A CROSS-SECTIONAL STUDY FROM TURKEY REGARDING STIGMATIZING ATTITUDES AND BEHAVIORS TOWARDS ABORTION

KÜRTAJA YÖNELİK DAMGALAYICI TUTUM VE DAVRANIŞLAR İLE İLGİLİ OLARAK TÜRKİYE'DEN KESİTSEL BİR ÇALIŞMA

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ABSTRACT

Objective: The aim of the study is to investigate the perspective on the stigma of abortion within the scope of reproductive health services

Material and methods: This study was conducted between 01.02.2023 and 01.04.2023 in Giresun Gynecology and Pediatrics Training and Research Hospital. A survey form assessing sociodemographic characteristics and stigmatizing attitudes, beliefs and behaviourstowards abortion was administered face to face by the researchers to volunteers aged 18 and over. All analyses were evaluated for statistical significance with a threshold of p <0.05 and used IBM SPSS Statistics for Windows Version 26.0 (IBM, NY, USA). The difference between the scale and subscale score averages according to sociodemographic variables was determined by the Mann Whitney U test for two independent groups and the Kruskal Wallis test for more than two groups.

Results: A significant difference was found in total stigmatizing attitude scores and all sub-dimensions according to education level, household income and living in the province/ district (p<0.001). Stigmatizing attitudes were significantly lower in those with an educational level of university and above compared to other educational levels (p<0.001). Stigmatizing attitudes were significantly higher in those with a household income below minimum wage compared to those with a household income above minimum wage (p=0.01). Stigmatizing attitudes were significantly lower in those living in the city centre compared to those living in the districts (p<0.001).

Conclusion: In general, stigmatizing attitudes and behaviours towards abortion may differ in different segments of society, and their consequences may also vary. Stigmatizing attitudes towards abortion maintain their importance on issues such as the goal of reducing deaths, social awareness, respect for human rights, health and safety. A more comprehensive view of reproductive health may be helpful in changing this attitude.

Key words: Reproductive health, Abortion, Stigmatization

ÖZET

Amaç: Çalışmanın amacı üreme sağlığı hizmetleri kapsamında kürtajın damgalanmasına bakış açısını araştırmaktır.

Materyal ve metot: Bu çalışma 01.02.2023- 01.04.2023 tarihleri arasında Giresun Kadın Hastalıkları ve Çocuk Sağlığı ve Hastalıkları Eğitim ve Araştırma Hastanesi'nde gerçekleştirilmiştir. 18 yaş ve üzeri gönüllülere sosyodemografik özellikleri ve kürtaja yönelik damgalayıcı tutum, inanç ve davranışları değerlendiren anket formu, araştırmacılar tarafından yüz yüze uygulanmıştır. Tüm analizler istatistiksel anlamlılık açısından p <0,05 eşiğiyle değerlendirilmiş ve IBM SPSS İstatistikleri Windows Sürüm 26.0 (IBM, NY, ABD) kullanılmıştır. Sosyodemografik değişkenlere göre ölçek ve alt ölçek puan ortalamaları arasındaki fark, iki bağımsız grup için Mann Whitney U testi, ikiden fazla grup için Kruskal Wallis testi ile belirlenmiştir.

Bulgular: Eğitim düzeyi, hane geliri ve il/ilçede yaşama durumuna göre toplam damgalayıcı tutum puanları ve tüm alt boyutlarda anlamlı farklılık bulunmuştur (p<0,001). Damgalayıcı tutumlar üniversite ve üzeri eğitime sahip olanlarda diğer eğitim düzeylerine göre anlamlı olarak daha düşük bulunmuştur (p<0,001). Hane geliri asgari ücretin altında olanlarda hane geliri asgari ücretin üzerinde olanlara göre damgalayıcı tutumların anlamlı olarak daha yüksek olduğu görülmüştür (p=0,01). Damgalayıcı tutumlar ilçede yaşayanlara göre il merkezinde yaşayanlarda anlamlı düzeyde daha düşük tespit edilmiştir (p<0,001).

Sonuç: Genel olarak kürtaja yönelik damgalayıcı tutum ve davranışlar toplumun farklı kesimlerinde farklılık gösterebildiği gibi sonuçları da farklılık gösterebilmektedir.Kürtaja yönelik damgalayıcı tutumlar; ölümleri azaltma hedefi, toplumsal farkındalık, insan haklarına saygı, sağlık ve güvenlik gibi konular üzerinde önemini korumaktadır. Üreme sağlığına daha kapsamlı bir bakış açısı bu tutumu değiştirme konusunda faydalı olabilir.

