Effectiveness of Information, Education and Communication (IEC) on the Public Acceptability of Unsafe Abortion Solutions.

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Abstract

Context: *Public health measures suggested to curb the menace of unsafe abortions in developing countries include liberalization of abortion law, family life education and family planning. However public acceptability of these solution options are poor.*

Objective: *To examine the efficacy of information, education and communication (IEC) on the public acceptability of unsafe abortion solution options of contraception, family life education including sex education and liberalization of abortion laws. Our aim was to use IEC to improve public acceptability of the recommended solutions.*

Methods: *Trained questionnaire administrators interviewed randomly selected civil servants in Ilorin, Nigeria to asses the level of their acceptability of the various options. There were 95 respondents for the baseline interviews and 93 respondents for the post IEC interviews. The responses were compared pre- and post-IEC to assess the effectiveness of the IEC.*

Results: *Contraception for adults was the most acceptable solution to the public both pre- and post-IEC, the acceptability doubling (46.3% to 93.4%) after IEC. Contraception for adolescents, and family life education showed appreciable improved acceptability post IEC (25.3% to 40.2% and 40% to 67.4%) respectively Liberalization of abortion law also appreciated marginally in the amount of yes answers (14.8% to 18.5%). Ironically, the percentage of rejecters also appreciated from 78.9% to 79.3%, giving a very weak correlation coefficient of 0.42.*

Conclusion: *IEC is effective in improving public acceptability of unsafe abortion solutions. The need for an extension and sustenance of this intervention strategy to all segments of the society for effective advocacy is an imperative*

Key Words; Unsafe Abortions, Information, Counselling, Education [Trop J Obstet Gynaecol, 2002, 19: 00-00].

Introduction

The World Health Organization (WHO) estimates that about 80,000 deaths result from unsafe abortions annually in developing countries. This translates to 400 deaths per 100,000 abortions as a result of the fact that most abortion providers are untrained apart from the procedures that are usually unsafe [1,2]. In Nigeria approximately 610,000 abortions are performed annually and most of them (60%) are unsafe. An estimated 13% of all maternal deaths in the world are due to unsafe abortion while in Nigeria, it is estimated to be about 12%, but this can be as high as 40% in some centers, [1,2,3,4,5,6,7]

Although recent studies have shown an improvement in the safety of the abortion procedures being used, the number of women requiring treatment for serious complications of unsafe abortion remains very high [2,3,4]. Preventing mortality and morbidity from unsafe abortions in countries where they remain high will be an important part of implementing the safe motherhood initiative and it is an important aspect of **good public health policy** [5,6,7,8]. **Various studies have** Recommended family planning for both adults and adolescents; family life education emphasizing sex education; and liberalisation of abortion laws as possible solutions to the problems of unsafe abortion in developing countries [6,7,8,9,10,11,12,13]. The importance of public acceptability of unsafe abortion solution options as a prerequisite for effective advocacy activities cannot be over emphasised [5,11,14,15]. It is known that these options have poor public acceptability in Nigeria [6,11,13,19], and therefore there is the need for improved information and education of the public to enhance the acceptability of the options. This is the objective of this pilot project that hopefully will be extended to various groups such as journalists, lawmakers, jurists, and religious and cultural leaders to enlist their support for measures directed towards the eradication of unsafe abortions.

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erials and Methods

ained questionnaire administrators who were made cover randomly selected public institutions in the pital city of Ilorin, Kwara state, Nigeria, carried out this prospective survey.

Randomly selected civil servants were interviewed. The interviews were conducted twice. The first interview assessed the acceptability of the various solution options for unsafe abortion such as family life education (including sex education), adolescent contraception, adult contraception, and liberalisation of abortion laws. This first set of interviews was followed by a session of information, education and communication (IEC) describing the problem of unsafe abortion and the solutions accurately [6,12]. During the IEC sessions, explanation of the definition of unsafe abortion was made, including descriptions of the complications and the associated morbidity and mortality. Data were also made available as to the difference in statistics of these complications between Nigeria and most developed countries where liberal abortion laws and other suggested solution options had been put in place.

The details of the suggested solution options were also made available. Liberalised abortion laws were explained in the context of accessibility and skilled provision of abortion services to those in need. Family planning services for adolescents and adults were also explained in the context of the difficulties of controlling sexual activities. Family life education was presented as including education on fertile period (safe period) and the dangers of premarital sex such as unsafe abortions and sexually transmitted diseases.

The post-IEC interviews were conducted immediately after the IEC sessions. The responses gathered during the first interview were then compared with the responses obtained for the same questions during the second interview. The second interview took place approximately one week after the first one.

