

**FACTORS INFLUENCING MALE INVOLVEMENT ON SAFE
ABORTION: A CASE OF MALE INVOLVEMENT ON SAFE
ABORTION PROGRAM IN KISUMU MEDICAL & EDUCATION
TRUST**

**BY
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**A Research Project Report Submitted in Partial Fulfillment of the
Requirements for the Award of Degree of Masters of Arts in Project Planning
and Management of the University of Nairobi**

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DECLARATION

This research project is my own original work and has not been presented for award of any degree or any other examination body in any university or college.

Sign:.....

Date:.....

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L50/69378/2013

This research project has been submitted for examination with my approval as the supervisor.

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DEDICATION

This work is dedicated to loving wife Serah Nyokabi Kimaru

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ABBREVIATION AND ACRONYMS

KDHS	Kenya Demographic and Health Survey
MISA	Male Involvement in Safe Abortion
MVA	Manual Vacuum Aspiration
USA	United States of America
WHO	World Health Organization

ABSTRACT

Safe abortion is often treated exclusively as a women's health issue. Most of the research on the topic deals with the female party involved in an unwanted pregnancy. This is in part because, the women's perspective is more important, as it's ultimately her body and her choice, but also because the female party involved in the abortion is the patient seeking medical intervention. The role male partners play in women's reproductive health takes place directly and indirectly, biologically and socially. This study examined the influence of male involvement programmes on safe abortion a case of MISA. The MISA project is a program that seeks to promote safe abortion access by: educating men on prevention of unsafe abortion, building providers' capacity on male-friendly RH service provision, and enhancing pro-choice organizations' capacities to influence provision of safe abortion within the reviewed 2010 constitution. The study looked at the following variables; examined how awareness of safe abortion programs influences male involvement programmes on safe abortion; examined how perceptions of abortion influences male involvement programmes on safe abortion; investigated whether cultural beliefs influences male involvement programmes on safe abortion; examined whether costs influences male involvement programmes on safe abortion. The study reviewed related literature and the theories related to the study and also identified a conceptual framework. The study used a descriptive survey design to yield quantitative and qualitative data. The target population for this study was the male champions of MISA program in Kisumu Medical & Education Trust. A sample of 35 respondents was picked using simple stratified random sampling techniques from 132 male champions of MISA program in Kisumu Medical & Education Trust. The data for this research was collected using a survey questionnaire. The study collected both primary and secondary data. Collected data was sorted and edited for completeness and consistency, checked for errors and omissions and then coded to SPSS and analyzed qualitatively and quantitatively. The study found that there was adequate awareness of male involvement in safe abortion and its importance among men in Kisumu County. The program creates awareness through several programs and seminar is the one that is mainly used. The level of community perceptions of Male Involvement in Safe Abortion is low. The study found that cultural beliefs affect men involvement is safe abortion. High costs of procuring a safe abortion has been a barrier for men to be involved in safe abortion.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Abortion is the termination of a pregnancy after, accompanied by, resulting in, or closely followed by the death of the embryo or fetus: or a spontaneous or induced expulsion of a human fetus during the first 12 weeks of gestation. However, the nebulous nature of 'abortion' has given rise to several definitions of the term across a wide range of health-related disciplines. Still, the central point made by majority of the definitions on abortion is the fact that the pregnancy is not wanted. Unwanted pregnancies and abortion have existed since time immemorial. The influential work of Devereux (2010) on the history of abortion around the world points to the frequency of abortion across cultures and time. Specifically, he points out that Chinese, Greek and Roman cultures all developed systems of dealing with unwanted pregnancies and regulating population growth in their respective societies. Also the Egyptians were the first to create abortion techniques, which were discussed and reported in some of their first, and the oldest medical texts (Goodman, Sackett, & Vasilver, 2008).

Of the estimated 21.9 million safe abortions carried out in 2003, more than two-thirds (15.8 million) took place in the less developed world, predominantly in Asia. Together, Eastern Asia and South Central Asia accounted for more than half of safe abortions, largely because of China (8.8 million safe abortions) and India (2.4 million). Elsewhere in Asia, 2.1 million safe abortions occurred in the Southeast region (primarily in Vietnam, Cambodia and Singapore); the former Soviet republics of Central Asia contributed 0.9 million; and an estimated 0.8 million occurred in Western Asia (mainly in Israel, Turkey, Armenia, Azerbaijan, Georgia). Safe abortions in

Tunisia, South Africa, Cuba and a number of other smaller countries also contributed to the developing country total. The remaining 6.1 million safe abortions took place in the developed world: 3.9 million in Europe, 1.5 million in the United States and Canada, and an estimated 600,000 in Japan, Australia and New Zealand (Centre for Reproductive Rights 2008).

When performed by properly trained doctors and nurses using modern methods in hygienic conditions, induced abortion is a very safe medical procedure, which explains why virtually no maternal deaths in the developed world are due to abortion. The health rationale for legalizing abortion has been demonstrable for many years. In Romania, the criminalization of abortion in 1966 led to a soaring maternal death rate that remained high until the procedure was again made legal in 1990, after which the rate dropped. Maternal mortality also declined in South Africa following legalization of the procedure in 1996: Deaths due to unsafe abortion decreased by an estimated 91% between 1994 and 1998–2001 (Centre for Reproductive Rights 2008). The severity of health complications associated with unsafe abortion declined in South Africa as well, possibly because of increased use of medication abortion and manual vacuum aspiration (MVA). It is also likely that as safe abortion services became available, post-abortion services improved; this would have reduced the death rate among women with complications that required treatment. In countries where abortion is broadly legal, provider systems vary widely. In developed countries with national health systems, pregnancy termination is often part of the basic services available. In England and Wales, 87% of abortions carried out in 2006 were funded by the National Health Service 39% in public hospitals and 48% in private facilities under contract to the government.⁷⁰ In Spain, almost all abortions are performed in private clinics, which receive reimbursements from the state. In Sweden, pregnancy termination up to 18

weeks' gestation is free. In the United States, which has no national health service, pregnancy terminations are performed in specialized abortion clinics, other clinics, hospitals and private doctors' offices; most of these are private-sector facilities. In China, where most pregnancy terminations are carried out using MVA and medication abortion, public-sector facilities provide free abortions in rural areas, but in urban areas some women pay for them. In India, all legal abortions must in principle be performed in facilities registered with and approved by the government (Centre for Reproductive Rights 2008).

