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Awareness of the Termination of Pregnancy Act of the Laws of Zambia among Women of Reproductive Age at Kanyama First Level Hospital in Lusaka District Zambia

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Abstract

Background: Termination of pregnancy (TOP) in Zambia is guided by the Termination of Pregnancy (TOP) Act of 1972 and as amended in 1994 of the laws of Zambia. However, despite provision of Comprehensive abortion care services with the liberal law, statistics at Kanyama First Level Hospital in relation to unsafe illegal abortions are alarming. This study sought to understand the Awareness on the TOP Act of the laws of Zambia among women of reproductive age 15 - 49 years at Kanyama First Level Hospital in Lusaka District. **Purpose of the Study:** To assess awareness on the TOP Act among women of reproductive age at Kanyama First Level Hospital in Lusaka, Zambia. **Methodology:** A convergent parallel mixed method design was conducted using both survey and in-depth interviews among women of reproductive age at Kanyama First Level Hospital in Lusaka District. The study surveyed 370 randomly sampled women aged 15 to 49 years old while the in-depth interviews included eight women purposively sampled from the survey population. Survey data was analyzed using descriptive and inferential statistics while qualitative data thematic analysis was used. **Results:** The study found that 37% of the participants were aware of the TOP Act while 63.8% viewed legalization of abortion for any reason as wrong. The study results also showed that widowed women were 8 times more likely to be aware of the TOP Act compared to single women (AOR: 8.262; 95% CI: 1.105, 61.778). Women in business were significantly more likely to be aware of the TOP Act compared to those who reported having no occupation. (AOR: 2.61; 95% CI: 1.246, 5.499). Limited access to information, the social stigma attached to

abortion, health care providers' attitudes, cultural norms, values and religious beliefs, restrictive legal requirements, and absence of a supportive network were some of the barriers affecting awareness and utilization of available safe abortion care services. **Conclusions:** The research findings concluded that a significant lack of awareness among women of reproductive age regarding the Termination of Pregnancy (TOP) Act. The majority of respondents held the view that abortion should only be legalized for medical reasons. Furthermore, there was a notable gap in knowledge concerning the penal code's provisions on abortion.

Keywords

Awareness, Termination of Pregnancy Act, Barriers, Determinants, Women

1. Introduction

The World Health Organization [1] defines abortion as the termination of pregnancy before 28 weeks of gestation. According to WHO's 2017 guidelines, comprehensive abortion care should include counseling, consent, appropriate abortion methods based on gestational age (surgical abortion when pregnancy is below 12 weeks of gestation while medical abortion from 12 weeks up to 28 weeks) and family planning.

Zambia's legal framework on abortion is governed by the Republican Constitution (Cap 1), the Termination of Pregnancy (TOP) Act (Cap 304), the Health Professions Act (No. 24 of 2009), the 2005 Revised Penal Code (Cap 87), and the Gender Equality and Equity Act (2015). These statutes outline conditions for legal abortion and ensure patient confidentiality, privacy, and right to decision-making.

Abortion draws varied emotions based on individual and societal beliefs and often, women known to have sought or those seeking legal abortion services experience stigma and social exclusion within their communities [2]. Ushie *et al.* further alluded that understanding community awareness of abortion is critical in informing the design and delivery of interventions that reduce the gaps in access to safe abortion services for women. Illegal abortions are prevalent in most developing countries, particularly in Africa. For instance, over 4 million abortions are carried out annually in Africa, [3] of which 99% are conducted under unsafe circumstances [4]. Termination of pregnancy can be either safe termination conducted by a skilled person in an accredited environment with required medical standards or unsafe termination carried out by a person lacking the required skills or in an environment lacking required medical standards or both [5]. The rising burden of unsafe abortion and the resultant magnitude of severe complications constitute a significant public health challenge in Sub-Saharan Africa (SSA) [4]. The high incidence of unsafe abortion opposes the growing availability of safer and quality procedures, based on the WHO guidelines for terminating pregnancies [6]. Across SSA, unsafe abortion remains prevalent ac-

counting for up to 29% of the global burden of unsafe abortions and about 62% of global abortion related deaths [7].

Cultural and religious intolerance to abortion among communities and service providers manifesting most saliently as abortion stigma, as well as the cost of care continues to drive women and adolescent girls to self-managed abortion procedures or those offered clandestinely mainly by unqualified providers [2].

In Ethiopia, 32% of all maternal deaths reviewed, were as a result of illegal abortion and 35.7% of women of reproductive health interviewed were aware of legalization of abortion [8]. Strengthening information dissemination regarding the legalization of safe abortion was required for females of reproductive age group in general and higher institutions for female students in particular. In Ghana, Atakro [9] factors that contributed to a high incidence of unsafe abortion practices among women of reproductive age (15 to 49 years) were poor knowledge of the availability of safe or therapeutic abortion policies and services in their health facilities and lack of awareness of the abortion laws. In Nigeria, Eyitayo *et al.* [10], among undergraduate University students lack of knowledge of legal provisions was generally responsible for unsafe abortions despite the law permitting abortion.

In Zambia, unsafe illegal abortions contribute to maternal morbidity and mortality. The Ministry of Health [11] reported that 30 out of every 100,000 women died due to illegal and unsafe aborting procedures. At Kanyama Level I Hospital, 97% of women who accessed abortion services from 2020-2022 had unsafe and illegal abortion access in the community. A study by Trevor *et al.* [12], among adolescents in Ndola Zambia on awareness of the availability of legal abortion services among female adolescents attending secondary school demonstrated that most females have high levels of ignorance on the provision of the law on TOP. Further research [13] in three provinces of Zambia (Central, Copperbelt and Lusaka) on women's knowledge and attitudes toward abortion showed that only 16% of the participants had knowledge of the legal status of abortion services.