The respondents were asked whether they accept or reject each of the suggested solution options. Their responses were recorded as yes, no or not sure, including reasons for the answer. A comparison of the level of acceptability pre- and post-IEC were made using crude percentage responses, first using overall total yes, no or not sure answers and secondly after separating the results between the two religions of Islam and Christianity. This is important because Muslims dominate the northern part of Nigeria while Christians dominate the southern part. The results were further analysed using product moment correlation coefficient and the value cross-checked with rank correlation coefficients and significance testing. This essentially was to assess the impact of the IEC sessions on the acceptability of the suggested solutions. The sampling for this project simulates a national survey, because Kwara State is in the middle belt region of Nigerian with a sizeable number of Muslins and Christians. Major Nigerian ethnic groups are also present in sizeable numbers.

Results

A total of ninety-five (95) people were interviewed comprehensively for analysis during the pre IEC visit. Out of this total, thirty-six (36) were Christians, while fifty-nine (59) were Muslims. They were all aged eighteen (18) years and above, mostly educated to secondary leaving certificate levels (89.5%) and majority were also married (85.3%). By the second visit (post IEC), three (3) respondents could not participate making the total responses to be from 92 people. This is shown in Table 1.

Results for the acceptability of each of the four solution options are shown in Table 2. Adolescent contraception was poorly accepted pre IEC, largely because the majority of Muslim respondents (78%) were against it. However the acceptability increased from 23.5% pre IEC to 40.2% post IEC and the main contribution to the positive effects was from Christian respondents (41.9% - 64.7%). The correlation coefficient of 0.75 was however, weak in relation to the effect of IEC, which makes the effect of IEC low and therefore Adolescent contraception was weakly acceptable.

As for legalization (liberalization) of abortion law, the result is similar to that of adolescent contraception in the fact that the acceptability pre and post IEC showed marginal improvement (14.8% to 18.5%) and correlated weakly (Correlation coefficient of 0.42) despite the IEC and subsequently remained weakly acceptable. The results were similar from the two religions.

Adult contraception was the singularly most acceptable solution option the acceptability more than doubled (46.3% to 93.4%) after IEC with a very high correlation coefficient (2.22) showing that the difference pre and post IEC was highly significant and therefore directly reflected the usefulness of the IEC with a resultant high acceptability of this option by the two religious groups.

The result of family life education was similar to that of adolescent contraception and abortion liberalization (Acceptability pre IEC of 40% increased to 67.4% post IEC). The acceptability of this solution option was more among the Christians both pre and post IEC, even though marginal improvement was recorded for Muslims too. However the correlation coefficient of 0.45 was low meaning that the IEC exercise resulted in a marginal improvement in public acceptability of this option.

Table 1

Sociodemographic Characteristics of Respondents

Characteristic	*Christians* Number (%)		*Muslims* Number (%)		*TOTAL* Number (%)	
Age	*Pre*	*Post*	*Pre*	*Post*	*Pre*	*Post*
18-35	9(25)	9(26.5)	16(27.1)	16(27.6)	25(26.3)	25(27.5)
36-55	22(61.1)	21(61.8)	34(57.6)	33(56.9)	56(59.0)	54(58.7)
>55	5(13.9)	4(11.8)	9(15.3)	9(15.5)	14(14.7)	13(14.1)
Total	36(100)	34(100)	59(100)	58(100)	95(100)	92(100)
Sex						
Male	19(52.8)	19(55.9)	38(64.4)	37(63.8)	57(60)	56(60.9)
Female	17(47.2)	154(4.1)	21(35.6)	21(36.2)	38(40)	36(39.1)
Total	36(100)	34(100	59(100)	58(100)	95(100)	92(100)
Level of Education						
$\leq 1^0$	-	-	10(16.9)	9(15.5)	10(10.5)	9(9.8)
2^0	14(38.9)	13(38.2)	21(35.6)	21(36.2)	35(36.8)	34(37.0)
$\geq 3^0$	22(61.1)	21(61.8)	28(47.5)	28(48.3)	50(52.6)	49(53.3)
Total	36(100)	34(100)	59(100)	58(100)	95	92
Marital Status						
Single	5(13.9)	5(14.7)	9(15.3)	9(15.5)	14(14.7)	14(15.2)
Married	31(86.1)	29(85.3)	50(84.7)	49(84.5)	81(58.3)	78(84.8)
Total	36(100)	34(100)	59(100)	58(100)	95(100)	92(100)

Discussion

A positive change in health policies and practices will be needed to achieve the much-desired reduction of unsafe abortion mortality and morbidity [6,8,9,15]. The required changes can only be brought about by appropriate information and education of all stakeholders in the society for support and in order to make those changes effective. The characteristics of the respondents fit very well into what is expected of a typical urban setting in Nigeria where the problems of unsafe abortion is pronounced [11]. The age distribution showed more middle-aged people. Adolescents were said to be largely involved in unsafe abortion complications [11,16], but other studies have also shown that quite a large number of women are also involved [13,17]. The database further showed that more men were interviewed, even though unsafe abortion is primarily a problem of women. However men are the family heads and more of them are involved in moulding societal attitudinal changes than women. The preponderance of educated respondents is in line with studies that have confirmed higher incidence of unsafe abortions among educated members of the society [13,17].