In Kenya, until the new constitution came to being on 27th of August 2010, termination of pregnancy was allowed to save the life of the mother (Ogutu, 2001). The new constitution allows abortion in cases of emergency, to save life and to protect health of the woman or as may be allowed by any other law. The Kenya Medical Practitioners and Dentists Board, under the old constitution, stipulated that abortions could only be done by a medical practitioner after consultation with two senior colleagues. The current constitution requires a single trained health professional to take the decision. The Ministry of Health will be developing further guidelines on provision of abortion services based on the new constitution.

In Kenya, unsafe abortion has long been recognized as a leading cause of maternal morbidity and mortality. Unintended pregnancy is a major contributor to unsafe abortions in Kenya and in most of Africa. In Kenya, the prevalence of unintended pregnancy remains high. The 2008–09 Kenya Demographic and Health Survey (KDHS) showed that 43% of births in the preceding five years were reported by women as unwanted or mistimed. Many women in Kenya fear the side effects of contraceptives and cannot afford family planning products and services. Facilities where

family planning products and services are subsidized or provided free of charge regularly experience stock outs or a dearth of qualified providers. Stigma, inadequate information on sexuality and cultural pressure also hinder contraceptive use among women and girls. A 2002 study on the magnitude of abortion complications in Kenya found that about 20,000 women annually sought medical care for abortion-related complications in public sector hospitals alone. The treatment of abortion complications uses a large amount of scarce health systems resources. Incomplete abortions also account for a large proportion of gynecological admissions in public health facilities. The need for updated information on the abortion situation in Kenya was an important impetus for the current study (Ogutu, 2001).

In 2010, Kenya adopted a new constitution that explicitly permits abortion when there is need, in the opinion of a trained health professional, for emergency treatment; if the life or health of the woman is in danger; or if it is permitted under any other written law. Previously, abortion was only permitted to protect a woman's life. To date, it is unclear how widely the new legal status of abortion is understood or being implemented. Sections of the Kenyan penal code have not been revised to reflect the language in the new constitution; thus, many medical providers may be reluctant to perform abortions for any reason for fear of legal consequences (Koster 1998).

The role male partners play in women's reproductive health takes place directly and indirectly, biologically and socially (Dudgeon & Inhorn, 2004). In relation to abortion, for example, in some countries women even need their husband's permission to have an abortion (Gürsoy, 1996). The relationship that the man has with the woman, i.e. whether the woman is his wife, mistress or girlfriend, most likely influences his involvement as well as his desires regarding

how to manage her reproductive health (Rausch & Lyaruu, 2005). Whereas expectations about childbearing within marriage may lead a man to support his wife to carry a pregnancy to term, a man might encourage a girlfriend abort since social sanctions might be brought to bear on them for having a child out of wedlock.

Men play a critical role in reproductive decision-making in sub-Saharan Africa (Fayorsey, 1989; Mbizvo & Adamchak, 1999). In the minimal work which has been done with men on abortion in Africa, research has identified men's opposition to abortion spanning the continent. A recent qualitative exploration of men's attitudes and involvement in abortion in Burkina Faso found that men do not want women to have abortions. As a consequence, women have them secretly so as to minimize difficulties that could accompany telling the man about the abortion (Rossier, 2007). Qualitative data collected with men in Zimbabwe found that men viewed abortion as a sign of illicit sexual activity (Chikovore et al., 2002). These authors framed men's attitudes towards abortion within men's attitudes towards control over women and concluded that men felt anxious and vulnerable regarding their role in society due to shifting gender roles and greater rights accorded to women. Abortion, as a concrete manifestation of the shift towards smaller families and greater female autonomy, is the site of a great deal of social tension. One of the reasons women said they did not disclose their abortion intentions or experiences to their male partners was because they feared violence (Chikovore et al., 2002).

Men in Kenya are condemnatory toward abortion, viewing it as women's strategy for concealing deviation from culturally acceptable gender/motherhood standards. In Nyanza Kenya, gender norms affect male involvement in RH and safe abortion. Given the restrictive legal environment,

the MISA project sought to promote safe abortion access by: educating men on prevention of unsafe abortion, building providers' capacity on male-friendly RH service provision, and enhancing pro-choice organizations' capacities to influence provision of safe abortion within the reviewed 2010 constitution

1.2 Statement of the Problem

Studies investigating men in abortion situations are extremely rare. Most studies of legal abortion are focused on the women and when abortion and contraception are discussed, attention is mostly centered on the role and responsibility of the woman. Hospital staff often meets only the woman and not the man in cases of legal abortion, which can result in the risk of abortion being regarded solely as a female issue. Thus, the participation of the man remains largely invisible. However, many women have stated that they are influenced in their decision about abortion by the man and one of the most frequently stated reasons for terminating a pregnancy is related to the partner (Torres and Darroch Forrest, 1988; Skjeldestad, 1994)

Many of the safe abortions carried out occur in established relationships (Törnbohm, Ingelhammar, Lilja, Johansson, Nguyen, and Tran, 1994). One of very few studies carried out in Western countries that included both women and men showed that the majority of those who had legal abortion had good socio-economic positions and were in relatively established relationships. Many couples had no children but the majority planned to have children in the future. Nevertheless, many women felt alone when making the decision to have an abortion and they also had to take responsibility for contraception (Jacobsson, Lalos, and von Schoultz, 1980). Other studies including only women also show that many women make the

decision to have a legal abortion more or less on their own (Holmgren, 1988). In contrast, another study of both women and men concluded that few women seemed to be alone in their decision (Graff-Iversen and Kristoffersen, 1990). Furthermore, a study on 60 men who accompanied their partners to the hospital showed that the men considered themselves responsible, along with the partners, for preventing unwanted pregnancies and choosing abortion (Rothstein, 1977). However, abortion studies usually ignore the involvement of the man or examine it only indirectly, that is women are asked about how they regard their partners' attitude and participation and how they are influenced by them. Therefore, roles and reactions of men in connection with unwanted pregnancy and legal abortion remain a virtually unexplored and neglected field. Therefore this study examined the influence of male involvement programmes on safe abortion.

