EXPERIENCES OF WOMEN IN MALE SUPPORT DURING, AND AFTER POST ABORTION CARE IN KENYATTA HOSPITAL AND NAIROBI WOMEN'S HOSPITAL

FAITH OPIYO

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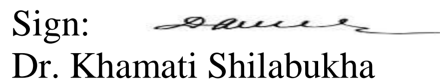
DECLARATION

I declare that the project proposal is my original work and has not been presented for examination for award of degree in any other university.

Sign: Date: 5/12/2023

Faith Opiyo

This project proposal has been submitted for examination with my approval of the university supervisor.

Sign:  Date: 6/12/2023
Dr. Khamati Shilabukha

DEDICATION

This project is dedicated to women across board that have gone through abortion and either received or did not receive support from the men in their life. It is equally dedicated to my husband Ram Aguko who has been extremely supportive during this study period.

A special dedication goes to my parents for cheering me on when I felt like giving up. Their prayers have for sure paid off.

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LIST OF ABBREVIATIONS AND ACRONYMS

PAC	Post Abortion Care
SRHR	Sexual Reproductive Health and Rights
WHO	World Health Organization
LMICs	Low Middle Income Countries
KOGS	Kenya Obstetric and Gynecological Society
KMA	Kenya Medical Association
MOH	Ministry of Health
UON	University of Nairobi
ERC	Ethical Review Committee
KNH	Kenyatta National Hospital
HCP	Health Care Provider
ICPD	International Conference on Population and Development
NWH	Nairobi Women Hospital
ANC	Ante-Natal Care

ABSTRACT

This was a cross-sectional descriptive study on experiences of women in male support during and post abortion care. The study examined the attitude and experiences of women in involving men in their abortion trajectory, also it looked at the perceived challenges men go through while supporting women in these abortion trajectories. A sample of 34 women comprised the study population and data were obtained through semi structured interviews, key informant interviews and case narratives. The study was guided by the stand point theory that highlighted on social norms that affects how men and women engage.

Data analysis was done using grounded approach and guided by the study objectives. The findings indicate that men affected women abortion trajectory and for some (men) when they are involved women recover quickly. None the less, men also have barriers that prevent them from giving support needed for women. Major cases of PAC resulting from botched abortion was reported in KNH unlike NWH.

The study concludes by highlighting major demographics that also affect women's trajectory which includes age finances and marital status, it further highlights the government policies that are weak towards sexual reproductive health and rights interventions and ability of a woman to decide whether she wants to procure abortion or not. The study recommends awareness creation to the community on botched abortion and the need to involve men in decision making processe

CHAPTER ONE
BACKGROUND OF THE STUDY

1.1 Introduction

Abortion is when a pregnancy is ended so that it doesn't result in the birth of a child. Sometimes it is called 'termination of pregnancy'. Article 26(4) of Kenyan constitution talking about Right to life, declares that abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law. The constitution further under article 240 on surgical operation claims that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

On the other hand, health workers are allowed to do Post-Abortion Care for any woman who comes to the hospital with any complications whether it is within the confinement of the constitution of unsafe abortion procured somewhere else, this aims to minimize morbidity and mortality following unsafe abortion, addressing incomplete abortion by treating complications, and reducing possible future unwanted pregnancies by providing contraceptive advice.

Men's influences on women's abortion decision making and care seeking operate on different levels. At the structural level, men typically control the exercise of power—political, economic and social— and the institutions, laws and policies that govern access to abortion. For example, in most countries, abortion law was written and is enforced by men, and reflects assumptions about their domination in male-female relations Western Asia and Central America revealed higher rates of unsafe abortion estimates (Shah and Ahman 2010), emphasizing how important accurate data are in understanding abortion.

In Africa at the individual level, men may be involved in women's abortion care seeking because they are sexual partners, relatives or friends. In many cases, they exert their influence by withholding support, denying paternity, threatening or committing violence, or abandoning the

woman. For example, studies in Ghana found that male partners' denial of paternity and subsequent withholding of financial support had a significant impact on whether women sought an abortion.

Access to legal, safe and comprehensive abortion care, including post-abortion care, is essential for the attainment of the highest possible level of sexual and reproductive health. In East Africa the abortion trajectories are almost the same. Abortion is illegal in Uganda except to save the life of the woman. Nevertheless, the practice is quite common: about 300,000 induced abortions occur annually among Ugandan women aged 15–49 (Singh *et al*.,2005) . Most men believe that if a woman is having an abortion, it must be because she is pregnant with another man's child, although this does not correspond with women's reasons for having an abortion – a critical disjuncture revealed by the data between men's perceptions of, and women's realities regarding, reasons for seeking an abortion. If the woman does experience post-abortion complications, the prevailing attitude among men in the sample was that they cannot support a woman in such a situation seeking care because if it had been his child, she would not have had a covert abortion. Since money is critical to accessing appropriate care, without men's support, women seeking an abortion may not be able to access safer abortion options and if they experience complications, they may delay care-seeking or may not obtain care at all.

Also, in many public health facilities in Kenya, PAC is currently offered as part of the government free maternal health care service package (Bourbonnais, 2013; Ndunyu, 2013). The Constitution also empowers trained health professionals, particularly medical doctors, gynecologist and obstetricians, and experienced midwives to offer abortion service. Research from Kenya found that some men used financial power to try to persuade their partners to either terminate a pregnancy (e.g., by buying abortion drugs) or continue it (e.g., by promising financial support for the woman or child); others left responsibility for preventing pregnancies to their wives, who subsequently sought abortion without disclosing the pregnancy to them.

Research has also documented the persistence of a longstanding practice among many Kenyan women and girls to induce their abortions outside formal facility settings or with the support of unqualified providers but to seek formal facility-based treatment for the attendant complications (African Population and Health Research Center, 2013; Gebreselassie et al., 2005; Ndunyu, 2013). A related research issue is how an abortion decision is made, in which case Mirande and

Hammer (1976) propose a model that incorporates the number of times a woman has been in love and her experiences with her acceptance of abortion. Others have related abortion attitudes to sex roles attitudes (Finlay,1981: Rosen & Martindakle, 1978, to moral reasoning (Smetana,1981) and to religiosity (Jones and westoff, 1978) However all these models involve only the woman.

The treatment of abortion complications utilizes a large amount of scarce health systems resources. At the Kenyatta National Hospital, Kenya's premier health facility, incomplete abortion accounted for more than half of all the gynecological admissions in 2002. Most of these admissions were emergencies, requiring long periods of hospitalization, repeated visits to hospitals, intensive care, and attendance by highly-skilled health providers (Gebreselassie et al., 2005).

Recent evidence in abortion research has suggested the role men can play in women‘s abortion trajectories, but the extent of this involvement is unknown. This paper seeks to identify and synthesize the current evidence of male involvement in abortion.

1.2 Statement of the Problem

The involvement of men and boys in interventions to achieve universal SRHR was highlighted by the ICPD (Basu 1996). This relates not only to men and boy’s own SRHR, but the role that they have on the SRHR of others. Men and boys have been found to have positive impacts on women’s access to SRHR (Hook et al. 2018), but also control over contraceptive decision making (DeRose and Ezeh 2010) and health seeking behaviors of women and girls (John et al. 2015). Where decision-making in SRHR is inherently gendered (Malhotra and Schuler 2005) men and boys are able to exert significant influence over women and girl’s SRHR (Chikovore et al. 2002). The increased recognition of men’s involvement in, influence over and needs for SRHR, including abortion, remains under-explored.

It is clear that the roles of partners/men vary enormously, not only with regards to the impact they have on women and girl’s abortion decision-making processes and outcomes, but also regarding the man’s relationship with the women or girl. Financial support most frequently comes from partners: boyfriends, husbands, sexual partners, transactional partners etc.

In the male-dominant society like Kenya, where men control most of the financial resources, men play a critical part in determining whether women receive a safe abortion, or appropriate treatment if they experience abortion complications. Since money is critical to accessing appropriate care, without men's support, women seeking an abortion may not be able to access safer abortion options and if they experience complications, they may delay care-seeking or may not obtain care at all. Barriers to involving men in abortion decision-making endanger women's health and possibly their lives. Experiences of women in involving men in decision making process have not been widely articulated even though men are more engaged in SRHR issues.

Thus, in aiming to understand experiences of male involvement in women and girl's abortion trajectories, this scoping review is unique. It seeks to collate knowledge on male involvement in two angles first the women who procure termination under Article 26 (Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law) and second the women who procure unsafe abortion and come to the facilities for PAC. In view of the problem, the study will attempt to answer the following research questions:

i. What are the factors that influence men's participation during and after PAC?
ii. What are the perceived challenges men face in supporting their partners during and after PAC

1.3 Research Objectives

1.3.1 General Objective

The general objective is to explore women's experiences in men support during and post abortion care.

1.3.2 Specific Objectives

i. Examine experiences of women in involving men during and after PAC
ii. Analyze perceived challenges men face in supporting women during and post PAC

1.4 Assumption of the study

i. Men support and involvement influence women's experiences during and after PAC
ii. Men face challenges in supporting women during and after PAC

1.5 Significance of the study

The findings of this study will add to the growing body of knowledge of policy frameworks for PAC for example, Reproductive Health Bill and The Health Act 2017. Moreover, finding in this study if adopted will help the scholars to analyze further male involvement in SRHR issues especially safe abortion.

The findings of this study, if adopted, will aid in improving interventions on SRHR with lenses of male engagement not only by ministry of health but also, NGOs, development partners and private sectors in reducing maternal mortality and achieving universal access to sexual and reproductive health and rights (SRHR) are fundamental tenants of Sustainable Development Goal. Moreover, this study will heighten milestones of ministry of health in SRHR issues since it compliments male engagement in maternal, nutrition, childcare and adolescent health.