2. Methodology

The study was conducted at Kanyama First Level Hospital among women of reproductive Age from August 2023 to January 2024. A mixed method employing both quantitative and qualitative methods, results were compared and interpreted. The researcher used the above model to validate quantitative results with qualitative findings, hence ending up with valid and well substantiated conclusions about the Phenomenon being studied, Data was collected using researcher-administered questionnaires for both quantitative and qualitative data. For the qualitative aspects, data collection was through semi-structured interviews and audio recording for data recording. Data were entered in Microsoft Excel and exported to SPSS V.25 for analysis. After cleaning, descriptive statistics were calculated and presented as means with respective standard deviations, or medians as appropriate. Chi square statistical test was used to establish the association between dependent and independent variables at a 95% confidence level

and P-value of <0.05. Data were manually analyzed using thematic analysis as indicated by sub-themes generated during data analysis. The narration of themes was coded, and verbalism was used to indicate the actual voices of participants.

3. Results

Table 1 showed that the majority of the respondents were in the age group 21 - 30 years 200 (54%), 189 (51%) were single and most attained higher/tertiary and secondary education levels. The most common occupation was business 122 (33%). The majority of participants were Christians 361 (97.6%).

Table 1. Demographic and socio-economic characteristics of respondents (n = 370).

Variable	Values	Frequency	Percent (%)
Age	15 - 20	74	20
	21 - 30	200	54
	31 - 40	61	16.5
	41 - 49	35	9.5
Marital status	Single	189	51.1
	Married	162	43.8
	Divorce	12	3.2
	Widowed	7	1.9
Number of children/Parity	0	101	27.3
	1 to 3	177	47.8
	4 to 5	60	16.2
	6 to 7	14	3.8
	8 and above	18	4.9
Family size	1 to 3	76	20.5
	4 to 5	122	33
	6 to 7	93	25.1
	8 and above	25	6.8
	Not stated	54	14.6
Educational level	No education	7	1.9
	Primary	85	23
	Secondary	138	37.3
	Higher/Tertiary	140	37.8
Occupation	None/nothing	83	22.4
	Student	113	30.5
	House wife	41	11.1
	Business	122	33
	Not stated	11	3
Religious affiliation	Christians	361	97.6
	Muslim	7	1.9
	Hindu	2	0.5

3.1. Awareness of TOP Act

The results in Table 2 revealed that the majority 233 (63%) of the participants were not aware of the TOP Act while 137, (37%) were aware of this legislation.

Table 2. Respondents' awareness of the TOP Act (n = 370).

Variable	Values	Frequency	Percentage (%)
Awareness of TOP Act	Aware	137	37
	Not aware	233	63
	Total	**370**	**100**

Most of the respondents got information on abortion services from hospitals and clinics (35%), followed by those who got from family and friends (19.1%), those who got from the community, schools and least got from Radio, TV and books (Figure 1).

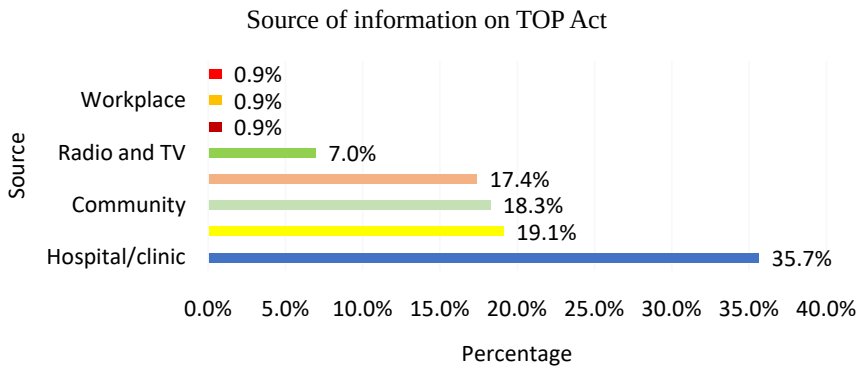

Figure 1. Source of information on TOP Act.

Table 3 results as above revealed that 270 (73%) of respondents believe in obtaining abortion pills from private clinics and pharmacies. The majority of respondents 207 (55.9%) believe that treatment for abortion complications is provided at government clinics and hospitals.

Table 3. Sources of abortion services and treatment (n = 370).

Statement	Place				
	Private clinics & pharmacies	Traditional healers	GVNT clinics & hospitals	All	Not stated
Where do you think people get abortion pills?	270 (73%)	56 (15.1%)	30 (8.1%)	5 (1.4%)	9 (2.4%)
Where do you think people are most likely to get abortion complication treatment?	53 (14.3%)	103 (27.8%)	207 (55.9%)	2 (0.6%)	5 (1.4%)

Table 4 showed that Age, Culture and provision of safe abortion services are significant factors influencing the awareness of TOP Act among respondents. Age had a P-Value of 0.048, Religion P-Value of 0.376, Culture P-Value of 0.001

and provision of safe abortion service P-Value of 0.029. Therefore age, culture and provision of abortion services were statistically significant.

Table 4. Association of demographic and socio-economic factors with awareness of the TOP Act.

	Awareness of TOP Act (%)			
Independent variables	**Not aware**	**Aware**	**Number of women**	**P-value**
Age				**0.048**
≤30 years	60.4	39.6	275	
31 - 40 years	67.2	32.8	61	
≥41 years	76.5	23.5	34	
Religion				0.376
Christian	62.6	37.4	361	
Muslim	85.7	14.3	7	
Hindu	50	50	2	
Culture				**0.001**
Agree	56.3	43.8	176	
Disagree	73.1	26.9	156	
Neutral	48.4	51.6	31	
Provision of safe abortion services				**0.029**
Private clinics and pharmacies	66.3	33.7	270	
Traditional healers	57.4	42.6	61	
Government clinics and hospitals	43.3	56.7	30	

According to Table 5, results showed that Age, religion and education levels were not statistically significant. Widowed women are significantly eight times more likely to be aware of the TOP Act compared to single women (AOR: 8.26; 95% CI: 1.11, 61.78). Also, business women are significantly 3 times more likely to be aware of the TOP Act compared to those who report nothing as their occupation (AOR: 2.62; 95% CI: 1.25, 5.5).

Table 5. Logistic regression: Factors associated with awareness of The TOP Act among women.