1.3 Purpose of the study

The main purpose of this study is to examine the factors influencing male involvement on safe abortion. A case study of Male Involvement in Safe Abortion (MISA) Program in Kisumu Medical & Education Trust

1.4 Objective of the study

1. To examine how community awareness of Male Involvement in Safe Abortion (MISA) influence safe abortion in Kisumu Region.
2. To investigate the influence of community perceptions of Male Involvement in Safe Abortion (MISA) on safe abortion in Kisumu Region.

3. To examine how cultural beliefs are influenced by Male Involvement in Safe Abortion (MISA) and in turn safe abortion in Kisumu Region.
4. To examine how financial resources of Male Involvement in Safe Abortion (MISA) influences safe abortion in Kisumu Region

1.5 Research Questions

1. How does community awareness of Male Involvement in Safe Abortion (MISA) influence safe abortion in Kisumu Region?
2. What is the influence of community perceptions of Male Involvement in Safe Abortion (MISA) on safe abortion in Kisumu Region?
3. How does Male Involvement in Safe Abortion (MISA) influence cultural beliefs and in turn safe abortion in Kisumu Region?
4. How does financial resources of Male Involvement in Safe Abortion (MISA) influences safe abortion in Kisumu Region?

1.6 Significance of the study

It is hoped that the findings of the study would be important to the practitioners and academicians both in contributing to the existing body of knowledge in the area of male involvement programmes on safe abortion.

The study is expected to give a clear understanding of the influence of male involvement programmes on safe abortion and is important for the counties and country's population policy and safe abortion programs. Other beneficiaries are the stake holders in the safe abortion programs such as male, females and children due to improved safe abortion strategies and

policies. It would provide policy makers, planners and program managers with the information required for strengthening safe abortion programs.

1.7 Limitation of the study

According to Best and Kahn (1998), limitations are conditions beyond the control of the Researcher that may place restrictions on the conclusions of the study and their application to other situations. Time and resources were the main limitation since the researcher did not seek funding from external source, and therefore used personal resources. The data that to be collected is quite confidential but the researcher is in need of it to draw conclusions. Thus, in this particular case there was no way the researcher would avoid handling sensitive data. However, the collected data was only used for intended purpose and the researcher observed research ethics throughout the research.

1.8 Delimitation of the Study

The study was delimited to the MISA project sought to promote safe abortion access at Kisumu Medical & Education Trust.

The study was only concerned with the influence of male involvement programmes on safe abortion. This emanates from community awareness, community perceptions, cultural beliefs and financial resources of Male Involvement in Safe Abortion (MISA) influences safe abortion in Kisumu Region. This all entail execution, management and relation in the project which is the basis for the successful implementation of the project.

1.9 Basic Assumptions of the Study

Mugenda and Mugenda (2003) Defines assumptions as any fact assumed to be true but not actually verified. This research was guided by the following assumptions:

- i. That the respondents were honest and truthful when answering the questions.
- ii. The sample was a representative of the whole population

1.10 Definition of Significant terms used in the Study

For the purpose of this study the following terms were used in the given context.

Abortion: termination of pregnancy before the foetus is able to survive outside the uterus.

Community awareness: Being aware of issues pertaining the community and working in a way to address them and educating the community so that they can also know and assist in addressing them

Community perception: The process by which people translate sensory impressions into a coherent and unified view of the world around them. Though necessarily based on incomplete and unverified (or unreliable) information, perception is equated with reality for most practical purposes and guides human behavior in general.

Cultural beliefs: are the established beliefs, values, traditions, laws and languages of a nation or society. These factors also include the artistic values, marriage customs and religious beliefs that are indigenous to a particular region.

Financial Resources - Is the mobilization and allocation of funds to various activities of a program.

Knowledge: Knowledge is the fact or condition of knowing something with familiarity gained through experience or association (Merriam Webster online Dictionary). It is the familiarity with someone or something, which can include facts, information, descriptions, or skills acquired through experience or education. It can also refer to the theoretical or practical understanding of a subject.

Safe Abortion: This is the termination of pregnancy by a skilled health provider either surgically through aspiration or medical through administering of tablets in an environment with required medical standards.

Unsafe Abortion: It is defined by WHO as any procedure to terminate an unintended pregnancy either by people lacking necessary skills or in an environment that does not conform to minimal medical standards or both.

1.11 Organization of the Study

Chapter one of the study contained introduction, giving a background of the study while putting the topic of study in perspective. It gives the statement of the problem and the purpose of study. This chapter outlined the objectives, limitations, delimitations and the assumptions of the study. Chapter two gives scholars' work on the influence of male involvement programmes on safe abortion. This chapter also contains literature reviewed based on the objectives, a conceptual framework is drawn and theoretical framework that guides the study has been identified in this chapter. Chapter three consisted of research methodology which was used in the study. It

covered the research design, target population, sample design, data collection, validity and reliability of data collection instruments, data analysis techniques, and ethical considerations. Chapter four will deal with data analysis and interpretation. Chapter five presented the summary of the study, conclusion and recommendations of the study and suggest areas for further research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter critically analyses by objectives, some of the factors that influence men's involvement in programmes on safe abortion. The literature outlines what has been done by others in this area and then identifies some knowledge gaps as far as male involvement in programmes on safe abortion is concerned. It utilizes the literature from these previous studies to generate theoretical and operational frameworks that forms the basis of this study.