1.6 Scope and limitations of the study

This study was done in Kenyatta National Hospital and Nairobi Women's Hospital given the fact that they are referral hospitals and they have large number of patients to choose from. Therefore, the experiences of women outside these two facilities were beyond the scope of this study. Having one hospital as private and the other one as public also contributed richly to the findings especially the financial status of the respondents

The study was highly qualitative in nature to capture the narrative in the study in terms of trends and trajectories of abortions among women. Whereas the study dealt with highly stigmatized groups that were not easily willing to share their experiences, study participants were assured of anonymity through the study phases through informed consent before their participation. The study faced a number of limitations including language barrier, to ensure this was sorted out the in-depth interview was conducted in Swahili for some respondents. Some participants were also biased or reluctant to answer certain questions in a way as to please the researcher thus tamper the actual aim of the research.

Access to the specific key informants was a challenge meeting them physically or discussing via email. However alternative key informants were sought to act as substitute solution Also, since the study will be at the hospital, the response may capture immediate complications and not late

complications, the service providers will be encouraged to do a follow up on the participants and report any changes during the study period.

Finally, the study was biased on women only given the fact that it will be conducted in a hospital targeting women who are seeking PAC services, it was the assumption of the study that men will rarely accompany the patient during such visits.

1.7 Definition of terms

Abortion- in this study, this is the termination of a pregnancy**.**

During abortion- in this study means the process/ experiences taken a woman realizes that she needs to procure abortion.

Post abortion- in this study is the process/experiences the woman goes through after going through abortion.

Criminalization in this study is the situation where health providers report to the law enforcers women who have procured abortion outside the confinement of the law.

Disclosure in this study it refers to the act of women revealing their abortion decision making process to HCW

Experiences- in this study, it is what the process women go through when engaging with men on abortion issues.

High volume hospital in this study it means hospitals with high number of referral cases like Nairobi Women's Hospital and Kenyatta hospital.

Men's support- this is the assistance and care given by men to their women in the process of experiencing abortion issues

PAC- this is the care given to patients after abortion

Partners in this study it refers to people who are having sexual relationship.

Stigma in this study it refers to the mark of disgrace associated with abortion by the health care providers in the process of seeking health care at the health facilities in Nairobi Women's or Kenyatta hospital. The disgrace as a result of social norms.

Support- in this study it refers to assistance being given to women, it can be spiritual, mental emotional and financial.

Botched abortion- this refers to termination of pregnancy being done outside the health facility, most times its in dingy places or self-induced in the hospitals.

Marginalization- this term in this study refers to unequal treatment of women from their men counterparts, it also refers to unequal treatment of women based on their locations.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This section reviews literature on the role men play during and post PAC at public health facilities. The review has been carried out along the following topic: The role of men in women abortion trajectories and the challenges they face in supporting the women. The section concludes by discussing the theoretical frame work and its relevance to the study. Calls to include men in sexual and reproductive health agendas, both as clients themselves and as actors who influence women's sexual and reproductive health outcomes have been answered by research and programs focused primarily on male influences on contraceptive use and maternity care. Much of the early work necessarily focused on identifying and understanding the ways in which men obstruct women's attainment of sexual and reproductive health. Later work illustrated a range of male actions (and inactions) that affect women's sexual and reproductive health and well-being, as well as their self-determination and rights, in positive and negative ways. However, men's roles in abortion have received little attention.

2.2 Role of men in women abortion trajectories

The ICPD recognized the significance of men in the attainment of universal SRHR. Recent evidence in abortion research has suggested the role men can play in women’s abortion trajectories, but the extent of this involvement is unknown. Previously, systematic reviews have focused on post-abortion care costs (Shearer et al. 2010), post-abortion family planning counseling for women in low-income countries (Tripney et al. 2013), and access to contraception and SRH information post-abortion (Rogers and Dantas 2017).

2.2.1 Control of resources

Evidence suggested that men as partners and parents played a consistently significant role, e.g. through control of resources, finances, information services, in women’s abortion trajectories, particularly in women’s ability to access safe abortion services. Few studies have explored male perspectives of their roles or used representative samples.

The nature, impact and amount of financial support are difficult to uncover. It is clear that the roles of parents and partners vary enormously, not only with regards to the impact they have on women and girl's abortion decision-making processes and outcomes, but also regarding the man's relationship with the women or girl. A study of men and women in Uganda revealed that men would express support for women's abortion decisions by providing financial support, where cost estimates for safer abortions ranged from 1.5USD to 110USD (Moore et al. 2011).

Conversely, men are able to withhold financial support as a mechanism to exert control over abortion trajectories, with over 32% of men in a study in Zambia reporting denying financial resources to a woman / girl post disclosing pregnancy (Dahlback, 2010). The socio-economic status of women had an effect on the nature and impact of material and financial resources. In their qualitative study in Peru, Palomino et al. (2011) found that economically dependent women were more susceptible to third-party influence.

Whereas numerous studies have examined women's experiences with unintended pregnancy and induced abortion, few studies have focused on men's experiences, despite the fact that men often play a significant role in pregnancy decision-making (Dahlback, 2010). Men's involvement and mobilization of material resources is often a critical determinant of the decision to terminate a pregnancy and the choice of induced abortion method. Consequently, understanding men's role in pregnancy decision-making is necessary to identify factors that may lead to the use of unsafe abortion methods and stigma around PAC. Frequently, men and boy's attitudes align (publicly) with the prevailing socio-cultural norms of the context (Moore et al. 2011). Men have reported fear of losing control over pregnancy related decisions (Hirz et al. 2017; Macleod et al. 2013; Moore et al. 2011) and expressed negativity towards what they perceive as the _secrecy' of women and girl's abortion-relate decision-making (Obiyan and Agunbiade, 2014)

2.2.2 Psychological support

Social and emotional support for / against abortion from men was found in numerous studies. In-depth interviews with 12 women who had abortions in Thailand emphasized the positive impact that emotional support from a male partner had in partially alleviating negative abortion experiences. (Chatchawet et al. 2010).

However, four studies identified partner denial / rejection of a pregnancy and the associated social and emotional impact on a woman to be critical in shaping an individual's abortion trajectory (Freeman et al. 2017; Aziato et al. 2016; Schwandt et al. 2013; Dahlback et al. 2010). Denial of pregnancy has a strong indirect impact on women and girl's decision-making, as denial of pregnancy is accompanied by the denial of financial / emotional assistance, as well as forcing women and girls to navigate social norms that might not be supportive of young / single / unmarried mothers. Denial of pregnancies by men and boys can also influence the transition of a pregnancy from acceptable to unacceptable, indicated in a study of young women in Zambia (Freeman et al. 2017).

The evidence highlights the significant role that men and boys can have in women and girl's abortion trajectories across low- and middle-income settings. Male influence exists across the three individual- and macro-context domains identified by Coast et al. (2018). The scoping review reveals 10 that men can have a critical role in a woman or girl's decision to abort as well as the abortion trajectory itself. In particular, sexual partners of any variety (boyfriends, husbands, transactional partners, etc.) and fathers are the men who are most often involved in a woman or girl's decision-making. The studies reveal the importance of male involvement, similarly to studies in other areas of sexual and reproductive health and maternal health (Yargawa and Leonardi-Bee 2015; Kalmuss and Tatum 2007; Chikovore et al. 2002)

2.2.3 Access to abortion provider

Fewer studies indicated the role of men and boys in women and girl's access to an abortion provider method. Rominski et al. (2017) reported in their qualitative study of young women in Ghana that drugs for abortions were provided by boyfriends without women necessary knowing what they were. Aziato et al. (2016) similarly found that women were concerned over the safety of the methods their partners provided them. Access could also include the provision of transportation (Freeman et al. 2017), which impacts a woman's choice by defining which facilities / methods are geographically accessible. Partners and parents could play a significant indirect role in a woman's ability to access a provider / method. A study of young women and men in China reported that young unmarried women were more likely to access abortions at private hospitals to avoid parental repercussions (Che et al. 2017). Such concerns over responses could result in the seeking of methods that are more clandestine / self-managing. Indirect

behaviors and actions can create barriers for women to seek particular methods over others, thereby reducing their choice of abortion.

2.2.4 Ability to seek accurate information about abortion

Lack of information of abortion-related services, including the legality of abortion in a particular context, impact an individual's decision-making process in whether and how to abort. Men were reported as being crucial sources of information for women seeking abortions (Freeman et al. 2017). In a study of women aged 15 and over in Zambia, the advice and information of trusted others was important in shaping a women or girls's abortion trajectory, in particular the facility type that a woman or girl felt she could access. As one respondent described: "He [boyfriend's brother] said No, there is actually a right way if you explain yourself and have a valid reason it can actually be done at [hospital] what made me decide‖ (Coast and Murray 2016). In their qualitative study in Cambodia, men revealed knowledge of abortion types, included medical abortion and surgical abortion (Petitet et al. 2014). This was cited as coming from successful campaigns by local NGOs through newspaper and radio adverts on SRH services in the country. Alternatively, respondents of a school and clinic-based study in Ghana cited their female peers as key sources of information (Challa et al. 2018).

2.3 Challenges men face in supporting women during and post PAC

Frequently, men and boy's attitudes align (publicly) with the prevailing socio-cultural norms of the context (Moore et al. 2011). Men have reported fear of losing control over pregnancy related decisions (Hirz et al. 2017; Macleod et al. 2013; Moore et al. 2011) and expressed negativity towards what they perceive as the secrecy of women and girl's abortion-relate decision-making (Obiyan and Agunbiade, 2014). A study of young Filipino men found that men were condemnatory of induced-abortion in focus group discussions with their peers, but more reflective of different circumstances during in-depth interviews.