Categories	**Awareness of TOP Act**			
	AOR	**P-value**	**[95% Conf. interval]**	
Age group				
15 - 20	1			
21 - 30	0.692	0.274	0.358	1.338
31 - 40	0.633	0.346	0.244	1.639
41 - 49	0.430	0.207	0.116	1.597

Continued

Marital status				
Single	1			
Married	1.216	0.552	0.638	2.316
Divorce	0.756	0.764	0.122	4.680
Widowed	8.262	**0.040**	1.105	61.778
Religious affiliation				
Christian	1			
Muslim	0.170	0.111	0.019	1.500
Hindu	3.497	0.523	0.075	162.269
Occupation				
Nothing	1			
Student	2.600	0.160	1.199	5.637
House wife	3.465	0.051	1.323	9.076
Business	2.617	**0.011**	1.246	5.499
Education level				
No education	1			
Primary	2.231	0.518	0.196	25.405
Secondary	7.783	0.097	0.690	87.732
Higher/Tertiary	8.571	0.081	0.768	95.610

3.2. Results from Qualitative Data

The qualitative approach aimed to understand, and determine the provision of safe abortion services and barriers affecting utilization of the TOP Act of the laws of Zambia among women of reproductive age. A total of eight Women of reproductive age accessing health services at Kanyama First Level Hospital were interviewed to triangulate the results from the questionnaire. Data was manually analyzed using thematic analysis as indicated by sub-themes generated during data analysis as shown in Table 6 below:

Table 6. Factors that influence the provision of safe abortion services and barriers affecting utilization of the safe abortion services.

Themes	Sub-Themes	Statement
Factors that influence women to seek for quality and safety of abortions services	• Adequate human resource	• The hospital has adequately trained and licensed healthcare professionals
		• The abortion services are provided in healthcare settings with well-established medical standards and infection control measures
	• Access to safe facilities services	• Medicines and other supplies are readily available at the abortion clinic at no cost.
		• The services are free of charge.
	• Access to post-abortion care	• I used to come for reviews,
	• Comprehensive Counseling and Informed Consent	• Before safe abortion services are offered explanation is done and consent of assent form is signed
		• The staff are welcoming and give us respective care with no judgmental sentiments
	• Privacy and Confidentiality	• Each client is attended to with individualized care in a private room

Continued

The barriers affecting utilization of the TOP	• Limited access to information	• Limited Access to safe abortion services • Women in our community lack information about abortion services and • Lack information about the laws surrounding abortion
	• Social stigma attached to abortion	• There is a social stigma attached to abortion especially is people see you entering the room at the hospital where a service is offered. • This stigma discourages women from seeking safe and legal abortion care.
	• Health care providers' attitudes	• The attitude of health care providers sometimes contributes to women coming for legal abortion in the hospital hence preferring private hospital
	• Cultural norms, values and religious beliefs	• At church abortion is a sin, making it difficult for individuals to access abortion services without fear of judgment • Some traditions do allow abortion
	• Restrictive legal requirements	• fear legal repercussions or harassment from anti-abortion activist
	• Absence of a supportive network	• Lack of emotional and social support from friends, family, or partners • Limited availability of services • Can't afford to buy medicine prescriptions they give at the hospital to go and buy abortion pills.

Source: Researcher's illustration based on field data.

3.3. Factors That Influence Provision of Safe Abortion Services

Below is a detailed presentation of findings cited above concerning what determines the provision of safe abortion services at Kanyama First Level Hospital. The participants were asked about key factors that influence women to seek for quality and safety of abortion services provided at Kanyama First Level Hospital. The general view from participants confirms the point being made above in quantitative.

3.4. Adequate Human Resource

It was observed that respondents access safe abortion because of the availability of qualified and licensed medical personnel in the health facilities which provides women with a sense of safety. One respondent said: "*What motivated me to seek for the abortion services here, I was told when I was having complications with my pregnancy that the hospital has certified doctors who provide abortion service when consent is signed*" (*W*-5)

Further, the providers have been trained with skill in offering safe abortion services, as one respondent added: "*The hospital has adequately trained and licensed healthcare professionals, such as doctors, nurses, and midwives, who are available to provide safe and competent abortion care*" (*W*-2).

3.5. Access to Safe Facilities Services

Further, there is easy accessibility to the facility. I think the hospital environment is safe and it is well-equipped. "*The abortion services are provided in healthcare settings with well-established medical standards and infection control measures, this motivates us women when we have a complication with the pregnancy to go for abortion*" (*W*-10)

The facility also provides post-abortion care to those who experience abortion. One respondent added: "*I was able to access other services after a successful abortion was conducted, I used to come for reviews, and doctors and nurses who were on duty used to attend to me with less difficulties*" (*W*-3).

Also, medicines and other supplies are readily available at the abortion clinic at no cost, as noted by one respondent: "…*the hospital has everything I was told that medication abortion, also known as the abortion pill was available when I visited the facility, and I was told they are readily available, the hospital has a safe and effective method for ending early pregnancies*" (*W*-1).

3.6. Comprehensive Counselling and Informed Consent

Another theme from the findings was Comprehensive Counseling and Informed Consent. There is a team to offer comprehensive counselling when you visit the hospital. When you are seeking abortion, services women where are subjected comprehensive counseling and we are given the opportunity to provide informed consent. This includes discussing the risks, benefits, and alternatives to abortion. One respondent said: "*The hospital subjected us to counselling to understand the implication of the action and about to make an informed decision when making consent for abortion to be conducted. So, women are counseled on primary prevention of unwanted pregnancies. Before safe abortion services are offered explanation is done and consent of assent form is signed*" (*W*-6).

Non-judgmental and respectful care is an approach to caregiving that emphasizes treating individuals with dignity, empathy, and understanding, regardless of their background, beliefs, or circumstances. One woman indicated that: "*the staff are welcoming and give us respective care with no judgmental sentiments*" (*W*-8).

Contributing to the same another woman indicated that: "*Healthcare providers offer non-judgmental and respectful care to women seeking abortion services, recognizing their autonomy and dignity. They could actively listen to you when explaining what you have been feeling trying to understand your situation*" (*W*-4).

3.7. Privacy and Confidentiality

Further, another theme from the findings was Privacy and Confidentiality. In support, one participant indicated that: "…*the hospital takes each woman who visits the hospital for abortion with privacy. Each client is attended to with individualized care in a private room. Abortion services are provided with a high level of privacy and confidentiality to protect the patient's rights and minimize stigma*" (*W*-8).