2.2 Prevalence of Safe Abortion

The termination of pregnancy (abortion) is a universal phenomenon occurring in all levels of societies. Abortion is defined as the discarding by the uterus of the product of conception before the 24th week of gestation. (WHO, 2010) The abortionists consist mainly of health workers or sometimes quacks. Places where abortions are conducted are numerous, including health facilities, hospitals, health centres, dispensaries, ordinary bedrooms, and occasionally in a simple room. Induced abortion is either safe abortion or unsafe abortion.

Safe abortion is the termination of pregnancy by a skilled health care provider with proper equipments and in an environment with required medical standards. In countries where women have access to safe services, their likelihood of dying from complications of unsafe abortion is very minimal. In developing countries, the risk of death following complications of unsafe abortion procedures is several hundred times higher than that of an abortion performed professionally under safe conditions (WHO, 2010)

According to the *Choice on Termination of Pregnancy Amendment Act*, of the Republic of South Africa (2004), a medical practitioner or a midwife who has undergone training on termination of pregnancy is qualified to provide abortion services. A study carried out by Dickson-Tetteh (2000) in twenty seven health facilities in South Africa to evaluate provision of abortion services by midwives following the implementation of the Act concluded that midwives could provide quality abortion services in the absence of physicians.

According to WHO (2008), most developed countries still require that gynaecologists carry out abortions, yet this is not necessary, particularly for abortions performed under 14 weeks of pregnancy, given that the skills needed have been greatly simplified and that the rate of complications is low. As such, WHO recommends that with appropriate training, nurse–midwives or those with comparable training would be the most appropriate abortion providers.

According to Hyman and Castleman (2005), training on abortion should include reproductive rights; community linkages; abortion pain management and medication abortion. It should also include patient assessment, uterine evacuation procedures, management of complications, contraceptive counseling and infection prevention.

The National Abortion Federation, USA, (2007) has developed a curriculum for training physician assistants and nurses on abortion care. The curriculum covers topics on pregnancy verification and estimation; counseling and informed consent; selection of appropriate uterine evacuation procedure; medication abortion; screening for medical conditions, pain management; and treatment of complications. Other topics include post-abortion follow-up and evaluation.

The WHO Technical and Policy Guidance on abortion (2003) has listed topics of importance in abortion care. These are not very different from the other curricula already highlighted and include: exposition on unsafe abortion as a public health problem; all aspects of clinical evaluation for a patient asking for abortion history, clinical examination, laboratory tests; infection prevention; uterine evacuation methods; and pain management. Other topics covered include: how to set up clinical services; creating an enabling environment for abortion services; and monitoring and evaluating abortion services. Legal and policy considerations, which are country dependent, are also included in the guidance document.

In Kenya the current legal dispensation on abortion allows trained health professionals - nurses, midwives or other mid-level professionals as well as doctors to provide abortion. In addition to these basic professional qualifications, they need to have undergone a specific training in abortion care. Many curricula exist for training in abortion but the Ministry of Health is yet to come up with a Kenyan specific curriculum

2.3 Male Involvement in Safe Abortion

Men play a significant role in procreation and should therefore not be excluded from issues of reproduction. Discourses that acknowledge the role that men can play in issues of reproduction and abortion need to be produced in order to alter some of the longstanding normative stereotypical ideas surrounding what it means to be a man. This is more so important in contemporary times as gender role definitions are transforming with changing times. Men are affected by abortion in terms of their personal emotional processes as well as what they envision

their partners to be going through during the procedure. Shostak (2008) reported that in a study conducted in 1999-2000, the results indicated that many men would have liked the opportunity to accompany their partners in the procedure room, to be there for them in the recovery room as well as the opportunity for counselling with their partners. Men experience feelings of guilt because they feel responsible for putting their partner through the traumatic experience. The guilt is further exacerbated by not being able to support their partners through the procedure.

Excluding men from the process and experience of abortion does not only pose a problem for the man, but also for the relationship. According to Shostak and McLouth in Myburgh et al. (2001), a pregnancy that isn't expected or wanted is both an individual crisis and a crisis for the relationship between the man and the woman". When excluded or neglected from the decision-making process and the abortion experience itself, men may detach from the experience and the relationship. This in turn could lead to the man being emotionally unavailable and unsupportive to the woman.

An unexpected pregnancy perturbs the dynamics of the relationship, and having to make the decision regarding whether or not to abort, aggravates the situation. According to Boyle (1997) men are central to abortion with regards to their role in making the decision as well as in the support they can give to their partners. How the woman copes with the abortion is often affected by how the man handles the abortion. This further indicates the importance of involving men in the abortion discussion and acknowledging their feelings on the abortion experience.

Men's decision regarding abortion is informed, among other factors, by their own desire to be fathers or rather to take on the identity of father (and its accompanying responsibilities)" (Reich, 2008: 10). Although the pregnancy is an affirmation of their virility, men find themselves in a position of considering whether they are prepared to become fathers and to take on the responsibility of being a provider. According to Reich (2008) men sometimes base their decision on their perception of their partner as a mother as well as whether or not they envision a future with their pregnant partner. A man's reaction to the abortion and how it affects him is often influenced by his readiness for fatherhood, whether or not he was included in the decision-making process as well as whether or not he agreed to the abortion.

The male role of being a protector is also compromised as some men view abortion as a failure to protect their unborn baby. Whether the possibility of an abortion has been discussed or not, the decision lies with the woman because the Act states that a woman does not need to inform her partner or have his consent to have an abortion. Men are, therefore, responsible for the pregnancy but marginalized when it comes to the decision to abort.

2.4 Community Awareness on Male Involvement in Safe Abortion

Safe abortion services and policies aim to achieve three ultimate outcomes: to reduce morbidity and mortality from unsafe abortion; to ensure reproductive choice for women faced with unintended pregnancy; and to reduce the incidence of repeat unintended pregnancies and unsafe abortion. Women who desire to terminate a pregnancy have access to and obtain an abortion or post abortion care under safe conditions, they will be less likely to suffer from abortion complications or to die from such complications. Furthermore, post abortion contraception, when

provided as an integral component of safe abortion care, can also reduce the incidence of repeat unintended pregnancies and reliance on unsafe abortions. Yet these premises presuppose that women are aware of their options, have positive attitudes about seeking safe services, and feel empowered to use such services (Bosveld, 1998).