Despite men in focus groups speaking negatively of abortion and describing it as a sin, in-depth interviews revealed further nuance around aspects of control, as one respondent explained It is abortion (Moore et al. 2011) I will really keep her from doing so but if she is already decided how can you restrain her since she's the one controlling her body? It depends on her (Hirz et al. 2017). There is evidence that male partners can have a negative impact (e.g.: restricting resources

abandoning pregnant women / girl, etc.) on women's decision-making, and that this is tied to both contextual norms but also the perception that men have of their place in their partner's decision-making.

Men, however, may not recognize their influence on women's abortion care seeking or may not consider abortion a men's issue, especially when they have no personal experience with unintended pregnancy or abortion. Some research has focused on men from a general population, rather than on those recruited via women's sexual and reproductive health care visits for abortion or contraceptives. These men may distance themselves from abortion, regarding it as being beyond their responsibility or concern (Freeman et al. 2017) as a strategy women employ to resolve socially problematic pregnancies; or as a female-led action that excludes men, violating paternal rights and prohibiting equality between partners. (Freeman et al., 2017). However, Nyanzi et al (2005). warn against using such findings to justify focusing interventions on women only. They argue that excluding men can enhance men's ability to distance themselves from abortion to escape social condemnation or penal consequences.

2.4 Theoretical Framework

Theoretical and conceptual framework used to carry out this study is based on feminist stand point theory (Harding 1986, 1991; Nicholson 1990). The standpoint theory is a post modernism approach on people's perceptions and how culture affect this perception. The choice of this theory is well thought out because many women in Africa and other developing countries are still suffering from the political economy of underdevelopment, marginalization, dependency, and gender inequality since their nation's independence, this includes depending on their male counter parts who have male privilege in the society. The same sentiments are echoed by dependency theorist, Boserup (1970) and Harris (1979).

Standpoint theory suggests that people from marginalized or oppressed groups (women) have epistemic advantages because they can see and understand aspects of the world that those in more privileged positions (men) cannot, according to standpoint theory, knowledge is not just an individual endeavor but a collective and social process. It highlights the importance of including diverse voices and experiences in the production of knowledge to create a more accurate and fair understanding of the world. This theory is relevant because, in women abortion trajectories, more

focus is on women, who majority lack resources to support them during abortion and PAC (Hirz et al. 2017; Macleod et al. 2013; Moore et al. 2011). For safe termination of a pregnancy, resources are needed to facilitate this process, this call for more engagement of men in this sector. The assumption of the study is that men have the resources to support the woman in abortion trajectories this includes support through capital.

Central to standpoint theory is the concept of social location which refers to an individual's position within various intersecting social categories, such as gender, race, class, sexuality, and more. Standpoint theory is often linked to the concept of intersectionality, which emphasizes the need to consider the simultaneous impact of various forms of oppression and privilege (Susan Hekman 1997) during this study, it was evident how experiences of women in public hospitals and private hospitals differed in terms of engaging men to support them, this speaks to where they coming from whether it is the informal settlement or formal settlement.

The assumption of this study is that male support influences women's experiences in PAC. This theory is therefore also relevant in this study because in societies where social norms contribute to socialization, gender roles both productive and reproductive have been universally distributed. In African culture, issues of pregnancy have been mainly left to women, during birth, traditional birth attendants are mostly women, prior to helping in delivery, and some communities would massage the woman. Aunties and elderly women are tasked to also prepare the woman for pregnancy during baby Showers and most often men are left behind these discussions for these reasons, men were partially or entirely left out on decisions around child birth. This can be the reason why women feel shy to involve the man deeply in pregnancy issues moreover, matters of abortion are still taboo and this makes it more difficult for women to share their perception with the partners. These cultural norms and beliefs are what the theory emphasizes affecting people's perception and actions. Therefore, these cultures may affect the support the men give not only on pregnancy but also abortion.

CHAPTER THREE
METHODOLOGY

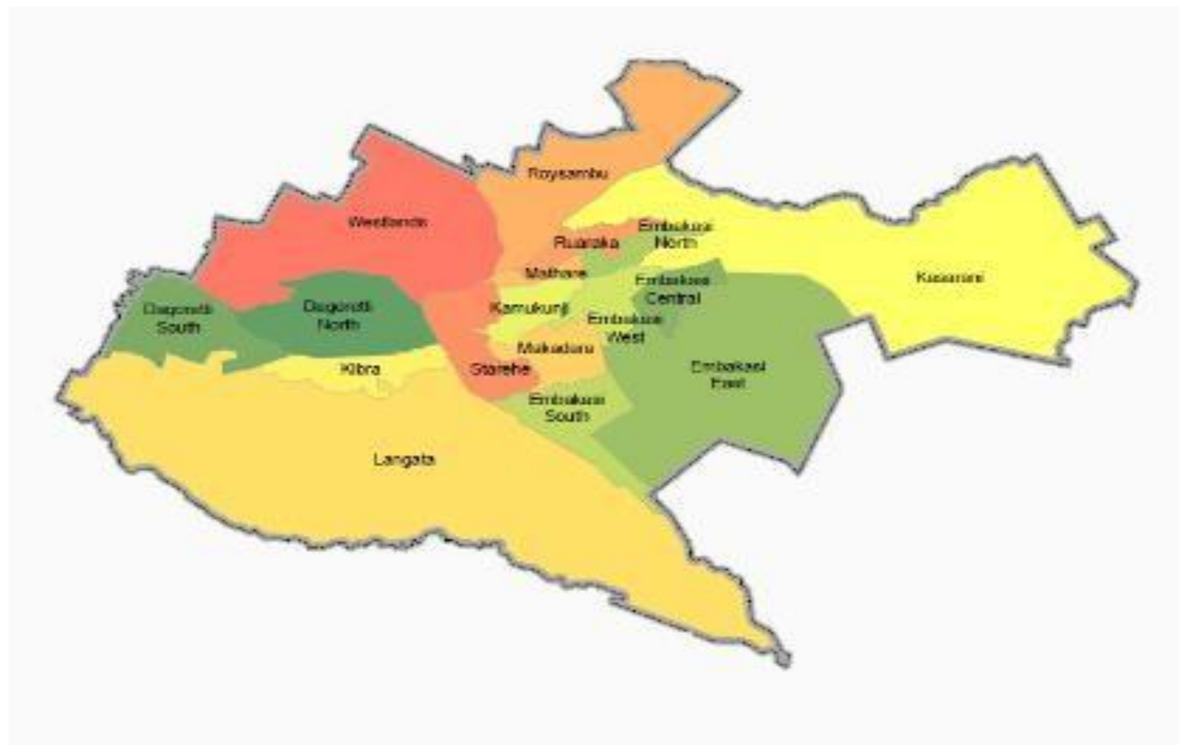
3.1 Introduction

This section describes the research site, design, study population, sample and sampling procedures, data collection methods, data processing, analysis and presentation. The section concludes by discussing the ethical considerations that will guide the study.

3.2 Research Site

Kenya's established abortion services are concentrated in the capital, Nairobi. At the Kenyatta National Hospital, incomplete abortion accounted for more than half of all the gynecological admissions in 2002. (Gebreselassie et al.2005). The study analyzed results between public and private hospital by introducing NWH as a private study site. On the other hand, Nairobi women hospital is well known to receive patients with reproductive issues, also this hospitals houses gender based violence recovery center that has patients seeking abortion services.

Figure 1: Map of Nairobi County



Nairobi Women Hospital: 1.2740°S, 36.8990°E; Kenyatta National Hospital: 1.3013°S, 36.8070°E

Figure 2: Map of Kenya

3.3 Research Design

This was a cross-sectional descriptive study. The fieldwork spanned for a period of 4 weeks between April and May 2023. In the study, qualitative data collection methods were employed to address the stated research questions. Specifically, data was collected using semi structured interviews, case narratives and key informant interviews. Given the exploratory nature of the study, triangulation of data collection methods was deemed necessary so as to compensate for limitations in single-line data collection approach.

To maximize on the data collection methods, the study began by conducting semi structured interviews with respondents on their experiences while seeking health care at public health

facilities. Case narratives were also introduced to give detailed experiences on the challenges women were facing with partners while seeking for PAC. Having received information from the women by way of case narratives and semi structured interviews, key informant interviews were conducted to bring in health care workers on the objectives of the study but also clarify some of the issues raised by the women. The data collected was translated then transcribed. Thematic analysis followed in line with the specific study objectives. In the presentation, verbatim approach was adopted where direct quotations were used to amplify the informants' voices.

3.4 Study population and Unit of Analysis

The study populations were women 18-49 years of reproductive age who had procured abortion from the 2 hospitals and those who procured abortion elsewhere and due to complication came for PAC in the 2 hospital. The, unit of analysis was individual woman who has procured abortion from the hospital and those who procured abortion elsewhere and due to complication came for PAC in the hospital.

3.5 Sample and Sampling Procedure

30 respondents were conveniently sampled in the health facilities, 18 from Kenyatta National Hospital while 12 from Nairobi Women's Hospital. Upon reaching the hospitals, the index persons in this case the health worker identified the participant based on demographic knowledge that included age, marital status and economic status, using the health worker was a way of ensuring that the participants of the study were comfortable and had for sure gone through PAC in those facilities. Those who were available and willing to take part in the study were recruited as study participants.

To get key informants' input, 3 key informants were purposively selected for interviews based on their interactions with the participants, 2 were from KNH and 1 from Nairobi Women Hospital. The informants to case narratives (numbering four) were purposively drawn from the hospitals as well, 3 from KNH and 1 from Nairobi Women's Hospital. They were sampled based on the number of times they have gone through abortion and their encounters in engaging their male partners every time they are going through PAC and their willingness and availability to delve more into discussing barriers that prevent them from engaging partners.