It was revealed that the hospital is accessible and affordability to conduct abortion from the facility. Commenting on the same, another participant had this to say: "*I was not charged for the service, it is free to everyone who needs it*" (*W*-2).

3.8. The Barriers Affecting Utilization of the TOP Act

The findings on barriers affecting utilization of the TOP Act of the laws of Zambia among women of reproductive age showed that women were restricted from accessing abortion services due to limited access to information, social stigma, healthcare provider attitudes, cultural and religious beliefs, restrictive legal requirements, and lack of supportive network.

3.9. Limited Access to Information

The results showed limited access to information on the challenge theme which emerged. Reacting to the question, participant (W-10) had this to say: "*There is limited Access to safe abortion services as they are only found at Kanyama First level Hospital around the big compound of Kanyama community which leads women to access unsafe abortions from the quacks found in the community*" (W-7).

Factors like education and access to information on safe abortion services have influenced women of child bearing age in the choices which have led to seeking unsafe abortion services in the community. In support, one respondent said: "*I think much of us are not aware of the Act and the services it supports. I think women in our community lack information about abortion services and the laws surrounding abortion*" (*W*-5).

3.10. Social Stigma Attached to Abortion

Another theme from the findings was the social stigma attached to abortion. In support of the finding, a participant (W4) said: "*There is a social stigma attached to abortion especially if people see you entering the room at the hospital where a service is offered. Seeking for safe abortion because it doesn't look well seeing entering the office where they do abortion*".

In contribution, the participant (W-6) had this to say: "*Societal stigma surrounding abortion discourages us women of Kanyama from seeking services under the Act due to fear of judgment or ostracism. Abortion can be highly stigmatized in many cultures and societies, leading to feelings of shame and guilt for those seeking abortion services. This stigma discourages us from seeking safe and legal abortion care.*"

3.11. Health Care Providers Attitudes

Further, it emerged that healthcare providers' negative Attitudes toward women seeking safe abortions can stop women from seeking the services from the facility. In response, one participant said: "*The personal beliefs and attitudes of healthcare providers affect the availability of services and the quality of care provided to us especially young women; the attitude of health care providers sometimes contributes to women coming for legal abortion in the hospital hence prefer private hospital*" (*W*-3)

3.12. Cultural Norms, Values and Religious Beliefs

Also, it emerged from the findings that strong religious beliefs and doctrines regarding abortion vary widely among different faith traditions. It's important to note that interpretations and perspectives within each religion can also differ. Strong religious beliefs and doctrines have influenced our attitudes toward abortion and hindered access to services provided by the Act. In support, one participant added: "…*from my church abortion is a sin*, *making it difficult for individuals to access abortion services without fear of judgment or ostracism*" (*W*-8).

Further, another participant asserted that: "M*y culture doesn't allow abortion unless with consent from the hospital and proven to be a danger to my health*, *otherwise it's a taboo to hear that you have done abortion*, *it becomes a shame to the family*" (*W*-3).

3.13. Restrictive Legal Requirements

The theme from the in-depth interviews is that restrictive legal requirements restrictive abortion laws can limit access to safe and legal abortion services, forcing individuals to seek unsafe and potentially life-threatening alternatives. This was evident from participant: "*Complex or restrictive legal requirements*, *such as parental consent laws deter us young women from seeking abortion services*. *Even in places where abortion is legal*, *individuals may still fear legal repercussions or harassment from anti-abortion activists*, *which can deter them from seeking car*" (*W*-1).

3.14. Absence of Supportive Network

Further, the theme of the findings was the absence of a supportive network. The absence of supportive networks, including family and friends, has influenced us women in our decision and ability to access abortion services. In support, one participant said: "*Lack of emotional and social support from friends*, *family*, *or partners can further isolate individuals who need abortion services*, *making it more difficult for them to access safe care*" (*W*-9).

Further, safe abortion services may be limited or unavailable, making it difficult for individuals to access the care they need. Geographical barriers and a lack of healthcare providers trained in abortion services contribute to this problem. As added by another participant: "*What I feel when you don't have doctors and nurses who re trained*, *it difficult for the hospital to provide abortion care*" (*W*-2).

Furthermore, economic constraints can prevent individuals from accessing safe abortion services, as they may not be able to afford the cost of the procedure or travel to a healthcare facility that offers these services. One woman commented: "*Some of us can't afford to buy medicine prescription they give at the hospital to go and buy abortion pills*. *Some can't afford transport to reach the hospital hence resorting to illegal methods or using traditional doctors who are*

readily available" (*W*-10).

4. Discussion of Findings

The purpose of this study was to assess awareness of the TOP Act among women of reproductive age in the Kanyama compound. The study found that women have varying awareness depending on the context. The socio-cultural norms, legal setting and illegal practices, information sources, and health providers' attitudes seemed to influence the utilization of abortion services in the Kanyama compound.

4.1. Characteristics of Respondents

The majority of respondents had strong religious affiliation 97.6% of them being Christians while 1.9% were Muslims. The religious values and beliefs of some respondents affect their decision and likelihood of supporting and being against [14]. Hence, victims of unplanned pregnancy in the area are likely to opt for clandestine abortion due to religious beliefs and commitment, as the decision to abort a foetus is mostly tragic for all concerned, and nowhere more so than in a profoundly religious society like Zambia [13]. However, religious affiliation and beliefs can also be a controlling factor in checking sexual behaviors in women, which will in turn help reduce unplanned pregnancies among women.

4.2. Respondents Level of Awareness on the TOP Act

The results in **Table 2** revealed that 63% of the participants were not aware of this legislation on TOP Act. The gap in providing correct information to this target population on the legal status of abortion (*i.e.*, abortion is permitted under predetermined conditions) through mainstream media including state television and radio in Zambia. The provision of correct information is a key determinant of the pathway to safe abortion. The absence of accurate knowledge and the fear of violating the law creates a disturbing effect and deter women from seeking health care services [15]. A systematic review conducted by Assifi and colleagues in 2016 reported that women's correct general awareness and knowledge of the legal status was less than 50% in nine studies. In six studies, knowledge of legalization/liberalization ranged between 32.3% - 68.2%. Correct knowledge of abortion on the grounds of rape ranged from 12.8% - 98%, while in the case of incest, ranged from 9.8% - 64.5%. Abortion on the grounds of foetal impairment and gestational limits, varied widely from 7% - 94% and 0% - 89.5%, respectively [16]. However, the current study finding related to media as the source of information does not corroborate with that of the previously reported studies [17] [18]. Therefore, media including state media should be considered as an important channel to reach women with no prior experience in public institutions with health information aimed at improving their knowledge of safe abortion care in their area. Technology-based health interventions may provide a means to reach these women with information about all reproductive health care ser-

vices including the legal status and availability of safe abortion care in their setting. The government should show concerns regarding technology as a means to deliver health information and interventions for safe abortion care.