At the same time, clinical facilities must be ready and willing to provide such services; they must have appropriate equipment and supplies, as well as personnel trained in the clinical procedure and counseling, and policies that support such service delivery. All of these program components are more likely to succeed in countries with a favorable social, cultural, economic, political, and legal climate. Safe abortion programs include both elective services to cover all legal indications for abortion and post abortion care for treatment of complications. Because almost all countries have at least some indications for elective abortion, such services should be included and evaluated as part of national safe abortion programs (Tamang & Tamang, 2005).

2.5 Community Perceptions on Male Involvement in Safe Abortion

Men are often of the view that the decision to abort remains that of a woman as it is her body and she will be the one to carry the baby should it be carried to term. Current legal instruments support this notion as the final decision regarding abortion is regarded as the legal right of the woman. The Choice of Termination of Pregnancy Act gives the woman the right to an abortion without the consent of the expectant father which therefore leads to his opinion not being worth much, if anything at all. In Coyle (2007), Myburghh et al, in their investigation of how nine men experienced abortion (pregnancy termination), identified the following three themes: (1) powerlessness related to the abortion decision; (2) emotional turmoil due to the impact of

abortion on both inter- and intrapersonal relationships; and (3) the use of defense mechanisms in response to stress.

One reason that many countries have legalized abortion was to reduce the complications of unsafe abortion. Unsafe abortion is the termination of pregnancy induced by the woman herself, a non-medical person or a health worker under unhygienic conditions (WHO, 2007). Before legalization of abortion in Nepal, 54% of all hospital admissions were women with post-abortion complications (Tamang & Tamang, 2005). The hypothesis by all 'safe abortion' advocates that legalization of abortion will result in safe abortion and less complication has not materialized. A post legalization abortion complication descriptive study was conducted in a Maternity Hospital in Kathmandu Nepal in 2004. A total of 305 cases of abortion complications were admitted during the 3-month study period accounting for 39.7% of total gynecological admissions (768). Seventy- seven percent of cases had incomplete abortion including cases of uterine perforation, bowel injury and peritonitis (Ojha, Sharma & Paudel, 2004). In addition to the physical complications, at least 102 studies worldwide demonstrate significant psychological disorders, major depression, and suicide risks among women who abort (Smith, 2010).

2.6 Cultural Beliefs on Male Involvement in Safe Abortion

The principle of informed choice focuses on the individual. Yet most people's abortion decisions also reflect a range of outside influences. Social and cultural norms, gender roles, social networks, religion, and local beliefs influence peoples' choices (Bosveld, 1998). To a large extent, these community norms determine individual childbearing preferences and sexual and reproductive behavior. Community and culture affect a person's attitude towards abortion,

desired sex of children, preferences about family size, family pressures to have children and whether abortion accords with customs and religious beliefs, (Dixon-Meuller, 2000). Community norms also prescribe how much autonomy individuals have in making abortion decisions. The larger the differences in reproductive intentions within a community, the more likely that community norms support individual choices (Bosveld, 1998).

Men's grief is often evaluated against social norms based on gender and because of this, men are often overlooked by caretakers at abortion clinics. Due to the neglect by caretakers and society in general regarding abortion, men may be more vulnerable than women and may experience delayed grief reactions (Gray, 2001). Coyle (2007) reports that Poggenpoel and Myburgh found that adolescent boys displayed feelings of guilt and helplessness as well as social pain due to being excluded from the abortion decision and not being acknowledged as an expectant father. These feelings of helplessness and guilt may be more intense with young adult males who feel ready for the fatherhood role and/or those who feel they should be ready to have a baby and be able to take care of it.

Coyle (2007) further states that men may experience confusion and uncertainty in their role or responsibility due to the emphasis of abortion being a woman's right. In *Male Attitudes* (2002), it is proposed that apart from being concerned about the physical and emotional damage the abortion might cause their partner, many men in clinic waiting rooms feel isolated and angry at their partners and at themselves for being in that situation.

There are different and conflicting views on abortion which centre around issues relating to the rightfulness of abortion, who has the power to determine the outcome of a pregnancy, who should be eligible for abortion if it is at all a consideration, as well as when (that is, how far along in the pregnancy) a woman should no longer be allowed to have an abortion. Discourses on abortion reveal two contesting camps, that is, those that are either for (pro-choice) and those that are against abortion (pro-life). The pro-life movement regard abortion as a rejection of motherhood and a denial of an innocent life while pro-choice movement view it as an expression of a woman's right to determine what happens to her body.

Oppositions to abortion practice are formulated around religious beliefs and moral values. Pro-life debates on abortion argue that the foetus should be seen as a human being right from conception and that the life of a foetus should be valued. This perspective puts more weight on the right to life of the unborn child and overrides the importance of the woman's right to decide what happens to her body. For some pro-life activists, abortion is not an option even if it places the woman's life in danger.

Pro-life advocates argue that the pro-life view of abortion is limited to the life of the baby and the value thereof. They point out that the pro-life argument does not necessarily take into consideration pregnancy complications and threats to the woman's life due to the pregnancy. The contradictions have been pointed out already in the 1970s by Thomson (1971) who indicates that some individuals support the pro-life view on the basis that abortion is directly killing the foetus (murder) whereas not having an abortion would only be *letting* the mother die from the pregnancy, not killing her. This sparks a new debate on whether the advocates of the movement

are pro-life for the foetus but anti-life for the mother (Meserve, 1983). They seem to be more pro-baby (foetus) than they are pro-life as the woman's life does not appear to be a priority. In an attempt to defend their case relating to being anti-life where the woman is concerned, pro-lifers extend their thesis to argue that abortion should not be an option as it is damaging to the woman's mental and physical health.