3.6 Data Collection Methods

3, 6.1 Semi-Structured Interviews

The semi-structured interviews were conducted with 26 women in the hospitals. The method was important in digging out data from the women on their health needs, experiences with men while seeking healthcare, the barriers they face and how these barriers affect their health seeking behavior. The semi-structured nature was important in probing deep in to the specifics of the barriers as well as the reactions attached. This was significant because it brought out new insights from the discussions. Stigma and lack of finances stood out from the experiences shared as a strong barrier while engaging men. The interviews were conducted with the help of a semi structured interview guide (Appendix 2).

3.6.2 Key Informant Interviews

These were semi-structured interviews carried out with professionals amongst them: 2 nurses and 1 doctor from KNH and 1 nurse from Nairobi Women's hospital. These interviews were important as they further put into perspective, men engagement in PAC, this discussion further highlighted the engagement the health workers have had with male partners and barriers the partners face while their women are going through PAC. The healthcare providers maintained that there was a need to sensitize healthcare providers. A key informant interview guide (Appendix 3) was used to collect the data.

3.6.3 Case narratives

The observation that some of the participants had multiple experiences on abortion and seeking for PAC necessitated the use of case narratives. To this end, the case narratives were carried out with four participants who were willing to talk more about their experiences in engaging male partners and the barriers involved. The narratives elicited information on the vast women's health needs and cited both policy and male engagement interventions needed to keep men involved in reproductive issues. A case narrative guide (Appendix 3) was used to guide the process of inquiry

3.7 Data Processing, Analysis and presentation

Data analysis involves the process of combing through the raw data to determine what is significant and transform the data into a simplified format that can be understood in the context of the research questions (Krathwohl, 1998; Miles and Huberman, 1994; NSF, 1997). Data analysis makes it measurable and articulate. According to Peter Drucker (2003) what gets

measured gets managed and implemented. Marshall McLuhan (2006) a Canadian research professor contends that analysis of data accords sense to the data.

In this study, the audio-taped data collected through semi structured interviews, case narratives and key informant interviews were translated, transcribed and coded for analysis. Data transcription, translation and analysis were carried out concurrently with data collection. This was done in order to get feedback from the data being collected and to add new insights significant to the study which led to adjusting the interview guides to accommodate for more information from the participants.

The transcripts were later coded so as to make the information discrete. Thematic analysis was done in line with the study objectives. Thematic analysis in these context meant grouping data into themes that help answer the research questions. (Taylor-Powell and Renner, 2003). The themes directly evolved from the research questions that were pre-set before data collection began. Some naturally emerged from the data as the study was conducted.

After identification of the themes the data was sub divided into thematic groups so as to analyze the meaning of the themes and connect them back to the research questions in line with the study objectives to ensure validity. The themes involved stigma related barriers, finances, staff attitude, criminalization, lack of confidentiality, fear of prosecution, weak policies and information related barriers. A verbatim approach was used in data presentation where direct quotations and selected comments from informants were used to amplify the informants' voices and to convey actual meaning intended in the discussions

3.8 Study ethical considerations

Essential ethical considerations and practices were undertaken to ensure that the study was conducted in line with sound research principles and regulations. Permit was obtained from AMREF ESRC P1239/2022. During fieldwork, informants were duly briefed on the purpose, the target groups, selection procedure, duration of the study, and potential use of the research results. An informed consent form (Appendix 1) was signed by the informants as surety of their understanding and acceptance to be involved in the study. Recruitments to participate in the study were based on informed consent of the FSWs. The rights of informants to withdraw at any point of the study were explained, however, the informants were encouraged to participate

throughout the study. The study subjects were assured of their anonymity by use of codes and pseudo names during presentation.

CHAPTER FOUR
PRESENATION OF THE FINDINGS

4.1 Introduction

The chapter begins by presenting the findings of the study. The first sub-section presents the background demographic characteristics of the respondents. Then other aspects of the findings are presented and discussed in line with the study objectives which include:

i. Women's experiences in involving male during and post PAC
ii. The perceived challenges men face in supporting women during and post PAC.

Discussions are carried out along the following sub-thematic areas: Men's absence, men's presence.

4.2 Demographic Characteristics of respondents

4.2.1 Age of respondents

Respondents were aged 15–43 years. They were primarily from Nairobi (90%), although a minority had traveled from as far as Limuru and Kiambu. We present data generated from interviews with 30 women who had received either safe or unsafe abortion and had received care following an incomplete abortion.

Table 1: Age of respondents

Age category	Number of women in KNH	Number of women in NWH
18-25	9	6
26-30	5	4
31-35	1	2
36-49	3	0

It was found out from the respondent that most of the health care providers were older than respondents which in their view made the healthcare providers treat them with contempt as one

of the young women explained, "For some of us who are young, the nurses at the hospitals look down on us and we feel intimidated" (Laureen). This was important to note in the study since their age could have been a limitation to their ability to involve the men in their lives.

This was retaliated by one of the key informants from KNH who expressed having difficulty counselling some teenage young mothers who thought that they were already being judged whereas that was not the case.

4.2.2 Marital status

Our sample included a higher proportion of current or recent students (e.g., those waiting for exam results to proceed in education). This is unsurprising because continuing education was a key reason for seeking abortion reported by many young women.

Table 2: Respondents marital status

Marital status	% of women in KNH	% of women in NWH
Single	60	80
Married	39.5	20
Separated/Divorced	0.5	0

4.2.3 Financial status

The financial status of the respondents was a very critical socio-demographic characteristic that hugely affected the women. In line with the financial status the respondents were grouped into two, as either being financially dependent or independent. The employment profile of nonstudents in our sample was as would be expected in a capital city.

Table 3: Respondents financial status

Financial status	% of women in KNH	% of women in NWH
Dependent	75	44
Independent	25	56

During discussions one of the respondents gave the following remarks: "Regardless of the shame that comes with abortion, I have very limited choice because my financial status doesn't

guarantee me a good man to marry me and also, I cannot afford to go to an expensive hospital for care in case something happens the way it happened when I procured abortion in Mathare. A key informant one of the healthcare providers at NWH contends with the views from respondent regarding their limited options of seeking healthcare as a result of their low income. “Abortion really affects women who are not financially dependent more, I have seen women walk in here because they have their husband’s insurance its more humiliating because they wanted to do it privately without the knowledge of their partners.

4.3 Experiences in men involvement during and after abortion care

Women’s reports of male participation in their abortion decision making and care seeking were roughly equally split between those of men who knew about the pregnancy and were actively involved in a woman’s abortion trajectory, and those of men who had no direct involvement or who were not aware that the care they helped the woman obtain was related to abortion (42% and 8%, respectively). Women’s abortion trajectories were influenced by men who were present and those who were absent (or unaware). Men’s actions, lack of action or anticipated actions had implications for the direction, complexity and timing of women’s abortion-related care seeking, for both safe and unsafe abortions and PAC by HCP.

4.3.1 Men’s absence

Some women simply did not mention men at all. For other women, men’s absence was an important factor in their abortion decision making or care seeking. Women who had received post abortion care at the hospital were more likely to report that no men were knowingly involved in their abortion trajectories than to discuss men’s involvement (63% vs. 35%). Almost three-quarters (72%) of women who reported that men were actively and knowingly involved in their abortion decision making and care seeking had received a safe abortion at the study hospital These sentiments were also echoed by the health workers in two different hospitals, for instance, below conversation was recorded;

> *Interviewer: To what extend do you receive a woman and her partner who are seeking for abortion or PAC?*
>
> *HCW: Actually, most cases that are presented to me. Let’s say up to 60% are mostly women who are brought by their friends without their partners knowing. Because we*

provide counselling I the hospital, rarely do these women mention involvement of their partners.

4.3.1.1 Paternity rejection

The study identified a variety of situations in which men's absence influenced both whether women continued their pregnancy and whether abortion was pursued safely or unsafely. These absences were all ultimately the results of male behaviors: They were caused either by men's active rejection of paternity or the relationship, or by women choosing to exclude men because of fear of men's interference with the abortion decision making process or their reaction to the pregnancy, based on men's previous behavior. For instance, these quotes related to men rejecting pregnancy:

> "*I was 18 and my boyfriend 19 he was my first boyfriend, and actually it was my first time ever having sex… About three weeks later, four weeks later, I panicked when I missed my periods and decide to call him. It was the craziest thing I have ever experienced... There's just no way you can plan for that or even know what to do, as a 18-year-old still in high school. I didn't have any money. I didn't have a job. I couldn't imagine telling my parents. He was like, "Yeah, I have to get an abortion, obviously because he didn't think having sex for the first time would result to pregnancy.*
>
> *(Nancy KNH)*

Partner rejection as a result of the pregnancy was a common reason why the men who had previously been important in women's lives were absent from their abortion trajectories. In these cases, men's denial of paternity or discontinuation of the relationship became a catalyst for what was to follow. Respondents' narratives document substantial negative social, educational and financial implications of pregnancy and parenting without a partner for a woman and her family. Consequently, some respondents reported that abortion reflected the lack of the option to continue a pregnancy, rather than an active choice to end it, and frequently presented abortion as their partner's decision, made in absentia for example, Jennifer was unemployed and lived with her older sister. When she became pregnant by her partner of six months, she spent two months attempting to convince him that they had a positive future together before he left her. Eventually she went to a pharmacist who sold her drugs for a medication abortion. She was subsequently

taken to the study hospital in pain and with heavy bleeding. Jennifer described the negotiation and delays as follows:

> *"When I told [my partner] that I am not attending [menstruating], he thought I was joking and was saying that [I was] just lying to him. So, I told him again that I was not [menstruating] and this was going to be my second month of not [menstruating], but still he was busy arguing with me.… I told him that I was worried and do not know what to tell people at home. He just said I was just joking and left. I also let go and stopped arguing with him [because] he never wanted anything to do with the pregnancy.… I really wanted to keep it, but so many issues were occurring at home.… I was just being shouted at every day over the pregnancy. [My sister] said that she didn't have money to take care of the child. She even told me that she did not want me at her home anymore."*

The influence of men's absence reflects societal-level gender inequities that play out differently for both men and women across ages and levels of wealth and education as well. Although age did not determine whether women reported men's involvement in their abortion trajectory, the nature of men's noninvolvement seemed to differ across age-groups. For example, instances of partner rejection or violence in response to pregnancy emerged more frequently in younger women's narratives than in those of older women, while older women were more likely than younger women to report having excluded their partners Wealthier women and more educated women more frequently reported that men played a role in their abortion trajectories (69% and 67%, respectively) than reported that men had no role (27% and 28%), or that the men involved did not know about the pregnancy or the abortion (4% and 6%).