TOP Act (P-value = 0.035). Women with high knowledge (67.6%) were more likely to be aware of TOP Act compared to women with medium (52.8%) or low (41.5%) levels of knowledge of the TOP Act. The results revealed that there was a statistically significant association between the provision of safe abortion services and awareness of TOP Act. The results showed that younger women (62%) were more likely to think that TOP Act is trying to protect mothers from dangers of unsafe abortion compared to older women (35.3%). Furthermore, perception of TOP Act was found to be strongly associated with knowledge of TOP Act Religion, culture and provision of safe abortion services were found to be not statistically significantly associated with perception of TOP Act. Similarly, Abdissa *et al.* [19] revealed marital status of respondents, family residence, maternal education level and prior pregnancy experience were factors significantly associated with the knowledge of female students towards liberalized safe abortion.

The logistic regression analysis on factors associated with awareness of TOP Act among women indicated that awareness of the TOP Act does not significantly vary with age. It was revealed that Awareness of TOP Act was found to be associated with Culture as compared to religion. Cultural and societal values play a significant role in shaping perceptions of abortion laws. In some societies, traditional values may impact views on reproductive rights and abortion (20. Further revealed that perception of TOP Act was found to be strongly associated with knowledge of TOP Act. The results showed that widowed women are significantly 8 times more likely to be aware of the TOP Act compared to single women. Business women are significantly more likely to be aware of the TOP Act compared to those who report nothing as their occupation. These findings were in line with Singh (6 who said that awareness is influenced by various factors such as educational background, socio-economic status, cultural and religious beliefs, access to information, and the overall legal and healthcare infrastructure in a particular region [20].

4.3. Religion, Culture and Abortion

A study by Coast *et al.* [21] argued that women's knowledge of the legal status of abortion may be negatively influenced by the wider social norms, cultural belief system, religious regulations and conventions surrounding abortion might coerce them to go for unsafe methods of abortion which usually does not occur in a public space. Further, women's knowledge of the legality of abortion might prevent them from seeking safer abortion services because of financial support especially from the partners since safe methods are relatively expensive to unsafe abortion practices. Women will rather prefer to practice unsafe abortions in order to avoid being victims of stigmatization, labelling and emotional trauma. Women's awareness of the law is only one factor in their being able to obtain

appropriate care. Knowledge of safe abortion services, and providing women with information on the legal context and methods to allow access to such information assist in decreasing the chances that a woman will seek unsafe abortion services and consequently decreasing her likelihood of suffering from abortion-related morbidity or mortality [16] [22].

Participants in this study found abortion to be ethically, morally, and culturally unacceptable. The participants in this study indicated that abortion should not be legalized as they viewed it as a sin and that it constituted murder. These findings are consistent with studies in Kenya and Nigeria that found that participants did not support abortion for religious and moral reasons [23]. Similarly, a study in the UK found that most participants acknowledged that abortion was socially unacceptable and viewed as highly taboo [24]. These findings were not surprising, considering that all the participants in this study were religious affiliates. It is highly plausible that the participants' perceptions regarding the legalization of abortion are deeply rooted in religious scriptures and doctrine, as well as perceptions and theories about when life begins. Religious doctrine and beliefs may impede public health recommendations regarding abortion [25] and may potentially propagate the prohibition of abortion in Zambia.

Furthermore, awareness of the TOP Act was found to be strongly associated with knowledge of provision of safe abortion services.

4.4. Determinants to the Provision of Safe Abortion Services

Women's access to safe abortion is mediated by the fact that providers are perennially in fear of any interface whatsoever with the criminal, or even civil, legal system. This fear acts as a chilling effect on service providers' willingness to provide abortion services. Further, given the overarching criminal law framework for abortion, as well as the stigma surrounding abortion, there is widespread (mis)understanding amongst service providers that anything to do with abortion may be unlawful, resulting in a fear of the legal process [26]. As explored in this study, the legal framework includes denying abortion services to women, especially to those under the age of 18, those in their second trimester of pregnancy, and those who have had more than one girl child previously. When abortion is provided, providers often make women unnecessarily jump through hoops, such as seeking enhanced consent, documentation, and third-party authorizations, to protect themselves from legal action.

Clients' satisfaction with the safe abortion service is a key factor in the continuing utilization of the service by the community. During the in-depth interviews, the study found that most of the interviewees felt that the safe abortion care providers were highly skilled and were satisfied with the service provided. This finding is comparable to a study by Oda *et al.* [27], where more than 98% of the clients were satisfied with the skills of the providers and the services they received. The quality of legal abortion services was an issue raised by interviewees in this study. This was in support of previous reports where teenage women from Hong Kong SAR and abortion providers from South Africa said that women

preferred to go to private clinics and pay higher fees to receive a personalized service with more privacy, less stigmatization, shorter waiting times and better pre- and post-abortion counselling.

4.5. Barriers to the Utilization of TOP Services

During the in-depth interview, interviewees indicated that women have limited knowledge regarding where and how to access post-abortion services. Many (44.6%) of the women interviewed did not know that treatment is provided in public health care facilities and believed that such services were available only in private facilities. This discourages women from seeking the service, even when they suffer complications, or causes them to incur unnecessary expenses by going to private facilities. In addition, despite the government's policy to provide all maternal, newborn, and child health services—which include post abortion care, free of charge—many are not aware of this policy and are asked to pay when seeking treatment at a public facility [13].