Men's roles have often been "underpinned by cultural stereotypes, which call for men to be tough, objective, stoic and emotionally inexpressive" (Myburgh et al, 2001). Due to these social expectations, men tend to not acknowledge their feelings and, as a form of a defense mechanism, may end up rationalizing and intellectualizing their feelings. Although these cultural stereotypes and social expectations are diminishing in intensity, men are still not as emotionally expressive as they could be (Myburgh et al., 2001). Many men would rather suppress their emotions in an attempt to be strong for, and to show support to their partner.

2.7 Financial Resources on Male Involvement in Safe Abortion

High costs prevent many poor women from obtaining safe abortions. In general, the less skilled an abortion provider is, the lower the cost of the abortion to the woman and the greater the likelihood that the techniques the provider uses will be dangerous and will result in complications. In low-income countries with restrictive abortion laws, cost is often a major barrier preventing poor women from being able to end unwanted pregnancies safely. In a very real sense, then, the ability to pay can buy women a greater chance of safety (WHO, 2003). The men will not refer their women for safe abortion because of the high costs involved.

In Kenya, some private clinics and organisations committed to safeguarding and promoting sexual and reproductive health such as the Marie Stopes centers dotted around the country do offer safe abortion services and care but, at a fee many of the women who need the services cannot afford readily. A wide range of barriers can make safe abortions difficult or nearly impossible to obtain, even where they are legal generally or in specified circumstances. In many countries, particularly those in the developing world, public information about the legal status of abortion and about women's right to a legal abortion are often lacking. Doctors may refuse to provide abortion services because of conscientious objection (WHO, 1992). Health care workers may fail to refer women seeking a pregnancy termination to an appropriate facility. Access to safe services might be geographically limited, or compromised by a shortage of trained providers or by requirements that the procedure be performed only by a doctor, or in a hospital or other accredited facility. Gestational age limits, the need for spousal or parental consent, and mandatory waiting periods or counseling may deter some women from obtaining services

If abortion services are expensive, or are excluded from private and public health insurance plans, many adolescents (who usually have few resources of their own) and poor women may not be able to afford the procedure. Health systems may stigmatize women seeking reproductive health care, deny pain medication during an abortion or require the authorization of a spouse or third party (even if not required by law). Social values that stigmatize providers who offer safe abortion services constitute another barrier, because providers may stop offering the service (WHO, 2004).

There may be stigma related to the abortion itself: safe or unsafe, and stigma related to secondary infertility that may result from the unsafe abortion. The sources of stigma include the woman's family, community, health care providers who may give the post abortion care needed by the woman. Kumar et al (2009) posited that women who seek abortions challenge localized traditional social and cultural norms about the essential nature of women and womanhood. Men as partners also often alleviate or contribute to social costs when they support or create barriers to women who want to end a pregnancy. Thus the power dynamics within relationships often tend to influence whether or not the woman may or may not end up with an unintended pregnancy; and when she does end up with an unintended pregnancy, whether she can resort to accessing an abortion through a safe procedure and not clandestinely. Conversely, stigma surrounding abortion may keep women from seeking or receiving social support (WHO, 1993).

2.8 Theoretical Framework

The study will be guided by the systems theory and social construction theory.

2.8.1 Systems Theory

Systems theory is not concerned with the cause of behaviour as people are viewed as mutually interacting and influencing each other (Becvar & Becvar, 2009). In the 1940's, cyberneticists began focusing on patterns of communication and the processing of information in an attempt to understand complex systems. Behaviour was looked at as being influenced by feedback. In systemic terms, feedback is a change regulating mechanism where positive feedback acknowledges and accepts that a change has occurred in a system and negative feedback on the other hand points to the maintenance of the status quo. When discovering that a woman is

pregnant, the couple's relationship is perturbed and they are required to make a decision relating to the disruption of the past state of affairs that has been brought about by the pregnancy. Positive feedback therefore would occur when they accept that there is a change in the system. Whether or not the feedback is perceived as being good or bad is context-bound. Feedback in a system does not *cause* anything; rather it describes the process in the system at a particular point in time.

Systems theory is about looking at the behaviour as well as the response to the behaviour. From this perspective phenomena are not understood in a linear cause-and-effect manner, but rather "as a function of the context or 'systems' within which they occur and where they serve important adaptive or stabilizing functions" (Lindegger, 1999, p. 257). Systems go through both stability and change at various points as a means of survival. A potential change in the system is either accepted or opposed depending on what the system needs for a stable, functional state. A well-functioning system experiences both homeostasis and change depending on the need and the context.

An integral point in systems thinking was the shift from first order cybernetics to second order cybernetics. First order cybernetics viewed the observer as an outsider who is observing what is happening inside the system. The focus was on describing what is happening and the observer was not seen as part of what is happening. Second order cybernetics considers the observer as part of the system as her observations, thoughts and actions have an influence on the system.

Systems theory is an ecological perspective which looks at individuals in relation to their psychological, social and physical environment. It is not a pragmatic theory although it can be

used to describe relationships, understand events or make changes (Becvar & Becvar, 2009). It proposes that “an individual’s thoughts and actions can be explained and described only by understanding microsystem and macro system of the person’s environment” (Woodside, Caldwell & Spurr, 2006). There is no judgement regarding good or bad as an individual is viewed relative to his context. An individual’s thoughts and actions are viewed in terms of appropriateness within a particular context. Systems theory implies viewing people and situations from a holistic perspective and it aims at understanding the world as a set of systems at interplay with each other. It attempts to move past the either/or dichotomy and attempts to view situations from a both/and perspective. The both/and perspective looks at both sides of the story and does not disregard or reject one view over another. From this perspective each side of the story is seen as giving meaning to the other. The use of a particular view therefore depends on the particular context.