Anahtar sözcükler: Üreme sağlığı, Kürtaj, Damgalama

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Received:09.12.2023
Accepted:12.12.2023
Published:29.12.2023

Introduction

Although abortion is an essential component of reproductive health services and sexual health, social values and stigmatization concerns affect women's decision-making process (1). Abortion stigma has been defined as "a negative quality that internally and externally stigmatizes women who want to have an abortion as inferior to ideals of femininity such as the inevitability of motherhood" (2). Erving Goffman defined stigmatization as "deeply discrediting an individual, reducing him/her from a whole and ordinary human being to a defective, disdainful one" (3). Kumar et al. define abortion stigma as "a negative characteristic attributed to women who attempt to terminate a pregnancy, portraying them as inferior to the ideal of 'femininity,' whether intimately or outwardly." (4). Stigma is the review of a person in a way that singles them out, looks down on others, and generally degrades them. Current literature speaks of three levels of stigma: flexible, social, and internalized. Structural stigma at the systemic level, social stigma takes place at the group level, while individualized stigma takes place at the individual level (5). The reason, form and timing of abortion are important, even in appropriate cases where the laws are very determinative for the termination of the existence of a potential human being from the beginning to the end of fertilization, which is one of the most controversial issues of medical ethics from past to present (6). The decision to terminate pregnancy is the result of very complex conditions in terms of culture and society (4). In this context, social stigma towards abortion is conceptualized in three areas: perceived stigma (fear or expectations of stigma), experienced stigma (being treated negatively for having an abortion) and internalized stigma. This framework is very important to further define and understand stigmatization towards abortion (5). The aim of this study is to evaluate the perspective on stigma related to abortion within the scope of reproductive health services.

Material and methods

This cross-sectional study was conducted between 01.02.2023 and 01.04.2023 at Giresun Gynecology and Pediatrics Training and Research Hospital. Ethics committee approval for the study (dated January 16, 2023, Decision no: 07) was obtained from Giresun Training and Research Hospital Clinical Research Ethics Committee.

The study was conducted at Giresun Gynecology and Pediatrics Training and Research Hospital with volunteers aged 18 years and over. After the individuals included in the study group were given detailed information about the purpose and scope of the study, a face-to-face questionnaire form was applied to the volunteers who agreed to participate in the study.

The questionnaire included questions about the sociodemographic characteristics of the individuals and the scale of stigmatization attitudes, beliefs and behaviours towards abortion. In the sample size calculation using the G Power 3.1 program (type 1 error 0.05, effect size d: 0.03, power: 95%), it was determined that at least 484 people should be included in the sample for intergroup difference analysis and at least 138 people for correlation analysis. With the non-probability sampling technique, 203 people were reached.

Stigma attitudes, beliefs and behaviours towards abortion scale

It was used to assess stigma attitudes, beliefs and behaviours towards abortion. The scale was developed by Shellenberg et al. in 2014 (7). Turkish validity and reliability study was conducted by Güner et al. in 2021 (5). The scale consists of three dimensions: negative stereotypes, discrimination and exclusion, and fear of contamination. For this study, the Cronbach's alpha value of the whole scale was 0.89. Cronbach's alpha value for negative stereotypes is 0.81, for discrimination and exclusion is 0.80, and for fear of meeting is 0.86. The scale consisting of 18 questions is answered on a 5-point Likert scale (Strongly agree-1, Strongly disagree-5) and the 15th item of the scale is reverse scored. The higher the scale score, the higher the stigmatizing attitudes, behaviours and beliefs towards abortion. The scale does not have a cut-off point.

Statistical analysis

All analyses were evaluated with a threshold of $p < 0.05$ for statistical significance and were performed on IBM SPSS Statistics for Windows, Version 26.0 (IBM, NY, USA). In descriptive analysis, numerical variables are presented as mean and standard deviation, and categorical variables are presented as number and percentage.

The compatibility of the data with normal distribution was evaluated by Kolmogorov Smirnov test. The difference between the scale and subscale mean scores according to sociodemographic variables was determined by Mann Whitney U test for two independent groups and Kruskal Wallis test for more than two groups. Variables with significant Kruskal-Wallis test results were analysed with Dunn's test as a post hoc test.

Results

A total of 203 individuals were included in the study, of whom 90.6% (n=184) were female and 9.4% (n=19) were male. Among the women, 6.2% were between the ages of 18-29, 50.2% had a university education or higher, 50.2% were not actively working, and 66.5% lived in the city centre. 83.3% of the participants live in nuclear families and 59.6% of them have a household income above the minimum wage. 84.2% of the women were married and 48.3% were married between the ages of 20-24. Regarding the obstetric history of the women, 53.7% had a history of pregnancy, 13.8% had a history of miscarriage and 9.9% had a history of abortion. The rate of induced abortion was 3.9%. The sociodemographic and obstetric characteristics of the women are shown in Table 1.

