SSM - Population Health 5 (2018) 38–47

Contents lists available at ScienceDirect

SSM - Population Health

journal homepage: www.elsevier.com/locate/ssmph

Article

Do perceived contraception attitudes influence abortion stigma? Evidence from Luanda, Angola

Madeline Blodgett[a], Karen Weidert[a], Benjamin Nieto-Andrade[b], Ndola Prata[a,*]

[a] Bixby Center for Population, Health and Sustainability, School of Public Health, University of California at Berkeley, Berkeley, CA, USA
[b] Population Services International/Angola, Luanda, Angola

ARTICLE INFO

Keywords:
Abortion
Stigma
Angola
Contraception use
Social-ecological model

ABSTRACT

Abortion stigma is influenced by a variety of factors. Previous research has documented a range of contributors to stigma, but the influence of perceived social norms about contraception has not been significantly investigated. This study assesses the influence of perceived social norms about contraception on abortion stigma among women in Luanda, Angola. This analysis uses data from the 2012 Angolan Community Family Planning Survey. Researchers employed multi-stage random sampling to collect demographic, social, and reproductive information from a representative sample of Luandan women aged 15–49. Researchers analyzed data from 1469 respondents using chi-square and multiple logistic regression. Researchers analyzed women's perceptions of how their partners, friends, communities, and the media perceived contraception, and examined associations between those perceptions and respondents' abortion stigma. Stigma was approximated by likelihood to help someone get an abortion, likelihood to help someone who needed medical attention after an abortion, and likelihood to avoid disclosing abortion experience. Higher levels of partner engagement in family planning discussion were associated with increased stigma on two of the three outcome measures, while higher levels of partner support of contraception were associated with decreased stigma. Perceived community acceptance of family planning and media discussion of family planning were associated with a decrease in likelihood to help someone receive an abortion. These results suggest that increasing partner support of family planning may be one strategy to help reduce abortion stigma. Results also suggest that some abortion stigma in Angola stems not from abortion itself, but rather from judgment about socially unacceptable pregnancies.

1. Introduction

Recent global estimates indicate that approximately 15% of total maternal mortality is attributed to abortion-related causes (Kassebaum et al., 2014), and abortion stigma, a shared understanding that abortion is morally wrong or socially unacceptable, is increasingly identified as a contributor to this mortality. Abortion stigma puts women's mental and physical health at risk by silencing their ability to speak about their abortion experiences (Goyaux, Yacé-Soumah, Welffens-Ekra, & Thonneau, 1999; Kimport, Foster, & Weitz, 2011). Stigma also reduces access to safe abortion, driving providers away from providing services and rendering abortion a clandestine service accessed through word of mouth, if at all (Bingham et al., 2011; Freedman, Landy, Darney, & Steinauer, 2010). Deaths from abortion-related causes are most common in countries with highly restrictive abortion laws (Say et al., 2014; Singh, Remez, Sedgh, Kwok, & Onda, 2018).

1.1. Angola

Little is known about abortion in Angola. The country spent nearly three decades ravaged by a violent civil war, which, despite having officially ended in 2002, has had ongoing devastating effects on health record-keeping and health systems infrastructure (Bloemen, 2010). Moreover, abortion is largely illegal in Angola (Population Policy Data Bank, n.d.), with exceptions for saving the life of the pregnant person and pregnancies resulting from rape. The available abortion estimates are regional: an estimated 1 million abortions took place in Middle Africa between 2010 and 2014, equivalent to an abortion rate of approximately 35 abortions per 1000 women aged 15–44 years (Sedgh et al., 2016).

Imprisonment for performing an abortion in Angola can range from 2–8 years Angola's abortion restrictions and started during colonization, originating in Portugal's Criminal Code of 1886 (Ngwena, 2004). Though the colonial law itself was not based on moral or religious

* Correspondence to: Bixby Center for Population, Health and Sustainability, School of Public Health, University of California at Berkeley, School of Public Health, University of California, 229 University Hall, Berkeley, CA 94720-7360, USA.
E-mail address: ndola@berkeley.edu (N. Prata).

https://doi.org/10.1016/j.ssmph.2018.05.005
Received 19 December 2017; Received in revised form 6 April 2018; Accepted 14 May 2018

considerations (Brookman-Amissah & Moyo, 2004), Angola's strict abortion penal code is reinforced by religious attitudes in the country, which are predominantly Christian and 41% Roman Catholic (Central Intelligence Agency, 2014; Population Policy Data Bank, n.d.). In 2009, Pope Benedict XVI inveighed against abortion in a speech to nearly a million Angolan Catholics, calling abortion a strain on the traditional African family (Simpson, 2009). Angolan bishops have expressed similar attitudes, fervently opposing efforts to shift abortion laws (Baklinski, 2012). Norris et al. (2011) argue that legal restrictions on abortion cause abortion stigma: encoding abortion in law as an illicit act can "reinforce the notion that abortion is morally wrong" (2011). Illegality, in turn, compromises the safety of abortion and creates the view that abortion is dirty or unhealthy.