Public acceptability of adolescent contraception was (25.3%) in the baseline survey and this increased marginally (40 .2%) in the follow up survey, which was preceded by a session of information, education and communication (IEC). There is a possible greater positive effect of the IEC in the fact that many respondents gave not sure answer after the IEC (i.e.20.7 % post as against 9.5% pre). There is a theoretical possibility that if IEC persist most respondents in this category may graduate to accepting the adolescent contraception option. This is a positive development and will be in line with the W.H.O desire [20]. The result for abortion legalisation was less impressive as regards improvement in acceptability after the IEC session. There was only a marginal improvement even though more number of respondents moved from not being sure to the group of rejecters. This is worrisome because, it paints a gloomy picture for abortion liberalization, which has been argued to be the singularly important factor in the prevention of unsafe abortion [6]. The acceptability for family life education was better, looking at the crude figures (initial acceptability of 40% to 67.4%, with most respondents who were not sure of their stand before the IEC moving to the acceptors group).

Table 2
Acceptability of Solution Options, Pre and Post IEC and their Correlation Coefficients

	Christians		Muslims		Total		*rho*
	Number(%)		Number(%)		Number(%)		
Adolescent Contraception	Pre	Post	Pre	Post	Pre	Post	
Yes	15(41.7)	22(64.7)	9(15.3)	15(25.9)	24(25.3)	37(40.2)	
NO	16(44.4)	3(88)	46(78)	33(56.9)	62(65)	36(39.1)	
Not sure	5(13.9)	9(26.5)	1(1.7)	s10(17.2)	9(9.5)	19(20.7)	
Total	36(100)	34(100)	59(100)	58(100)	95(100)	92(100)	0.75
Liberalisation							
Yes	9(25)	11(32.5)	5(8.5)	6(10.3)	14(14.8)	17(18.5)	
NO	25(69.5)	23(67.5)	50(84.7)	50(86.2)	75(78.9)	73(79.3)	
Not sure	2(5.6)	0(0)	4(6.8)	2(3.4)	6(6.3)	2(2.2)	
Total	36(100)	34(100)	59(100)	58(100)	95(100)	92(100)	0.42
Adult Contraception							
Yes	23(63.9)	33(97.1)	21(35.6)	53(91.6)	44(46.3)	86(93.4)	
NO	6(16.6)	1(2.9)	21(53.6)	3(5.2)	27(28.4)	4(4.3)	
Not sure	7(19.4)	0(0)	17(28.8)	2(3.4)	24(25.3)	2(2.2)	
Total	36(100)	34(100)	59(100)	58(100)	95(100)	92(100)	0.22
Family Life Education (FLE)							
Yes	19(52.8)	28(82.4)	19(32.2)	34(58.6)	38(40)	62(67.4)	
No	10(27.8)	4(11.8)	26(44.1)	16(27.6)	36(37.9)	20(21.7)	
Not sure	7(19.4)	2(5.4)	14(23.7)	8(13.8)	21(22.1)	10(10.9	
Total	36(100)	34(100)	59(100)	58(100)	95(100)	92(100)	0.45

rho: Pearson's Coefficient of Correlation

The correlation coefficient for the three options just discussed, however gave similar result with an interpretation of weak acceptability despite the session of IEC. This certainly is better that no acceptability, which would have translated to an ineffective IEC as an intervention strategy. Adult contraception was the option that enjoyed greatest acceptability and reflected positive IEC intervention in this project. This is a welcomes positive development not only for the prevention of unsafe abortion but also for family planning services and to some extent sexually transmitted diseases (STD).

The reasons respondents generally put forward for opposing Adolescent contraception family life education, liberalization of abortion law were essentially religions and moral in outlook. Most respondent see these options as ungodly akin to licensing immorality in the society, which is in line with previous findings [13,18,19]. Most acceptors of the options of adolescent contraception, family life education and liberalization of abortion law were interested in a more liberal life style as against religious and cultural conservatism. These respondents see health as rights and support enabling environment for the protection and expression of such rights in line with the desires of ICPD[8]. This calls for a concerted effort towards an improved sensitization of our religious leaders who will now serve as laggards and initiate the much-desired support for abortion liberalization. In the interim, the marginal effectiveness of IEC as an intervention measure for adolescent contraception, liberalization of abortion law and adult contraception must be built upon while sustaining the improved acceptability obtained for adult contraception. An extension of this model of intervention for an effective campaign against unwanted pregnancy is recommended for all segments of the society. It is possible that acceptability will vary from place to place necessitating differential adaptations and adoptions of these unsafe abortion solution options.

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