Table 1. Sociodemographic and obstetric characteristics of women

	n	(%)
Age	18-29 30-39 40-49 >50	114 (56.2) 58 (28.6) 20 (9.9) 11 (5.4)
Level of education	Primary school Secondary school High school University and above	19 (9.4) 19 (9.4) 63 (31.0) 102 (50.2)
Place of residence	City centre District centre	135 (66.5) 68 (33.5)
Family structure	Elementary family Extended family	169 (83.3) 34 (16.7)
Household income level	Above the minimum wage Below the minimum wage	121 (59.6) 82 (40.4)
Marital status	Single Married Divorced	27 (13.3) 171 (84.2) 5 (2.5)
Marriage age	15-19 20-24 25-29 30-35	27 (13.3) 98 (48.3) 40 (19.7) 26 (12.8)
Child presence	Yes No	120 (59.1) 83 (40.9)
Experiencing pregnancy	Yes No	109 (53.7) 94 (46.3)
Miscarriage-free	Yes No	28 (13.8) 175 (86.2)
Abortion	Yes No	20 (9.9) 183 (90.1)
Voluntary abortion	Yes No	8 (3.9) 195 (96.1)
Total		203 (100.0)

The mean total score of the stigmatizing attitudes, beliefs and behaviours towards abortion scale was 34.07±15.33 (minimum 18, maximum 139). It is 16.51±9.32 for the negative stereotype sub-dimension, 12.40±4.86 for the exclusion and discrimination sub-dimension, 2.96±1.06 for the fear of contamination sub-dimension, and 5.14±2.69 for the energy consumption sub-dimension. The relationship between the scale and its subscales and sociodemographic and obstetric variables is shown in Table 2.

Table 2. The stigmatization attitude, belief and behaviour scale and sub-dimensions of women towards abortion are related to socio-demographic and obstetric variables.

	Total Median	Negative stereotype Median	Exclusion and discrimination Median	Fear of contamination Median
Age	31.00	14.00	11.00	4.00
18-29	31.50	16.00	11.00	4.00
30-39	34.50	14.50	12.00	6.00
40-49	32.00	16.00	11.00	5.00
>50	p=0.78	p=0.91	p=0.47	p=0.81
Educational level	36.00	16.00	12.00	6.00
Primary school	38.00	18.00	14.00	6.00
Secondary school	36.00	17.00	12.00	6.00
High school	25.00	12.00	11.00	3.00
University and above	p<0.001	p<0.001	p=0.03	p=0.01
Place of residence City	29.00	14.00	11.00	3.00
center	37.00	17.00	12.00	6.00
District center	p<0.001	p<0.001	p=0.04	p=0.01
Family structure	31.00	14.50	11.00	4.00
Elementary family	35.00	16.00	12.00	6.00
Extended family	p=0.19	p=0.28	p=0.18	p=0.25
Household income level	27.00	13.00	11.00	3.00
Above the minimum wage / Below the minimum wage	34.50 p=0.01	16.50 p=0.02	14.00 p=0.03	5.50 p=0.04
Marital status	24.00	11.00	11.00	3.00
Single	33.00	16.00	11.00	5.00
Married	36.00	16.00	12.00	6.00
Divorced	p=0.05	p=0.08	p=0.17	p=0.09
Marriage age	31.00	16.00	11.00	5.00
15-19	34.50	16.00	12.00	6.00
20-24	26.50	13.00	11.00	3.00
25-29	31.50	13.00	11.50	3.50
30-35	p=0.17	p=0.20	p=0.07	p=0.21
Child presence	33.50	16.00	11.50	5.00
Yes	27.00	13.00	11.00	3.00
No	p=0.34	p=0.51	p=0.17	p=0.09
Experiencing pregnancy	33.00	16.00	11.00	4.00
Yes	30.50	14.00	11.00	4.00
No	p=0.13	p=0.27	p=0.05	p=0.65
Miscarriage-free	35.50	16.00	11.50	5.00
Yes	31.00	15.00	11.00	4.00
No	p=0.77	p=0.82	p=0.57	p=0.99

* Dunn Test was used as a post hoc test.

There are significant differences in total stigmatizing attitude scores and all sub-dimensions according to women's education level, household income and living in the province/district (Table 2). Stigmatizing attitudes were significantly lower in those with an education level of university and above compared to other education levels ($p<0.001$). Stigmatizing attitudes were significantly higher in those whose household income was below the minimum wage compared to those whose household income was above the minimum wage ($p=0.01$). Stigmatizing attitudes were significantly lower in those living in the city centre compared to those living in the districts ($p<0.001$).