Due to the absence of a clear policy or guidelines, and limited dissemination of information regarding the current legal framework on abortion, women lack knowledge of when and how to legally terminate pregnancies. As a result, many believe the law to be more restrictive than it is. That discourages them from seeking abortions at public health care facilities and compels them to resort to unsafe methods. This finding was supported by studies conducted in Ghana, and northern Ethiopia [28]. This could be attributed to a high likelihood of utilizing safe abortion services due to knowledge of safe abortion services, such as the legal framework of abortion at the national level and the place where safe abortion services are provided.

As demonstrated in the in-depth sessions, respondents indicated that many of the women have limited avenues to access information and mostly refer to newspapers, radio, and TV, which, for the most part, do not provide accurate information when it comes to abortions. As a result, they fear being reported and arrested, and prefer not to seek abortion services from health facilities even in situations where they might have qualified for a legal abortion. Similarly, Makleff *et al.* reported that lack of clarity leads to the restrictive interpretation of the law by health care providers and the denial of services to women and girls who would have qualified for legal abortions [29].

Abortion stigma and patriarchal assumptions about women's sexual, reproductive, and decision-making capabilities also limit women's access to abortion. Since the law empowers service providers to act as gatekeepers to abortion access, their views on the morality of abortion shape women's access to safe abortion services. Some women in this study indicated that medical practitioners' views on the morality of abortion are shaped by a range of factors including general abortion stigma, medical practitioners' own religious views, as well as their understanding of women's place and role in society [6].

The majority of women and other stakeholders interviewed for this study said that stigma from the community and health care providers can force women to

delay seeking post abortion care or to stay away from public health facilities. Some refrain from going to health facilities because they fear that they will be seen by people they know, while others fear a negative reaction from health care providers. Even Medical practitioners who are open to providing abortions, often make their own determination, beyond what the TOP Act requires them to do, as to whether women's reasons for seeking an abortion are sound. For example, women who seek an abortion because they want to space the birth of their children, or women who seek abortion in the second term onwards for reasons that the medical practitioner does not consider good enough, are often discouraged from going through with the abortion [30]. This stigma discourages women from seeking safe and legal abortion care. These findings were in conformity with the study by Sheehy *et al.* [31] who revealed that social stigma attached to abortion is a complex and pervasive issue that can have significant impacts on individuals seeking or having undergone abortions.

A qualitative analysis of print media in Great Britain found abortion to be portrayed as negative, risky and associated with "discredited" social practices [32]. In relation to abortion and surrounding stigma, others have described the way abortion stigma is felt and perpetuated at multiple levels—including individually, with internalised, perceived, and experienced stigma, and more externally, within communities and at service delivery and policy levels [33].

The results of this study are somewhat similar to the systematic review performed in high income countries when it comes to the barriers related to the health system and the strong influence that the providers' attitudes have on them. According to Doran and Nancarrow, judgmental attitudes of providers had a negative effect on the women's experience with abortion services and physicians struggled with ambivalent feelings about the provision of abortion [34]. Some health providers refuse to get involved in any step of the provision of abortion based on religious and conscientious objection [35] and 65% of Ethiopian midwives believed that providers had the right to do so [36]. Nevertheless, other providers expressed that they were facing contradictions between their personal beliefs and their professional duty, which was especially notorious when pregnancy was a result of rape or incest, to save a woman's life or in cases of foetal malformations [35].

It was observed from the study that most women were restricted from accessing abortion services because of the prevailing cultural norms and religious beliefs. This was comparable to reports from a previous study in Botswana which found that women's expected submission to male partners and to their role in society as child bearers continue to occur in traditionally patriarchal societies. Therefore, abortion policy makers need to take into account the realistic freedom with which women decide over their reproduction and make adjustments to current laws to decrease gender inequality [35]. However, the effect of the disadvantageous position of women as a barrier to access to abortion can be underestimated, since it is part of the status quo of these societies. Also, women in this position may not look for abortion services in the first place.

The study finding revealed that most of the women during the interviews in this study were of the view that the legal requirements of abortion laws were restrictive such that they could limit access to safe and legal abortion services, forcing individuals to seek unsafe and potentially life-threatening alternatives. This finding is supported by a Nigerian study where 17% of women thought that the law was too restrictive and only 2% thought it was "alright", while physicians from the same country considered that if complete legalization occurs, the access to the service would be hindered by social determinants and that quackery and promiscuity would increase. There was a general perception that law is not accessible to any women, which is aggravated by the requirement of the signature of two doctors to perform an abortion on medical grounds or a conviction by the court in the case of rape, considering that most rapes go unreported.

Beyond religious and personal beliefs, the restrictive law on abortion can fuel the stigma related to abortion. When access to a health service is criminalized or highly restricted, it conveys the message that those who access the service should be condemned. The restrictive abortion law is a major contributor to the high level of unsafe abortions in Zambia, and it disproportionally affects women who are not able to afford the high cost of obtaining an abortion from a private facility [30]. Most of the interviewees said that women who have the means to pay can access safe abortion services in a private facility with trained health care professionals. By contrast, low-income women who, due to the restrictive law, cannot go to public facilities where the services are provided free or at low cost, are compelled to resort to unsafe methods to terminate their pregnancies as the cost at a private health facility can be as high. This finding is consistent with studies conducted in Chile and Ethiopia, indicating that women with higher average daily incomes were more likely to utilize safe abortion. Also, findings indicated strong religious beliefs and doctrines. Religious beliefs and doctrines regarding abortion vary widely among different faith traditions. Strong religious beliefs and doctrines influence women's attitudes toward abortion and hinder access to services provided by the Act and by a church, abortion is seen to be a sin. These results resonate with Ahinkorah *et al.* [1], who revealed that religious values often play a significant role in shaping cultural perspectives on abortion. Some religious traditions strictly prohibit abortion or consider it morally wrong, influencing individuals to adhere to these beliefs. Our strictly cultural norms and values play a role in shaping our perceptions of abortion and have affected us in terms of the decision-making process in relation to abortions.

Even though abortion was given freely in a semi-liberal approach in Zambia, women with low income may have been unable to access service delivery points because of some additional costs of transportation and medication, leading them to undergo unsafe abortion services [13]. Women with low incomes, on the other hand, may face challenges related to the fate of their new-borns while growing up in a fatherless environment and may be afraid to raise their new-borns independently in such an environment, which may impede the uptake of safe abor-

tion services [13]. As a result, a concerted effort is needed from local administrative and healthcare managers to engage those insecurely housed women in income-generating activities that allow them to access safe abortion and other reproductive and maternal health services. This could also imply that health care providers should offer outreach activities aimed at the most vulnerable segments of the population who are unable to access health care due to financial constraints.