In contrast, poorer women and less educated women were more likely to report that no men had a role (57% and 52%, respectively) than to report that men were knowingly involved in the abortion decision making and care seeking (30% and 38%); 14% and 9% of these women, respectively, reported that the man involved did not know about the pregnancy or abortion. Women of all backgrounds acknowledged gendered opportunity and social costs of pregnancy and future parenthood, which were complicated by other social inequities they experienced Men's rejection of paternity or relationship. Wacera, age 21, and her boyfriend ended their

relationship a month before she realized she was pregnant. She had hoped the pregnancy would reunite them, but instead he "denied her]," telling her to abort or raise the child on her own. Wacera felt she had no choice but to terminate the pregnancy:

> *"I talked to him over [the pregnancy], but unfortunately, he just could not accept the responsibility of it and said that he will not be part of it that I should either remove it or [I] will be on my own.... I cannot raise a child on my own. Though I needed my child, I never had a choice."*

4.3.1.2 Fear of men's interference with abortion decision.

Other women purposefully excluded their partners from abortion decision making because of the responses they anticipated. Based on their partners' previously expressed fertility preferences and beliefs about motherhood, these women decided not to discuss their abortion in an attempt to avoid pressure to continue a pregnancy they did not want. This urgency arose from the fact it was not their first time seeking for abortion or PAC. They had procured abortion before. Their need to maintain secrecy was often the reason they had a clandestine, unsafe abortion. For Gloria (age 26) and Halima (age 35), pregnancy entailed a loss of personal autonomy.

They understood that excluding their partners from the abortion decision was necessary for self-determination. Gloria was poor, already a mother and not working, but had plans to start college. When she discovered she was pregnant, her husband told her she would no longer be able to pursue her education. She subsequently secured abortion pills from a friend in secret. Halima's husband was frequently adulterous and would regularly disappear with the family's money, leaving Halima unable to feed herself and her children. Her desperation to avoid raising a fifth child with him caused her to attempt abortion by inserting a stick into her cervix. Both women subsequently needed and received care for incomplete abortion at KNH.

Women's desire to exclude men from their abortion decision making also reflected men's roles in controlling women's fertility. Against her husband's wishes, Terry, age 27, secretly took oral contraceptives to prevent a fourth pregnancy that would exacerbate her chronic respiratory illness. On discovering her pregnancy, Terry took a full packet of contraceptive pills in the hope that this would induce abortion. This caused severe symptoms, but not wanting to involve her

husband, she delayed seeking the emergency post abortion care, by the time I was interviewing her she had been in the hospital for two weeks due to complications.

4.3.1.3. Fear of men's reaction to pregnancy.

In cases such as Terry's, the anticipated conflict was over a woman's desire not to become pregnant. For other women, the problem was that they anticipated disapproval of the pregnancy and feared punishments, including beatings, from male authority figures. For a number of younger, unmarried women, fear of their fathers' or uncles' reactions to pregnancy influenced their decision to terminate it; keeping the pregnancy and abortion secret from these men was their paramount concern. Esther, age 22, was living in university halls and training to be a lawyer. When she became pregnant unexpectedly, she discussed the pregnancy with a male friend, but felt she could not reveal it to her father:

> *Esther(E): So, my friend advised me, he was like "No, looking at your status, the way your father talks and all that, and I know definitely you will have nowhere to go" and that's how I decided to come to seek for abortion in majengo before I was taken to NWH.*
>
> *Interviewer (I): How is your father?*
>
> *E: My father is really I can say harsh. And sometimes when he is talking, I feel like he can go after me and then he can just disown me.*
>
> *I: Okay, does he know what you are going through?*
>
> *E: He doesn't know.*
>
> *I: What do you think he would have done if he knew?*
>
> *T: He would have actually stopped me from going to [university], and I would have been sent to my mother [in a rural village] So, I looked at it in the form of my education who will pay for me? And at the moment, I am almost done getting my diploma, so I looked at it in those lines.*

4.3.2 Men's active role

In other cases, boyfriends and husbands, as well as other men (male family members, friends and in-laws), actively helped women to obtain an abortion. These men were most influential when they acted as shared decision makers or sounding boards and as facilitators to obtaining care by paying for an abortion, arranging it or accompanying a woman to obtain it. When actively involved in these ways, men were most frequently a positive influence on women's abortion

decision making and care seeking, and helped facilitate access to safe abortion. Conversely, none of the 30 women in our study who used unsafe abortion methods reported that they had done so on the basis of men's advice or instruction, or with men's knowledge, support or financial assistance.

4.3.2.1 Men's participation in abortion decision making.

Some women turned to uncles, brothers or male friends for advice. Viola, a student, sought the advice of a classmate because he was "married and has experienced such things around him." However, husbands and boyfriends featured more commonly in respondents' narratives. Four respondents reported that men had had a strong influence on their decision to abort. A few of these women reported that the suggestion to abort had been a man's but felt that the decision had been the right one; others reported that a partner or male family member had taken the decision away from them altogether. For example, when 18 year Happiness became pregnant as a result of rape by her parents' tenant, her father beat her before telling her she must abort through this quote:

> *"I was told that there was no way that I would take care of this child…. I was asked how I would care for that child, where I would find clothes and how I would finish school…. My father was very upset with me."*

Three respondents reported that they had convinced their partners that abortion was the appropriate course of action for their pregnancy due to complications that were detected by a doctor from their ANC visits. More commonly, however, in situations in which men were involved, women described a more balanced process in which the decision to seek abortion was mutually initiated and made. Whether they were in stable relationships (marital or no marital) or in consensual casual or short-term relationships, these women, older and younger, reported that they had made abortion decisions with their partner, recognizing sex, pregnancy and childbearing to be shared ventures.

For example, Tecla, age 43, and her husband already had six children and were using an IUD when they conceived. They agreed that they could not afford another child. Similarly, university students Letisha, age 19, and her boyfriend decided together to seek an abortion:

"He asked if I could keep it and if I could face that, and then we talked about it. Then we decided it's better if we don't bring problems to the family members paying for our education… He came to see me so that we could talk about it and decide what we were going to do. We talked about it for like two weeks, and then we decided to have a termination."

Even with the support from male partners, we noticed that many abortions were done outside the study hospitals apart from the ones that the study hospitals authorized. But highly noted that with the support and knowledge of the significant men in their lives, women's need to seek clandestine, unsafe abortion was diminished.

4.3.2.2 Men's roles in seeking abortion and PAC

Respondents who decided with their partner to abort the pregnancy typically reported that their partner continued to be involved when they obtained services. These men provided emotional support, facilitated abortion by seeking and providing information about where services could be obtained, and accompanied respondents to access care. Most frequently, men supplied the money for transportation and treatment. When Dionisia, age 22, thought she might be pregnant, her fiancé arranged for a pregnancy test and accompanied her to a clinic. They decided together to seek abortion so that Dionisia could finish school and pursue her plan to become a nurse. Her fiancé suggested that she accompany him to his appointment for circumcision at a sexual health clinic so that they could also ask about accessing abortion. Having received counseling about abortion and a referral to the study hospital from the clinic, Dionisia's fiancé accompanied her during her stay and paid for the abortion procedure and other expenses. Although financial assistance was the most commonly reported type of male involvement, men's ability to obtain information about safe abortion services appeared to be most influential in determining whether a woman ultimately had a safe or unsafe abortion.

Respondents reported very little awareness of the legality and availability of abortion services. Access to safe services at the study hospital depended on knowing, or knowing someone who knew, that such services were available. For some respondents, partners, male friends and brothers were instrumental in getting this information. Dionisia's boyfriend searched the Internet

to find a safe abortion provider. Several other men used extended social networks to get the private telephone number of a doctor at the hospital. As Brenda, age 22, recounted,

> *"(My boyfriend) just called me two days ago and told me to come to a hospital in Kariobangi; he said that one of his friends had connected him to someone there."*

In the absence of or as a supplement to support from partners, male family members and friends played key roles in facilitating access to abortion care. When 23years old Gertrude discovered she was pregnant by her boyfriend of three years, she did not disclose the pregnancy to him but instead told the uncle with whom she lived. Her uncle recommended abortion so that she could finish school. He accompanied her to a clinic and then to the hospital to obtain a safe abortion, and paid for her treatment when the abortion did not go well.

Some men had no involvement in the abortion decision or attempt but were instrumental in securing care following an unsafe incomplete abortion. These men instigated care seeking in response to the respondents' obvious illness, accompanied them to health facilities, and paid for travel and the costs of their care. Susan, age 30, had two children with her husband. She did not discuss with us why she wanted to end her most recent pregnancy and did not tell her husband that she had taken illegal abortifacients.

When she woke up bleeding, her husband rushed her to a local clinic and paid for her treatment before she was referred to the hospital. Susan's brother, a taxi driver, drove her and her husband to the hospital, waited while Susan was treated and paid the charges incurred there because her husband had spent all of his money at the clinic.

