allowed by people in authority • Having an abortion when it isn't allowed legally • Aborting without consent from family • Abortion done without a medical personnel • Killing an innocent baby • Abortion done against the legal standards • Not allowed by law • It is a crime I have seen people get arrested	**Theme: Safe abortion** **Codes:** • Abortion done by a qualified health specialist • The one where the doctors say it is necessary and there are serious health complications • Abortion that won't lead to complications • Safe abortion is a service of terminating a pregnancy using a procedure approved by the health

Theme: Reason for supporting abortion **Codes:** • For management of health issues or complications • Because of the situation a person is facing • If you are not ready to have a child • It is unchristian • It saves lives and helps people move on • In case someone has an unwanted pregnancy • Because many are young girls and want to continue with education • Not been financially prepared	**Theme: Reason for not supporting abortion** **Codes:** • Because am a Christian, it is unchristian • I wasn't aborted why should I abort no? It's supporting killing. • It is illegal, it's as good as murder • It's sin child are beautiful • Maybe the baby will be a savior of this world. Like they can be somebody in life to help others • Because a child is a blessing • It's risky and dangerous • Cause it leads to infection and death • Because it can kill someone • The guilt is too much! • It is against what the bible says • It's a sin to God • Abortion is against our beliefs • Abortion is against the culture • Our tradition doesn't allow abortion • It's a taboo	**Theme: Reason for supporting legalizing abortion** **Codes:** • Health complications and financial challenges • It will save a lot of lives from unsafe abortions and reduce illegal abortion • Many women and girls would still be alive if they knew it was legal unlike doing it from home • Help people have a choice **Theme: Reason for not supporting legalizing abortion** **Codes:** • Because people will take advantage and do it anyhow • Children should live no life should be taken. • People may take advantage, especially youths • It will increase deaths • Because Zambia is a Christian nation
4.2.3 Thematic Analysis for In-depth Interview of Key Informants **Theme:** Perception of information dissemination on abortion **Codes against:** • It is against what the bible says • It's a sin to God • Abortion is against our beliefs • Abortion is against the culture • Our tradition doesn't allow abortion **Codes for:** • For management of health issues or complications • It saves lives and helps people move on • In case someone has an unwanted pregnancy • Because many are young girls and want to continue with education • Not been financially prepared	**Theme:** *Perception of a person who intends to have an abortion* **Codes:** • It's sin child are beautiful • Maybe the baby will be a savior of this world. Like they can be somebody in life to help others • Because a child is a blessing • It's risky and dangerous • Cause it leads to infection and death • Because it can kill some **For** • It is a good practice if done legally and for a good reason • It saves lives • It gives women a choice • It gives women power of autonomy and rights to decision-making.	**Theme:** *Role of the church on issues of abortion* **Codes:** • To spread the word against sex before marriage to prevent unwanted pregnancies • To promote abstinence • To offer counseling and pastoral care
Theme: if put in a decision-making position, what would or what would not change regarding abortion **Codes:** • Abortion be legal for any reason • Abortion be legal for all minors • Abortion be legal only for medical reasons • Abortion should never be legalized in a Christian nation	**Theme:** Ideal situations if any to allow abortions **Codes:** • No situation guarantees abortion • Medical complication • Social economic factors • Choice • Family planning • Satisfied parity	

5.0 DISCUSSION

5.1 Overview of the Socio-Demographic Characteristics of the Respondents

The number of participants in the study with completely filled in questionnaires was 489 respondents for the quantitative questionnaire, 16 were for in-depth interviews with key informants, and 14 were for focused group discussions. Out of a total number of 489 participants, the majority had never been married. A larger proportion of participants had achieved secondary-level education. The respondents were evenly distributed due to the sampling method used and had little

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differences among interview sites (Chawama, Chilenje, Kanyama, Chipata, and Matero). The age of participants was distributed from 18 years as the minimum age and 46 as the maximum age. Following this description, it was noted that there was even representation from all age groups, areas of first-level hospitals around Lusaka, different education levels, socio-economic backgrounds, and marital statuses.