According to Systems perspective people, issues and events are not viewed in isolation, but rather in an integrated manner. Consistent with the interpretationist paradigm, the social and historical context in which a person exists is important when attempting to understand the individual. From Systems perspective the why of the matter is not of interest, rather how people interact and/or view the matter at hand. What is of focus are the patterns of interaction as well as the mutual influence between the individual, others and events. There is no isolated cause or effect because all elements of a system impact on each other. It is, therefore, important to acknowledge in this study that various factors, such as the kind of relationship the male has with the partner, will influence how the abortion is handled. From a systems perspective, interdependence and subjectivity are viewed as being an inevitable part of observation as the

“observer perceives, acts on, and participates in creating his or her own reality” (Becvar & Becvar, 2009). Reality is therefore not seen as external to the observer, but rather as constructed by the observer. When working from a Systems perspective, it is important to acknowledge that the research has an impact on the participants, the researcher and the research context.

2.8.2 Social Constructionism theory

Social Constructionism is a theory which in many ways is consistent with the tenets of postmodernism and there are many overlaps between the two. Social Constructionism suggests that the meanings that people ascribe to their experiences are created in social interactions through language. Our understanding of knowledge and experiences is constructed in our daily interactions with other individuals. Social construction cautions against merely accepting our assumptions about our reality of the world because there are multiple realities. It requires that a critical stance be taken in the way we understand the world and ourselves. It opens us up to exploring the constructions of reality that others may have and viewing them from a critical stance. Social construction does not subscribe to the notion of an objective reality therefore we need “to be ever suspicious of our assumptions about how the world appears to be” (Burr, 2003) Not only should the researcher view the perspectives of the participants from a critical stance, but also her own views. In social constructionist research the researcher cannot be separate from the research. Objectivity is viewed as an impossibility as it is believed that a researcher cannot fully disregard or move away from his or her values, beliefs, assumptions and opinions.

Looking at abortion from the perspectives of young males further directs the researcher’s views, opinions and assumptions regarding the abortion. The researcher can therefore be assumed to

view abortion as not only a woman's issue, but as one that also affects men. This means that "the task of the researcher therefore becomes to acknowledge and even to work with their own intrinsic involvement in the research process and the part that this plays in the results that are produced" (Burr, 2003).

Social Constructionism acknowledges the role that cultural and historical beliefs play in our ways of understanding. How we view ourselves, others and our world is influenced by past experiences and social learning. The way in which young men construct their experiences of abortion is influenced by their upbringing, their culture and their social standing. The same goes for the researcher. Social Constructionism proposes that through interactions people bring together their respective views and co-construct a context-specific reality or understanding.

2.9 Conceptual framework

The following conceptual framework represents a system of variable interrelationship, which will provide a logical view of the research problem. It specifies possible independent variables and illustrates their linkages to the dependent variable representing the research problem.

