Abortion stigma is a complex issue, and understanding its manifestation and perpetuation is challenging. However, abortion stigma may have profound social and health consequences for women and it is important for us to better understand it. Ipas is committed to better understanding stigma and this project moved us ahead on that goal. Using a framework of interrelated components (labeling, stereotyping, separating/excluding and discriminating), Ipas set out to further our understanding of abortion stigma at the community level in Ghana and Zambia, and to develop a scale to measure abortion stigma at the community level that could also be used in the design and evaluation of community-based stigma reduction interventions. Through this research, we specifically aimed to: 1) conduct focus group discussions (FGDs) with women and men about abortion in their communities; 2) use FGD data to develop a set of items for an abortion stigma scale; 3) pilot the scale in Ghana and Zambia; 4) identify scale items that naturally group together to measure abortion stigma; and 5) examine the relationships between abortion stigma and age, gender, marital status, educational attainment and religious affiliation. To achieve our objectives, we explored the context of abortion stigma through qualitative research and then used the findings to develop items for a scale to measure abortion stigma at the individual and community level. Our questionnaire was administered to 531 people (250 in Ghana and 281 in Zambia) and then we conducted factor analyses to identify items that would constitute a scale to measure abortion stigma.

Our FGDs generated a wealth of information about participants’ attitudes and beliefs about abortion, as well as community norms surrounding the issue of abortion, women who have them, men who are involved in an abortion decision, traditional providers who help women terminate pregnancies and trained medical professionals who perform abortions in a clinical setting. This qualitative data translated into 57 scale items that Ipas piloted with 531 individuals in Ghana and Zambia. Unfortunately, we were unable to identify an emergent factor structure that was both statistically and conceptually appropriate. In other words, our set of questionnaire items did not appear to be measuring a common underlying variable (or variables) in a way that would constitute a valid scale for measuring abortion stigma.

Despite our inability to produce a new abortion stigma scale, we believe that our qualitative and quantitative data provide relevant information on respondents’ attitudes and beliefs about abortion and plan to use these data to inform the development and implementation of community-based interventions to reduce abortion stigma in Ghana and Zambia.