4.4 Challenges that men face in supporting women during and after PAC

As research in Sub-Saharan Africa shows, men's involvement in women's trajectories to safe or unsafe abortion mirrors inequitable power relations between genders. We, too, found that socially constructed gender roles influenced men's involvement in abortion decision making at the individual level. Our respondents' abortion trajectories, and the absence or presence of men in them, reflected gendered differences in economic and social power, norms about fatherhood

and motherhood, and the implications of pregnancy and childbearing for men and women's lives (e.g., future opportunities for education, career and relationships).

4.4.1 Feelings of fear guilt and shame

Based on our studies most perceived challenges from men was reported by women who had mutually agreed with their partner to terminate pregnancy. As Christine reported;

'So when the doctor told us that the pregnancy was at risk and we needed to make a decision on aborting, I saw how he was lost in thought, we are all devoted Christian and believe in miracles, I decided to convince him that we terminate, during PAC Victor my husband kept regretting and withdrew from most friends because he felt like God will not forgive him."

These sentiments were echoed by Beatrice whose husband felt guilty for allowing her to go procure abortion without his company.

4.4.2. Financial constraints

In contrast to studies among men in the general population, we found that men's absence from women's abortion trajectories did not appear to reflect attempts to distance themselves from a problematic procedure. Instead, it reflected either a male partner's voiced and explicit desire to avoid responsibility for pregnancy and caring for a child. Both situations reflected gender inequity and influenced whether women's abortions were safe or unsafe by causing delays in care seeking or by increasing women's desire to terminate pregnancies without the knowledge of these men because the men had previously indicated that they may not be able to facilitate pregnancy of another child. As Ann quotes:

> *"You know this is my third pregnancy and my second abortion, my partner constantly tells me that he doesn't have a problem with many children only that he is struggling to even pay rent, what about hospital bills or even food for extra mouth."*

The study noticed that for those whose partners supported them financially especially in NWH, gender inequity enabled men to use their privileged access to social and economic resources to

facilitate safe abortion or care following unsafe abortion, but even during this support, the women reported that men complained of the finances since insurance did not cover some elements.

CHAPTER FIVE
DISCUSSION, CONCLUSION AND RECCOMENDATION

5.1 Introduction

This chapter presents summary of findings, conclusion and recommendations of the study in line with the objectives of the study. This Qualitative study was meant to examine and analyze the experiences of women in seeking support of men during the process of abortion and the post.

5.2 Discussion

The study found that Men have an influence on whether women seek safe or unsafe abortion; their actions, lack of action and anticipated actions negative and positive reflected broader gender inequities. Abandonment by men, and the desire to avoid disclosing pregnancy to men because of fear of their reactions or interference, were important influences on some women's decision to seek abortion. These thoughts are backed up by stand point theory that has been used to base this research because social norms impact on how men respond to pregnancy cases and how they choose to suffer support (Hardman 1990). Men's willingness to be part of the decision making process on safe aborting is not dependent on whether or not the men know about the pregnancy. However, a woman's abortion trajectory is highly influenced by the involvement of the man. Furthermore, men's actions, lack of action or anticipated actions have implications for the direction, complexity and timing of women's abortion-related care seeking, for both safe and unsafe abortions and PAC by HCP. Individual decision making by women reading safe abortion is highly influenced by their financial status. These findings are resonant with those of Hardman (1990), who found covariance between decisions about safe abortion and financial stability.

Along the same lines, the study identified a number of situations where men's absence influenced both whether women continued their pregnancy and whether abortion was pursued safely or unsafely. The absence is ultimately the results of male behaviors. The main causes were identified as either men's active rejection of paternity or the relationship, or by women choosing to exclude men because of fear of men's interference with the abortion decision making process or their reaction to the pregnancy, based on men's previous behavior. For instance, these quotes related to men rejecting pregnancy.

From the findings we can see that in some cases, the anticipated conflict is due to a woman's desire not to become pregnant. In such circumstances, the problem is mainly the anticipated disapproval of the pregnancy from both their social circles such as family and friends well as the man responsible. Such women fear punishment, including beatings, from male authority figures. This is even more complicated for younger, unmarried women, who are confronted with prospect of their fathers' or uncles' reactions to such a pregnancy. This fear is likely to influence their decision to terminate the pregnancy because keeping the pregnancy and abortion secret from these men was their paramount concern. Such women confide in their friends of both sexes. These findings are resonant with those of Strong (2022), who points out that women's decision about abortion in general and safe abortion in particular, are not only influenced by the expected reactions from their partners and social circles. For Strong (2022), an even more critical determinant is age. Accordingly, younger women abortion, whether or not it is safe, is a very open option, given the repercussions and backlash from society.

The influence of men's absence is a reflection of societal-level gender inequities which play out differently for women across ages and levels of wealth and education. Although age was not found to be a determent of whether women reported men's involvement in their abortion trajectory, the nature of men's noninvolvement seems to differ across age-groups. This is mainly reflected in the instances of partner rejection. It is also reflected in instances where men resort to violence in response to pregnancy, especially where younger women were involved. Freeman et al. (2017) also draws parallels between the decision making process and the age of the woman, pointing out that younger women are likely to procure an abortion whether safe or otherwise. The author also point out that the economic and social circumstances of the women also play a role.

The findings also point to situations where men also help in the decision making on whether or not the woman will procure an abortion. In such cases, boyfriends and husbands, as well as other men (male family members, friends and in-laws), actively participate in such decisions. These men are very influential in the women's lives, the reason why they are involved. They act as sounding boards and as facilitators to obtaining care by paying for an abortion, arranging it or accompanying a woman to obtain it. From the findings, the involvement of such men is frequently a positive influence on women's abortion decision making and care seeking. In many

cases, they help facilitate access to safe abortion. This resonates with the ideas of Freeman et al. (2017)

However, other women discussed men's positive influences on their abortion care seeking. In this setting of low awareness of the legality and availability of abortion, some men used their greater social and economic resources to facilitate safe abortion by providing information and paying for care, this is also backed up by stand point theory that speaks into social status of men and women highlighting that women are affected economically (Moore et al. 2011). this means that men stepped up to fill the financial need that was needed during care therefore validating the assumption that men affect women abortion trajectory.

Men's influences on women's abortion decision making and care seeking operate on different levels. At the structural level, men typically control the exercise of power political, economic and social and the institutions, laws and policies that govern access to abortion. This was highlighted by one of our key informants who elaborately spoke on reproductive policies that are also confusing to the health care workers. For example, in most countries, abortion law was written and is enforced by men, and reflects assumptions about their domination in male-female relations for some laws require spousal consent if the woman seeking abortion is married (e.g in Kuwait), while in some countries, such consent is frequently demanded even when not legally specified (e.g in India) (Harding 1986, 1991; Nicholson 1990).

When directly involved in women's abortion trajectories, men were most commonly providers of financial assistance for care seeking. However, in a context in which general awareness of the legality and availability of abortion is low and public information is scarce, men's ability to seek information about where safe abortion could be obtained was especially influential in determining how and if women obtained safe abortions.

In addition, the study found instances of gender equity in relationships that influenced trajectories to safe abortion. For some respondents, sex, pregnancy, the abortion decision and obtaining an abortion were shared concerns. This was mostly in private hospitals where women who were financially independent would seek the abortion and get better support from their male partner, this is in line with stand point theory talks of inter-sectionalities between people's status

i.e the rich and poor and factors influencing their participation in the society (Harding 1986, 1991; Nicholson 1990).

5.3 Conclusion

It is clear from this study and other studies elsewhere in Africa that a range of male actors is directly and indirectly involved in abortion decision making and care seeking. Therefore, increasing knowledge about the legality and availability of safe abortion is vital not only among sexually active women, but also among those they confide in, including men. Our research suggests that in addition to implementation of broader strategies to increase gender equity, there should be interventions to address unsafe abortion that are aimed at a much wider audience than women at risk of unwanted pregnancy (Dahlback 2010).

Knowledge about the legality and availability of safe abortion is vital for women seeking abortion and for the men and women in whom they confide. Future research might usefully consider how to best equip both women and men with knowledge about effective contraception and the availability of safe and legal abortion in their settings. Women and girls in poverty continue to have their abortion trajectories defined by others (Obiyan and Agunbiade, 2014). Men and boys, particularly male partners, can have a decisive influence on an abortion trajectory, from the decision to abort to the methods chosen, the safety of these methods and the experience of the abortion itself. Studies continue to focus predominantly on women and girls in order to better understand their experiences. The influence that men and boys are able to exert can directly and indirectly endanger women and girls, placing them at risk of self-managing in an unsafe way or accessing abortion services and methods that put them at greater risk of adverse outcomes, including death. Future sexual and reproductive health research should explore further the mechanisms, causes and intentions behind male involvement.

In conclusion, this study agrees that men and boy's involvement in women and girl's abortion trajectories are varied (Hirz et al. 2017; Macleod et al. 2013; Moore et al. 2011) it can be consensual or non-consensual, supportive or non-supportive, direct or indirect. Across studies, there remains the fundamental issue of women's ability to make her abortion decision autonomously, with third party input only when sought.

5.4 Recommendations

From the deductions of the study the following are the recommendations that were put forward;

- Awareness should be created to the community and Education concerning abortion and post abortion care, the legal side of abortion and the health consequences or the experiences after abortion so that the women are able to make more informed autonomous decisions. This will help to address the fear of disclosure and also for men once they are involved in making informed decisions it will help reduce the feelings of fear, guilt and shame.
- The government should make the process of obtaining abortion at least affordable for the cases where the law allows it, when the life of the mother is at risk and in the advice of an expert doctor, so that women do not have to depend largely on the men to make their decisions.
- The women need to understand the positive impact and influence that the men have when they are involved in the decision-making process. The understanding will help the women get over the fear for disclosure and they are able to get support from the men.