According to the WHO, standards and guidelines on abortion are important to eliminate barriers to obtaining the highest attainable standard of sexual and reproductive health as they can refer to the underlying principles and essential requirements for providing equitable access to, and adequate quality of, lawful abortion services. Guidelines are important to improve the quality or process of care as well as patient outcomes. They further offer explicit recommendations for clinicians who are uncertain about how to proceed, overturn the beliefs of doctors accustomed to outdated practices, improve consistency of care, and provide authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies [1]. When it comes to the provisions of abortion services, beyond clinical guidance, guidelines are crucial to interpret and provide clarity on the implementation of the laws regulating the service. However, while many government documents recognize the high level of unsafe abortion and its contribution to maternal mortality in Zambia, no government policy or guideline appears to comprehensively address the provision of safe abortion services in Zambia or to clarify when providers may offer these services or who may provide them [30].

5. Conclusion

Recommendations for future research: Expanded demographic scope and examine how cultural, socioeconomic, and educational factors influence women's awareness and abortion laws. Investigate the knowledge and attitudes of healthcare providers regarding the TOP Act, as they are key in disseminating information and providing services.

Ethical Considerations

This study was reviewed and approved by the University of Zambia Biomedical Research Ethics Committee **(UNZABREC Ref No: 4177-2023)** and the National Health Research Ethics Committee **(NHRA Ref No: 000016/23/08/2023)** which in turn gave the ethical approval. Written permission was sought from the study site and was granted. Informed consent was obtained from all participants after explaining the purpose of the study, procedures involved, potential risks and benefits. Participants were assured of the confidentiality of their responses and the voluntary nature of their participation. Data were anonymized to protect participant identity and sensitive topics were handled with the utmost respect and care.

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Authors' Contributions

CN, SM, VMK, CS, MB AND NNT contributed to the conception of proposal writing, data collection and study supervision, data analysis and manuscript writing.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Ahinkorah, B.O., Seidu, A., Ameyaw, E.K., Budu, E., Bonsu, F. and Mwamba, B. (2021) Beyond Counting Induced Abortions, Miscarriages and Stillbirths to Understanding Their Risk Factors: Analysis of the 2017 Ghana Maternal Health Survey. *BMC Pregnancy and Childbirth*, **21**, Article No. 140. https://doi.org/10.1186/s12884-021-03633-8

[2] Adamczyk, A., Kim, C. and Dillon, L. (2020) Examining Public Opinion about Abortion: A Mixed-Methods Systematic Review of Research over the Last 15 Years. *Sociological Inquiry*, **90**, 920-954. https://doi.org/10.1111/soin.12351

[3] Aniteye, P., O'Brien B. and Mayhew, S.H. (2019) Stigmatized by Association: Challenges for Abortion Service Providers in Ghana. *BMC Health Services*, **16**, Article No. 486.

[4] Assifi, A.R., Berger, B., Tunçalp, Ö., Khosla, R. and Ganatra, B. (2016) Women's Awareness and Knowledge of Abortion Laws: A Systematic Review. *PLOS ONE*, **11**, e0152224. https://doi.org/10.1371/journal.pone.0152224

[5] Astbury-Ward, E. (2008) Emotional and Psychological Impact of Abortion: A Critique of the Literature. *Journal of Family Planning and Reproductive Health Care*, **34**, 181-184. https://doi.org/10.1783/147118908784734954

[6] Atakro, C.A., Addo, S.B., Aboagye, J.S., Menlah, A., Garti, I., Amoa-Gyarteng, K.G., *et al.* (2019) Contributing Factors to Unsafe Abortion Practices among Women of Reproductive Age at Selected District Hospitals in the Ashanti Region of Ghana. *BMC Women's Health*, **19**, Article No. 60. https://doi.org/10.1186/s12905-019-0759-5

[7] Benson, J. (2017) Social Judgments on Abortion and Contraceptive Use: A Mixed Methods Study among Secondary School Teachers and Student Peer-Counsellors in Western Kenya. *BMC Public Health*, **20**, Article No. 493.

[8] Purcell, C., Hilton, S. and McDaid, L. (2014) The Stigmatisation of Abortion: A Qualitative Analysis of Print Media in Great Britain in 2010. *Culture, Health & Sexuality*, **16**, 1141-1155. https://doi.org/10.1080/13691058.2014.937463

[9] Chandra, A., *et al.* (2021) Legal Barriers to Accessing Safe Abortion Services in India: A Fact-Finding Study. Center for Reproductive Rights.

[10] Coast, E. and Murray, S.F. (2016) "These Things Are Dangerous": Understanding Induced Abortion Trajectories in Urban Zambia. *Social Science & Medicine*, **153**, 201-209.

[11] Dibaba, Y., Dijkerman, S., Fetters, T., Moore, A., Gebreselassie, H., Gebrehiwot, Y., *et al.* (2017) A Decade of Progress Providing Safe Abortion Services in Ethiopia: Results of National Assessments in 2008 and 2014. *BMC Pregnancy and Childbirth*, **17**, Article No. 76. https://doi.org/10.1186/s12884-017-1266-z

[12] Doran, F. and Nancarrow, S. (2015) Barriers and Facilitators of Access to First-Trimester Abortion Services for Women in the Developed World: A Systematic Review. *Journal of Family Planning and Reproductive Health Care*, **41**, 170-180. https://doi.org/10.1136/jfprhc-2013-100862

[13] Coast, E., Norris, A.H., Moore, A.M. and Freeman, E. (2018) Trajectories of Women's Abortion-Related Care: A Conceptual Framework. *Social Science & Medicine*, **200**, 199-210. https://doi.org/10.1016/j.socscimed.2018.01.035

[14] Joseph Oyeyipo, E., Bolanle Adeyemo, A., Arisukwu, O., Rasak, B., Onyekachi Igbolekwu, C. and Josephine Oyeyipo, K. (2020) Awareness on Abortion Legality among Undergraduate Students in Nigerian Universities. *Cogent Social Sciences*, **6**, Article ID: 1747334. https://doi.org/10.1080/23311886.2020.1747334