5.2 Discussion of Findings

Perceptions towards abortion remain a volatile issue with diverse views across residents of Lusaka which are in line with the findings of other studies such as those of Stockton (2001), Dimoula *et al.*, (2007), and Ozmen (2019). The findings of this study indicated that the majority (*actual figure*) of individuals were not in support of abortion regardless of their education status. The results indicated that those not in support of abortion had various reasons including those *being a Christian and the act was perceived as unchristian*; *perceiving abortion as an act of killing and murder; regarding abortion as a sin; anticipation and uncertainty in case the child is the saviour of the world; the riskiness of the act; resulting morbidity of infection and death as well as it being against beliefs, culture, and tradition*. These findings were similar to the findings by Ushie *et al.,* (2019) which indicated that individuals who abort are regarded as black sheep in society, and often faced ostracism. This study also indicated that the opinions of people on whether abortion should be popularized or promoted were heterogeneous with a larger proportion being against it, citing the earlier advanced reasons for opposing it.

A small proportion of the participants reportedly had an abortion in their lifetime citing various reasons for having an abortion, among them being, shame, fear, and rejection of pregnancy by the partner. Cross tabulations indicated various relationships between variables and abortion and their significance. Among several variables, the analysed denomination for Christians and knowledge of abortion notably had an insignificant relationship with abortion. Non-traditional churches seemingly had a higher incidence of abortions with Pentecost recording the highest, followed by a combination of other denominations. These findings though not significant are in line with what was mentioned by United Nations (2014) and Chanda *et al*., (2017) that religious and traditional beliefs had an influence on abortion acts.

Regarding knowledge of abortion, a vast majority of participants had satisfactory knowledge of what abortion was of which a small proportion reported having had an abortion before. These numbers were a good testimony that individuals had knowledge of abortion. However, a good number had no knowledge regarding the legality of abortion in Zambia with half of those who aborted indicating that they acted without knowledge of the legality of their action. This was in line with the finding by Creswell *et al*., (2016) where they outlined that knowledge was a major obstacle in accessing safe abortion services.

Using the thematic analysis, reasons for abortion that came up included health complications, unwanted pregnancy, fear of parents, education reasons, financial reasons, shame, and having an unsupportive partner/denied responsibility for the pregnancy. Regarding legal and illegal abortion, some knew what legal abortion was by responding that it was the type of abortion that is allowed by the law while others did not by responding that it is one done when one is of the legal age to abort and one done in the open.

Respondents referred to Illegal abortion as one done without the consent of the pregnant woman and Killing an innocent baby while others correctly referred to it as having an abortion when it isn't allowed legally. Diversity characterized respondents' views in the qualitative responses where the church maintained the stance that it remains to spread the word against sex before marriage to prevent unwanted pregnancies, and promote abstinence, counselling, and pastoral care. Opinions regarding what individuals would do if put in a decision-making position included; promoting abortion regardless of the reason, legalizing it in minors only, and legalizing it only for medical reasons, and never legalizing abortion. Responses from clergy indicated that no situation guarantees abortion including, medical complications, Social-economic factors, choice, family planning, and satisfying parity.

5.3 CONCLUSION

The knowledge, attitudes, and perceptions regarding abortion are diverse as evidenced by the results of this study. This study has indicated that the knowledge levels on abortion are high; however, individuals do not have sufficient information regarding the legality of abortion in Zambia, places to seek a legal abortion, and that the Church denomination plays a role in an individual's decision-making and thought process regarding abortion.

Study Limitations

1. Some health facility staff/ superintendents were not very cooperative in terms of allowing the researcher to collect data, despite having ALL the necessary authorization letters from the National Health Research Authority, The District Health Office, and the school Ethics Board. This delayed the data collection process, thereby affecting timelines.
2. The topic under study is almost regarded as 'taboo', and so getting people to agree to first take part, then open up, was a tall order. This required a lot of convincing, especially in the area of confidentiality of information.

5.4 RECOMMENDATIONS

Considering the diversity in the legality of abortion in the country, the study recommends that there is a need to have a multi-sectorial approach in mapping the way forward regarding information dissemination which is believed to bridge the gap between individuals requiring abortion services and access to legal and safe abortion. Furthermore, the study recommends that places where individuals can access abortion services be publicized so that individuals can access the services and achieve the goals of reducing maternal-related mortalities. In addition, there is a need for further studies to indicate places where individuals seek abortion services so that necessary policies are made to curtail unsafe abortion and reduce the risk by creating demand in designated places using qualified and recommended procedures for the termination of pregnancy. It is a further recommendation of the study that a component of sexual Reproductive Health and Rights related policies and legal frameworks be part of the in-service training curriculum for healthcare providers, and that periodic orientation once in practice be instituted. This comes as a result of the fact that some of the healthcare providers spoken to in this study had no knowledge of the legality of safe abortion, despite being providers of reproductive services.

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