REFERENCES

Basu, A.M., ICPD (1996) What about men's rights and women's responsibilities*? Health Transition Review*. 6(2): 225-227.

Bearak, J., Popinchalk, A., Ganatra, B., Moller, A. B., Tunçalp, Ö., Beavin, C., ... & Alkema, L. (2020). Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *The Lancet Global Health*, *8*(9), e1152-e1161.

Chae S, Desai S, Crowell M, Sedgh G, Singh S (2017) Characteristics of women obtaining induced abortions in selected low- and middle-income countries. *PLoS ONE* 12(3): e0172976. https://doi.org/10.1371/journal.pone.0172976

Chibango V., Maharaj, P. (2018) Men‘s and women‘s roles in decision making about abortion in the context of HIV*, The European Journal of Contraception & Reproductive Health Care*, 23:6, 464-470, DOI: 10.1080/13625187.2018.1541078

Chikovore J, Lindmark G, Nystrom L, Mbizvo MT, Ahlberg BM (2002) The hide-and-seek game: men's perspectives on abortion and contraceptive use within marriage in a rural community in Zimbabwe. *J Biosoc Sci* 34(3):317-32

DeRose LF, Ezeh AC (2010) Decision-making patterns and contraceptive use: evidence from Uganda*. Population Research and Policy Review* 29(3):423-439

Dudgeon MR and Inhorn MC, Men's influences on women's reproductive health: medical anthropological perspectives, *Social Science & Medicine*, 2004, 59(7):1379–1395. 4

Freeman, Emily; Ernestina Coast and Susan F. Murray (2017). Men‘s Roles in Women‘s Abortion Trajectories in Urban Zambia, International *Perspectives on Sexual and Reproductive Health* 43 (2): 89 – 98.

Ganatra B et al. (2017) Global, regional, and sub-regional classification of abortions by safety, 2010-14*: estimates from a Bayesian hierarchical model.The Lancet* 390, 2372-2381. doi: 10.1016/S0140-6736(17)31794-4

Guttmacher Institute (2018) Fact Sheet*: Induced Abortion Worldwide*. Available at https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide. Accessed on 30 September 2019

Hameed S (2018) To be young, unmarried, rural, and female: intersections of sexual and reproductive health and rights in the Maldives*, Reproductive Health Matters*, 26:54, 6171, doi: 10.1080/09688080.2018.1542910

Heidi Bart Johnston 6, Leontine Alkema (2016a) Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *The Lancet* 388: 258-267. doi: 10.1016/S0140-6736(16)30380-4

Hirz, A.E., J.L. Avila, and J.D. Gipson, The role of men in induced abortion decision making in an urban area of the Philippines. *International Journal of Gynecology & Obstetrics*, 2017. 138: p. 267-271. https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0459- https://pubmed.ncbi.nlm.nih.gov/7371582/

Hursthouse, R. (1991). Virtue theory and abortion. *Philosophy & Public Affairs*, 223-246.

Izugbara C and Egesa C, The management of unwanted pregnancy among women in Nairobi, Kenya, *International Journal of Sexual Health*, 2014, 26(2):100–112.
J., I. Kwan, and K.S. Bird, *Postabortion family planning counseling and services for women in low-income countries: a systematic review*. Contraception, 2013. 87(1): p. 1725

John NA, Babalola S, Chipeta E (2015) *Sexual Pleasure, Partner Dynamics and Contraceptive Use in Malawi. Int Perspect Sex Reprod Health* 41(2):99-107 doi:10.1363/4109915

Kaye DK, (2006). Community perceptions and experiences of domestic violence and induced abortion in Wakiso district, Uganda, *Qualitative Health Research*, 16(8):1120–1128.

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, health & sexuality*, *11*(6), 625-639.

Kumi-Kyereme A, Gbagbo FY and Amo-Adjei J, (2012). Role-players in abortion decision-making in the Accra Metropolis, Ghana*, Reproductive Health*, 2014, 11(1):70.

Major, B., Appelbaum, M., Beckman, L., Dutton, M. A., Russo, N. F., & West, C. (2009). Abortion and mental health: Evaluating the evidence. *American Psychologist*, *64*(9), 863.

Mannheim, K. (1985). *Essays in Sociology and Social Psychology*. New York:, New York University Press.

Mohamed, S. F., Izugbara, C., Moore, A. M., Mutua, M., Kimani-Murage, E. W., Ziraba, A. K., ... & Egesa, C. (2015). The estimated incidence of induced abortion in Kenya: a cross-sectional study. *BMC pregnancy and childbirth*, *15*, 1-10.

Moore, A.M., G. Jagwe-Wadda, and A. Bankole, (2011). Men's attitudes about abortion in Uganda. *Journal of Biosocial Science,* 43: p. 31-45.

Obiyan, M.O. and O.M. Agunbiade, (2014). Paradox of parental involvement in sexual health and induced abortions among in-school female adolescents in Southwest Nigeria. Sexuality & Culture*: An Interdisciplinary Quarterly*, 2014. 18: p. 847-869.

Rogers, C. and J.A.R. Dantas, (2017). Access to contraception and sexual and reproductive health information post-abortion: A systematic review of literature from low- and middleincome countries. *J Fam Plann Reprod Health Care*, 2017. 43(4): p. 309-318.

Rosenwasser, Shirley Miller; Loyd S.Wright and R. Bruce BarberThe rights and responsibilities of men in abortion situations (1987). *The Journal of Sex Research*Vol. 23, No. 1 (Feb., 1987), pp. 97-105 (9 pages)

Schwandt Hilary M 1, Andreea A Creanga, Richard M K Adanu, Kwabena A Danso, Tsiri Agbenyega, Michelle J Hindin (2013)Pathways to unsafe abortion in Ghana: the role of male partners, women and health care providers, *Contraception*, 2013, 88(4):509–517.

Sedgh , Gilda; Jonathan Bearak , Susheela Singh Akinrinola Bankole , Anna Popinchalk , Bela Ganatra , Clémentine Rossier , Caitlin Gerdts , Özge Tunçalp, Brooke Ronald Johnson Jr, Sedgh, G., Singh, S., Shah, I. H., Åhman, E., Henshaw, S. K., & Bankole, A. (2012). Induced abortion: incidence and trends worldwide from 1995 to 2008. *The lancet*, *379*(9816), 625-632.

Shearer, J.C., D.G. Walker, and M. Vlassoff, (2010). Costs of post-abortion care in low- and middle-income countries. *Int J Gynaecol Obstet*, 108(2): p. 165-9.

Singh, Susheela, Lisa Remez, Gilda Sedgh, Lorraine Kwok and Tsuyoshi Onda. (2018) *Abortion worldwide 2017: Uneven progress and unequal access,* New York: Guttmacher Institute

Srivastava, A., Saxena, M., Percher, J., & Diamond-Smith, N. (2019). Pathways to seeking medication abortion care: A qualitative research in Uttar Pradesh, India. *PloS one*, *14*(5), e0216738. doi:10.1371/journal.pone.0216738

Strong J. Men's (2022). Involvement in women's abortion-related care: a scoping review of evidence from low- and middle-income countries. Sex Reprod Health Matters. 2022 Dec;30 (1):2040774. doi: 10.1080/26410397.2022.2040774. PMID: 35323104; PMCID: PMC8956302.

Sully, E., Dibaba, Y., Fetters, T., Blades, N., Bankole, A. (2018) Playing it Safe: Legal and Clandestine Abortions Among Adolescents in Ethiopia. *Jounral of Adolescent Health* 62(6), 729-736. Tripney,

World Bank (2009) *World Development Report 2009: Reshaping Economic Geography*. The World Bank, Washington, DC.GoogleScholar

World Health Organization (2007b) *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2003*. WHO, Geneva.GoogleScholar

APPENDIX 1 CONSENT FORMS

Ethics & Scientific Review Committee

Informed Consent Form (in depth & Case studies)

[This ICF should only be used for those who have attained the age of majority, 18 years]

Study Title	Experiences of women in male support during, and after post abortion care in Kenyatta Hospital and Nairobi Women's Hospital
Investigator(s)	Faith Opiyo 0723471290
Study Sponsor(s)	
Collaborators	

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Good morning/afternoon, my name is Faith Opiyo, an MA student in Gender and Development Studies at the University of Nairobi. I am carrying out a study on the role men play in abortion decision making process and post abortion care. You have been selected as a participant in this study by virtue of being a patient in one of our study site (KNH or Nairobi Women's Hospital). I want to assure you that all of your answers will be kept strictly confidential. To this extent, I will not keep a record of your name or address. There is no right or wrong answer in this study.

Your personal identity will remain confidential and will not be put in the public domain.

Who can participate?

Women of reproductive age between 18-49 years of age who have gone through post abortion care in Kenyatta Hospital and Nairobi Women Hospital.

Voluntary participation

Participation in this interview is voluntary and you can stop the interview at any point. Your feedback to this interview will help in programming of male engagement interventions in Sexual Reproductive Health and Rights (SRHR)

What is involved in this project?

The study involves answering questions by the interviewer, there will be recording if need be but this will be highly confidential as your name will not be used during transcription. The questions will take a maximum of one hour and feel free to ask any question and withdraw the consent in the middle of the interview.

How long will the project last?
This study takes place over two months in two hospitals.

What are the risks?
There are personal questions that may be difficult to answer or raise emotions kindly feel free to withdraw from the interview if you feel uncomfortable.

What are the benefits?
There will be no benefit from the interview.

How will we protect your information and maintain confidentiality?
The data gathered from the interview will be confidential, actual names will not be used and the recordings will be stored in a safe and secure place.