[15] Gebremedhin, M., Semahegn, A., Usmael, T. and 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**, Article No. 130. https://doi.org/10.1186/s13643-018-0775-9

[16] Gebreyesus, H., Mamo, A., Teweldemedhin, M., Gidey, B., Hdush, Z. and Birhanu, Z. (2019) Experiences of Homeless Women on Maternity Health Service Utilization and Associated Challenge in Aksum Town, Northern Ethiopia. *BMC Health Services Research*, **19**, Article No. 359. https://doi.org/10.1186/s12913-019-4201-3

[17] Geleto, A. and Markos, J. (2015) Awareness of Female Students Attending Higher Educational Institutions toward Legalization of Safe Abortion and Associated Factors, Harari Region, Eastern Ethiopia: A Cross Sectional Study. *Reproductive Health*, **12**, Article No. 19. https://doi.org/10.1186/s12978-015-0006-y

[18] Global Partnership International (2021) The Global Gag Rule and Access to Abortion: Impact on Law Reform in Zimbabwe, Zambia, Mozambique, Eswatini and Malawi.

[19] Huneeus, A., Capella, D., Cabieses, B. and Cavada, G. (2020) Induced Abortion According to Socioeconomic Status in Chile. *Journal of Pediatric and Adolescent Gynecology*, **33**, 415-420.E1. https://doi.org/10.1016/j.jpag.2020.03.003

[20] Cresswell, J.A., Schroeder, R., Dennis, M., Owolabi, O., Vwalika, B., Musheke, M., *et al.* (2016) Women's Knowledge and Attitudes Surrounding Abortion in Zambia: A Cross-Sectional Survey across Three Provinces. *BMJ Open*, **6**, e010076. https://doi.org/10.1136/bmjopen-2015-010076

[21] Dozier, J.L., Hennink, M., Mosley, E., Narasimhan, S., Pringle, J., Clarke, L., *et al.* (2020) Abortion Attitudes, Religious and Moral Beliefs, and Pastoral Care among Protestant Religious Leaders in Georgia. *PLOS ONE*, **15**, e0235971. https://doi.org/10.1371/journal.pone.0235971

[22] Haaland, M.E.S., Haukanes, H., Zulu, J.M., Moland, K.M., Michelo, C., Munakampe, M.N. and Blystad, A. (2019) Shaping the Abortion Policy—Competing Discourses on the Zambian Termination of Pregnancy Act. *International Journal for Equity in Health*, **18**, Article No. 20.

[23] Håkansson, M., Super, S., Oguttu, M. and Makenzius, M. (2020) Social Judgments on Abortion and Contraceptive Use: A Mixed Methods Study among Secondary School Teachers and Student Peer-Counsellors in Western Kenya. *BMC Public Health*, **20**, Article No. 493. https://doi.org/10.1186/s12889-020-08578-9

[24] Ngwako, K. and Banke-Thomas, A. (2020) 'I Guess We Have to Treat Them, But…': Health Care Provider Perspectives on Management of Women Presenting with Unsafe Abortion in Botswana. *Global Public Health*, **15**, 1308-1321. https://doi.org/10.1080/17441692.2020.1751863

[25] Muzeyen, R., Ayichiluhm, M. and Manyazewal, T. (2017) Legal Rights to Safe Abortion: Knowledge and Attitude of Women in North-West Ethiopia toward the Current Ethiopian Abortion Law. *Public Health*, **148**, 129-136,

[26] Holcombe, S.J., Berhe, A. and Cherie, A. (2015) Personal Beliefs and Professional Responsibilities: Ethiopian Midwives' Attitudes toward Providing Abortion Services after Legal Reform. *Studies in Family Planning*, **46**, 73-95. https://doi.org/10.1111/j.1728-4465.2015.00016.x

[27] Semahegn, A., Torpey, K., Manu, A., Assefa, N., Tesfaye, G. and Ankomah, A. (2018) Psychotropic Medication Non-Adherence and Associated Factors among Adult Patients with Major Psychiatric Disorders: A Protocol for a Systematic Review. *Systematic Reviews*, **7**, Article No. 10. https://doi.org/10.1186/s13643-018-0676-y

[28] Sheehy, G., Omoluabi, E., OlaOlorun, F.M., Mosso, R., Bazié, F., Moreau, C., *et al.* (2021) A Mixed-Methods Study Exploring Women's Perceptions of Terminology Surrounding Fertility and Menstrual Regulation in Côte D'Ivoire and Nigeria. *Reproductive Health*, **18**, Article No. 251. https://doi.org/10.1186/s12978-021-01306-5

[29] Tilahun, F., Dadi, A.F. and Shiferaw, G. (2017) Determinants of Abortion among Clients Coming for Abortion Service at Felegehiwot Referral Hospital, Northwest Ethiopia: A Case Control Study. *Contraception and Reproductive Medicine*, **2**, Article No. 11. https://doi.org/10.1186/s40834-017-0038-5

[30] Chigbu, U.E., Wanyonyi, A. and Antonio, D. (2018) Empowerment of Youth through Strengthening Their Land Rights Knowledge and Research Capacity: Evidence from Eastern and Southern Africa. *African Journal on Land Policy and Geospatial Sciences*, **3**, 129-142.

[31] WHO: World Health Organization (2015) Abortion Rates Drop in More Developed Regions but Fail to Improve in Developing Regions.

[32] WHO: World Health Organization (2016) Interagency List of Priority Medical Devices for Essential Interventions for Reproductive, Maternal Newborn and Child Health.

[33] WHO: World Health Organization (2015) Clinical Practice Handbook for Safe Abortion.

[34] WHO: World Health Organization (2019) Preventing Unsafe Abortion.

[35] World Health Organization (2016) World Health Statistics 2016: Monitoring Health for the SDGs Sustainable Development Goals.

[36] Zouein, N. (2018) The Lack of Correlation between Legality and Safe Abortion: The Effect of Abortion Stigma, Culture and Religion on Women's Decision-Making. Ph.D. Thesis, McGill University.