In contrast to the stigmatization and opposition to abortion prevalent in many parts of Angola, recommendations from international human rights, women's, and public health organizations have targeted mortality rates from unsafe abortion as a key priority for Angola. Angola's criminalization of abortion has been identified as an area of concern hindering implementation of the International Covenant on Civil and Political Rights (Human Rights Committee, 2013). Angola has ratified the African Union's Protocol to the Charter on People's and Human Rights on the Rights of Women in Africa, which affirms women's rights to control their fertility and advocates for abortion in several circumstances (Maiga, 2012). In recent years, non-government organizations (NGOs), in collaboration with the Ministry of Health, have implemented post-abortion care interventions to improve access to and management of cases of incomplete abortion and miscarriage, including the introduction of misoprostol to manage uncomplicated cases in peripheral health centers (Venture Strategies Innovations, 2013).

2. Theory

2.1. Conceptualizing abortion stigma

Many definitions and discussions of stigma build off Erving Goffman's characterization of stigma as "an attribute that is deeply discrediting" which transforms a "whole and usual" person into a "tainted, discounted" one (Goffman, 1963). Abortion stigma presents an interesting case for this theory, as Kumar et al. discuss in their examination of the phenomenon (Kumar, Hessini, & Mitchell, 2009). Per Kumar et al., abortion experiences usually leave no "enduring stigmata" to differentiate those who have had abortions from those who have not, abortion can be a relatively invisible experience and many people can choose whether to publically identify as having had an abortion (Kumar et al., 2009). This under-reporting of abortion, as well as misclassification of abortion, creates the perception that abortion is rare and exceptional, hence establishing people who have abortions as deviant. This perceived deviance establishes people who have abortions as opposed to assumed norms of womanhood. Once those who have abortions are established as non-normative, they can be labeled and are connected to a range of negative stereotypes, leading to discrimination. This discrimination leads people to fear stigmatization for having abortions, leading to underreporting and creating what Kumar et al. term the "prevalence paradox": though incidence of abortion is high, silencing of abortion experiences leads to the perception that abortion is rare, and therefore deviant (Kumar et al., 2009). This, in turn, leads to restriction of abortion access, social isolation, and negative health consequences for people who have abortions (Ellison, 2003; Major & Gramzow, 1999).

These various abortion stigma frameworks reinforce that though abortion stigma is a phenomenon with global health implications, it is fundamentally developed in a local social context. Norris et al. argue that people having abortions, their close peers, and abortion providers are the individuals primarily influenced by abortion stigma (Norris et al., 2011). When considering maternal health, however, it becomes clear that the health implications of abortion stigma extend beyond the individual level. Using a social-ecological framework for understanding abortion stigma helps clarify the ways in which individual beliefs create and are created by different social actors.

2.2. Social-ecological framework for abortion stigma

Social-ecological models situate health behaviors and beliefs within multiple levels of influence. Levels of influence are variously defined, but may include interpersonal relationships, organizations, and the policy environment (Sallis, Owen, & Fisher, 2015). In this article, we explore a few levels that may contribute to abortion stigma in Angola, based off the social-ecological model by Kumar et al. (2009) for understanding abortion stigma, which is in turn based off Heijinders and Van der Meij's model for health stigma (Heijnders & Van Der Meij, 2006). Kumar et al. (2009) propose five levels of influence in their model: framing discourses and mass culture; government and structure; organization and institutions; community; and individual levels. In Angola, individual, community, and mass culture are avenues for addressing stigma which are currently less-developed: government interventions, in the form of Angolan abortion law reforms, are already in process; the recent legalization of abortion in cases of rape and maternal health may help address elements of abortion stigma caused by abortion's illegal status. Similarly, organizational interventions, in the form of changes to healthcare systems, have been implemented within Angola by the government and NGOS, addressing stigmatizing concerns about abortion safety.

We break the individual and community levels out further into internalized, partner, friend, and community-wide attitudes, as each plays a different role in the creation of stigma. Internalized stigma refers the process of absorbing other people's negative attitudes about abortion (Shellenberg & Tsui, 2012). Male heads of household may use their authority to compel their partners to continue a pregnancy or have an abortion (Schuster, 2005; Tsui et al., 2011). In turn, pregnancy may be concealed from partners, especially if they know their partners do not approve of abortion or will exert paternal rights in an undesirable fashion (Rossier, 2007). Outside these circumstances, male partners are likely to be the first to know of an unintended pregnancy. Female friends are often next to know of unintended pregnancies (Rossier, Guiella, Ouédraogo, & Thiéba, 2006). Friends are also often relied upon for contraceptive knowledge, connection to abortion resources, and support around reproductive health (Agadjanian, 1998; Baker and Khasiani, 1992; Sims, 1996).

2.3. Stigma, abortion, and contraception

Per Norris et al., abortion is stigmatized in part because it separates procreation from female sexuality, complicating ideals of women's sexuality and womanhood (Norris et al., 2011). Contraception generally attracts less violent protest and outcry than abortion, but it similarly divorces sexuality from compulsory procreation. To the best of the authors' knowledge, there is no other literature that assesses how social attitudes towards contraception influence abortion stigma.

2.4. The purpose of this paper

This study seeks specifically to elucidate the relationship between perceived contraceptive attitudes and abortion stigma in Luanda, Angola. The motivation behind this investigation is twofold: first, to shed light on abortion attitudes in Angola, about which little literature has been published; second, to assess the impact of perceived social attitudes about contraception on abortion stigma. To do this, we analyzed survey data gathered in Luanda Province, Angola from women of reproductive age, which asked women how they thought their partners, friends, and communities felt about contraception. The same women were also asked questions to assess their level of abortion stigma, as