What will happen with the results
The results will be used by different organizations having interventions on male engagement in reproductive health but this will be after publication from the University of Nairobi where the data will be first shared.

Can I refuse to participate or withdraw from the study?
If in any case you feel uncomfortable with the questions kindly feel free to withdraw from the interview because this information is voluntary.

Compensation
There will be no compensation during this study.

Who can I contact?
If you have any questions, you can ask the interviewer now or later through,

Faith Opiyo
P.O Box 70014-00100
Cell: 0723471290
Email: faithopi05@gmail.com

OR

Ethics and Scientific Review Committee (ESRC)
Amref Health Africa in Kenya
P.O. Box 30125 - 00100
Nairobi, Kenya

Telephone: 254795746777
Email: esrc.kenya@amref.org

Do you have any questions at this time?

Ethics & Scientific Review Committee

Informed Consent Form KII

[This ICF should only be used for those who have attained the age of majority, 18 years]

Study Title	Experiences of women in male support during, and after post abortion care in Kenyatta Hospital and Nairobi Women's Hospital
Investigator(s)	Faith Opiyo 0723471290
Study Sponsor(s)	
Collaborators	

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Good morning/afternoon, my name is Faith Opiyo, an MA student in Gender and Development Studies at the University of Nairobi. I am carrying out a study on the role men play in abortion decision making process and post abortion care. You have been selected as a participant in this study by virtue of being a patient in one of our study site (KNH or Nairobi Women's Hospital). I want to assure you that all of your answers will be kept strictly confidential. To this extent, I will not keep a record of your name or address. There is no right or wrong answer in this study.

Your personal identity will remain confidential and will not be put in the public domain.

Who can participate?

Service providers who work in the hospital as nurses, doctors and specialists like counsellors.

Voluntary participation

Participation in this interview is voluntary and you can stop the interview at any point. Your feedback to this interview will help in programming of male engagement interventions in Sexual Reproductive Health and Rights (SRHR)

What is involved in this project?

The study involves answering questions by the interviewer, there will be recording if need be but this will be highly confidential as your name will not be used during transcription. The questions will take a maximum of one hour and feel free to ask any question and withdraw the consent in the middle of the interview.

How long will the project last?
This study takes place over two months in two hospitals.

What are the risks?
There are personal questions that may be difficult to answer or raise emotions kindly feel free to withdraw from the interview if you feel uncomfortable.

What are the benefits?
There will be no benefit from the interview.

How will we protect your information and maintain confidentiality?
The data gathered from the interview will be confidential, actual names will not be used and the recordings will be stored in a safe and secure place.

What will happen with the results
The results will be shared by the university of Nairobi and later on published so that organizations working on male engagement can get the outcome of the study

Can I refuse to participate or withdraw from the study?
If in any case you feel uncomfortable with the questions kindly feel free to withdraw from the interview because this information is voluntary.

Compensation
There will be no compensation during this study.

Who can I contact?
If you have any questions, you can ask the interviewer now or later through,
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Ethics and Scientific Review Committee (ESRC)
Amref Health Africa in Kenya
P.O. Box 30125 – 00100
Nairobi, Kenya
Telephone: 25479574677
Email: esrc.kenya@amref.org

APPENDIX 2: SEMI STRUCTURED INTERVIEW GUIDE

SEMI STRUCTURED INTERVIEW GUIDE

Age:
Marital Status:
Employment:

I am going to ask you your experience in making decision to do abortion

Possible probes

How did you arrive at the decision of carrying out a termination? Were you aware of abortion procedures and laws? Did you know of any modes of doing abortion? What motivated you to come to the specific facility you procured abortion? Did you confide in anyone and what was their reaction?

I am now going to discuss with you some of the role men in your life have played in this process.

Possible Probes

When you realized you were pregnant did you inform your partner, brother, father uncle etc (male) what was their reaction? What kind of support did the male figure give you from the time you disclosed your pregnancy to the time you decided to terminate pregnancy? Do you think abortion should be left for the woman or both partners should discuss?

What do you think are the barriers that influences male support in women abortion trajectories.

I am now going to discuss with you some of the experiences after post abortion care

Possible Probes

How can you describe the support you received from your partner/ male figure after PAC to aid in your recovery?

Was the support for PAC any different from the time you mentioned/agreed together to procure abortion?

What was the reaction of HCP towards your partner/male figure

Any recommendations on how men can be engaged better in SRHR decisions including abortion?

Any recommendations on how PAC can be improved?

APPENDIX 3: CASE NARRATIVE INTERVIEW GUIDE

Thank you for agreeing to discuss this subject further, more detailed information will enrich the study. Kindly describe to me your first experience and further experiences in seeking for abortion services and elaborate whether you received male support in all the instances. As a follow up question, what challenges do you think men face in supporting women abortion trajectories.

APPENDIX 4: KEY INFORMANT INTERVIEW GUIDE

(Nurse or Doctor)

i. How often do women and girls present cases of safe abortion
ii. How often do you treat PAC cases from outside the hospital?
iii. In cases of safe abortion how often do you engage male partner and to what extent?
iv. What are some of the roles that men should play in decision making process of SRHR including abortion?
v. Do you advise on contraceptives immediately after PAC and how are men engaged in this topic?
vi. What are the facilities-based barriers at the health centers that may discourage men to support women and girls to come for PAC services as out patients?
vii. What recommendation will you give to engage men more in SRHR issues including abortion?

APPENDIX 5: RESEARCH CLEARANCE

amref health africa

Amref Health Africa in Kenya

REF: AMREF – ESRC P1239/2022 **March 29, 2023**

Faith Opiyo
The University of Nairobi
P.O Box 30197-00100
Nairobi, Kenya
Tel: +254723471290
Email: faithopi05@gmail.com

Dear Faith Opiyo,

RESEARCH PROTOCOL: EXPERIENCES OF WOMEN IN MALE SUPPORT DURING, AND AFTER POST ABORTION CARE IN KENYATTA HOSPITAL AND NAIROBI WOMEN'S HOSPITAL

Thank you for submitting your protocol to the Amref Ethics and Scientific Review Committee (ESRC).

This is to inform you that the ESRC has reviewed and approved your protocol. Your application approval number is ESRC P1239/2022. The approval period is from March 29, 2023, to March 28, 2024, and is subject to compliance with the following requirements:

a) Only approved documents (including informed consents, study instruments, advertising materials, material transfer agreements, etc.) will be used.
b) All changes including (amendments, deviations, violations, etc.) are submitted for review and approval by Amref ESRC before implementation.
c) Death and life-threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the Amref ESRC within 72 hours of notification.
d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to Amref ESRC within 72 hours.
e) Clearance for export of biological specimen must be obtained from the relevant government authorities for each batch of shipment/export.
f) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
g) In case of late renewal, the Amref ESRC shall not be held responsible for any serious adverse events (SAEs) that may occur as a result of research activities that were carried out after the expiry of approval.
h) Submission of an executive summary report within 90 days upon completion of the study to the Amref ESRC.
i) All government regulations for prevention and control of the spread of COVID-19 including social distancing, provision of personal protective equipment for participants and research assistants should be adhered to during data collection. All research assistants should be monitored for COVID 19 symptoms and referred for testing in case they present with symptoms.

Board Members: **Mr J Kimeu | Mr G Macharia | Ms M Githinji | Ms E Munyoki | Mrs M Kinoti | Dr D Soti | Dr G Gitahi**

P. O. Box 30125-00100 Nairobi, Tel: +254 (0)20 699 4000, Fax: +254 (0)20 699 2531. www.amref.org

Winner of the Gates Award for Global Health
BILL & MELINDA GATES FOUNDATION

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://research-portal.nacosti.go.ke and also obtain other clearances needed.

Please do not hesitate to contact the ESRC Secretariat (esrc.kenya@amref.org) for any clarification or query.

Yours sincerely

AMREF - ESRC
29 MAR 2023
P.O. BOX 30125-00100, NAIROBI

Prof. Mohamed Karama
Chair, Amref ESRC
CC: Samuel Muhula, Senior Manager, Learning and Impact, Amref Health Africa.

Board Members: **Mr J Kimeu | Mr G Macharia | Ms M Githinji | Ms E Munyoki | Mrs M Kinoti | Dr D Soti | Dr G Gitahi**

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UNIVERSITY OF NAIROBI

FACULTY OF ARTS AND SOCIAL SCIENCES

DEPARTMENT OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES

Telephone: +254-020-3742080/78
Email: iagas@uonbi.ac.ke
Website: african-studies.uonbi.ac.ke

P.O. Box 30197-00100 GPO
NAIROBI, KENYA

REF: UON/CHSS/IAGAS/7/9

October 18, 2022

TO THE ETHICAL REVIEW COMMITTEE,
AMREF HEALTH AFRICA
NAIROBI

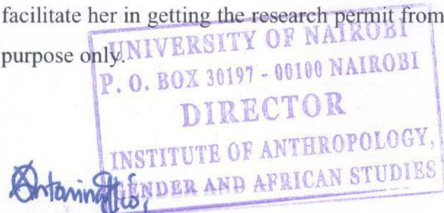
Dear Sir/Madam,

RE: Ms. FAITH OPIYO: N69/36759/2020.

This is to confirm that the above named is a Masters of Arts in (Gender and Development Studies) student at the Department of Anthropology, Gender and African Studies, University of Nairobi.

The student has completed coursework and is currently working on her research project entitled: " **Experiences Of Women In Male Support During, And After Post Abortion Care In Kenyatta Hospital And Nairobi Women's Hospital".** She will require data for the project to be satisfactorily completed.

She is expected to carry out her research from October to November, 2022. We would like to request you to facilitate her in getting the research permit from your Institution. The research being undertaken is academic purpose only.



Antonina Odock
Senior Administrative Assistant
Department of Anthropology, Gender and African Studies