Discussion

According to the 2013 Turkish Demographic and Health Survey (TDHS) data, the curettage rate decreased from 18% in 1993 to 5% in 2013. (8). According to 2018 TDHS data, it was revealed that 15% of married women experienced at least 1 voluntary curettage (9). In a study conducted with 335 female patients admitted to a family health centre, the number of patients who had at least one curettage among all patients was 67 (12.2%) (10). In this study, it was found that 9.9% of the women who participated in the study had a history of curettage and the rate of induced abortion was found to be 3.9%. The reason for the lower rate of curettage in this study may be the different socioeconomic level of the region where the study was conducted and the smaller sample size compared to other studies.

The mean total score of the stigmatizing attitudes, beliefs and behaviours towards abortion scale was 34.07±15.33. In the validity and reliability study of the scale conducted by Güner and Öztürk, as the score obtained from the measurement tool increases towards 80, it is interpreted as high stigmatizing attitudes, behaviours and beliefs towards abortion, and as it decreases towards 0, it is interpreted as low stigmatization, and it is seen that the average score determined in the study is below the average (5). The reason for this may be that more than half of the women who participated in the study were university graduates and had higher sociocultural levels because they lived in the city centre.

In the study conducted by Loi et al. with 10207 individuals, 89.9% of the participants stated that the person who experienced curettage committed a sin, 51.8% stated that the person who experienced curettage once could make it a habit, and 73.4% stated that the person who had curettage would bring shame to the family. 22.6 percent stated that no man should marry the person who had undergone curettage because she would not be a good mother (11). The stigmatization of curettage in society is a common understanding that curettage is a morally inappropriate and socially unacceptable practice, and every woman who undergoes curettage faces the risk of stigmatization to different extents depending on the sociocultural environment and family structure she lives in. In their study in Kenya, Yegon et al. found that participants viewed women who experienced abortion were socially isolated, murderers, malevolent, liars, unfaithful, and unmarriageable. It was also determined that these women were excluded by society and did not want to apply to the hospital because they were afraid of being stigmatized. (12). In stigmatization of curettage, the views and attitudes of the family and society in which the individual lives towards curettage are very important. In a systematic review conducted in our country on the subject, it was found that women could not share their curettage experiences because they were afraid of being shamed or stigmatized by other people; as a result, they exhibited social withdrawal behaviour; and symptoms of grief, anxiety and depression were observed more frequently in women who were worried about being stigmatized for having curettage (13).

Considering the data of the study, stigmatizing attitude was found to be significantly lower in those with an education level of university and above compared to other education levels. Studies show that stigmatizing attitudes and behaviours decrease as the level of education increases (14).

The level of education is a sociocultural factor affecting stigmatization in sexual and reproductive health and it is thought that low levels of maternal and paternal education, in addition to one's own education level, increase the level of stigmatization towards sexual and reproductive health. In a study conducted by

that stigmatization attitude was positively affected as the level of education increased (15). For these reasons, the level of education of the communities should be increased first; until a mass education level is reached, trainings on family planning and curettage should be organized especially for women with low level of education. In this regard, all health personnel, especially physicians, educational institutions, non-governmental organizations and health institutions should play an active role. According to the results of a study in the United States, two out of three women who have curated think that they will be stigmatized if others learn, and 58% think they should hide the curettage from their friends and families (16). A study of 4,000 women who underwent curettage surgery found that 58% of women needed psychological support after the operation. (17). According to the results of a study conducted in the United States of America, two out of every three women who had curettage thought that they would be stigmatized if others found out, and 58% thought that they should hide the curettage from their friends and family (16). In a study conducted with 4000 women who had curettage surgery, it was found that 58% of those who had the operation needed emotional support afterwards. (17).

In studies in which attitudes towards curettage were examined, it was observed that the reason for curettage was also effective on the attitudes of individuals. In a study conducted in our country, patients were asked about their opinions on curettage and the majority (38.8%) answered that it should be performed in case of necessity, followed by the view that it should be prohibited (33.7%). The most common reasons for necessity were not wanting the pregnancy (42.7%) and the baby having anomalies (31.3%). Even among patients who reported previous elective curettage, 35.6% stated that curettage should be prohibited (10).

The number of participants and the fact that the study was conducted from a single centre are the limitations of the study.

Conclusion

Stigmatizing attitudes and behaviours towards abortion in general may differ in different segments of society and the results may also vary. Stigmatizing attitudes towards abortion and the goal of reducing deaths, social awareness, respect for human rights, and important values such as health and safety are perpetuated. Overall, this can help us take steps towards understanding the complexity and diversity of abortion and making it a more inclusive place.

Acknowledgements

We would like to thank all participants who work ethically and morally.

Conflict of interest

None

Funding

None

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