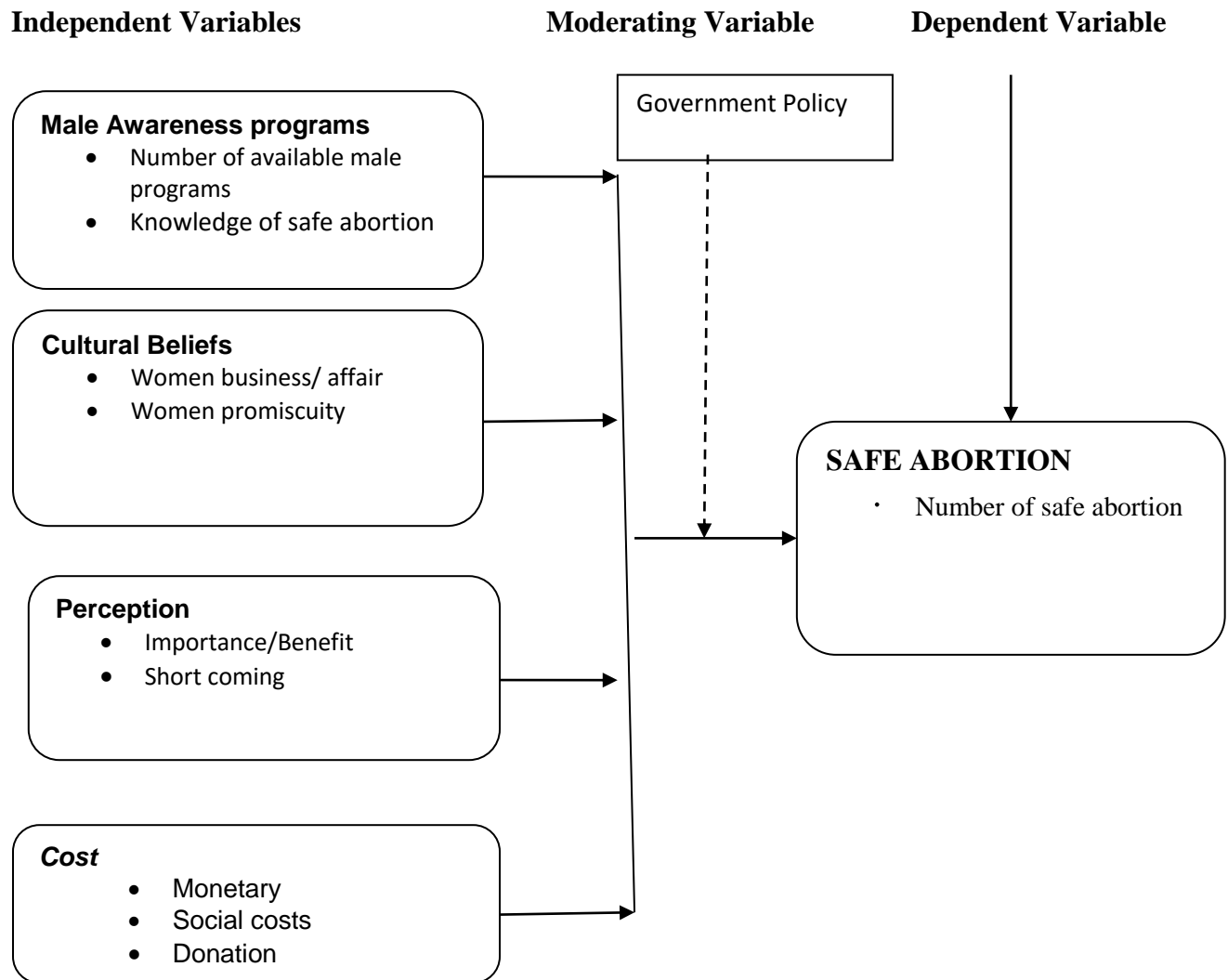


Figure 1: The conceptual Framework

2.10 Summary of Chapter

This chapter highlights other views on male involvement in safe abortion. Abortion, like any other loss of a baby, is a traumatic experience for both men and women. However, the experiences of men are often not given much attention when it comes to the issue of abortion. Men whose partners had undergone an abortion, reported an overwhelming feeling of powerlessness, a disorienting and unfamiliar emotion exacerbated by their loneliness. Most men

define their role in the relationship as one of having to support their partner and, often, due to societal norms and expectations, may repress their emotions regarding the abortion. It has been reported that a man whose partner has undergone an abortion may feel that he did not fulfil his role as a protector of his unborn child.

2.11 Knowledge Gap

Conspicuously absent from most discussions of the abortion issue are considerations of third party interests, especially those of the father. A survey of the literature reveals an implicit assumption by most writers that the issue is to be viewed as a two-party conflict—the rights of the fetus versus the rights of the mother—and that an adequate analysis of the balance of these rights is sufficient to determine the conditions under which abortion is considered to be morally permissible. This study therefore examines the influences of male participation in safe abortion as a bridge to the gap available since majority of literature is on women.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This section covered the procedure used in conducting the study. Pertinent issues discussed in this chapter include the target population, sample and sampling techniques to be used in the research design, a description of tools used in collecting the data, the measurement of variables and the techniques used in analyzing the collected data.

3.2: Research Design

The study used descriptive survey design to yield quantitative and qualitative data on the influence of male involvement programmes on safe abortion, a case study of Male Involvement in Safe Abortion (MISA) Program in Kisumu Medical & Education Trust. Descriptive survey design involved collection of data from a sample of a population in order to determine the current status of that population with respect to one or more variables (Mugenda and Mugenda 2003). Bryman (2007) suggests that bringing quantitative and qualitative findings together have the potential to offer insights that could not otherwise be gleaned.

3.3. Target Population

Population has been defined as a group of individuals having one or more characteristics in common that are of interest of the researcher (Amin,2004). Mugenda (1999) also defines population as the entire group of individuals events, objects, having common observable characteristic. The target population for this study was the male champions of MISA program in

Kisumu Medical & Education Trust. It is estimated that the program has about 132 male champions (MISA, 2015).

3.4 Sample Size and Sampling procedure

This section provides the sample size and sampling procedure.

3.4.1 Sample Size

Sampling technique provides a range of methods which enables reduction of data to be collected, by focusing on data from a sub-group rather than all cases of elements.

A sample of 35 respondents was picked using simple stratified random sampling techniques from 132 male champions of MISA program in Kisumu Medical & Education Trust using Krejcie and Morgan (1970) table in appendix IV for determining sample size. Another 10 respondents were chosen from the community members. This in total gave a 45 respondents for the sample size

3.4.2 Sampling Procedure

Sampling means selecting a given number of subjects from a defined population as representative of that population. Any statements made about the sample should also be true of the population (Orodho, 2002). This study used simple random sampling to get respondents as it is the ease of assembling the sample. It is also considered as a fair way of selecting a sample from a given population since every member is given equal opportunities of being selected. Simple random sampling is its representativeness of the population. The following are data collection procedures and research instruments that was employed in the research.

3.5 Research Instruments

The section discuss the research to be used in collecting data for the study

3.5.1 Questionnaire

The survey was created using suitable questions modified from related research and individual questions formed by the researcher. Likert scale will be used to determine if the respondent agreed or disagreed in a statement. The main advantage of close ended questions is that they are easier to analyze since they are in a usable form. They are also easy to administer because each item is followed by an alternative answers and is economical to use in terms of time saving. According to Gay (1992), a self-administered questionnaire is the only way to elicit self-report on people's opinion, attitudes, beliefs and values.

3.5.2 Pilot Testing

According to Trochim (2006), Pilot testing is a small-scale trial, where a few examinees take the test and comment on the mechanics of the test. In test development projects of all kinds, the trialing of new items is typically taken into Pilot Testing. According to Mugenda and Mugenda, (2003) pre-testing allows errors to be discovered before the actual collection of data begins and 10% of the sample size is considered adequate pilot study that is one university equating to ten purposively selected respondent perceived to be knowledgeable in procurement matters.

Researcher conducted a pilot test to ensure that there is validity and reliability of instrument using Cronbach's alpha while conducting the research in order to obtain data that is consistent with the main objective. Piloting was done in hospital with same research area characteristics,

which helped in revealing questions that might be vague, which allows for their review until they convey the same meaning to all the subjects

3.5.3 Validity of Instruments

Borg, & Gall, (1989) provides the following explanation of what validity is in quantitative research where Validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are. Researchers generally determine validity by asking a series of questions, and often looked for the answers in the research of others.

Jankowicz, (2002) describe the validity in quantitative research as “construct validity”. The construct is the initial concept, notion, question or hypothesis that determines which data is to be gathered and how it is to be gathered. They also assert that quantitative researchers actively cause or affect the interplay between construct and data in order to validate their investigation, usually by the application of a test or other process. In this sense, the involvement of the researchers in the research process would greatly reduce the validity of a test. Data quality will be incorporated in the entire study process especially at the data collection point to include completeness of questionnaires, legibility of records and validity of responses. At the data processing point, quality control included; data cleaning, validation and confidentiality. There are three types of validity which will be addressed and stated; Face validity with pre-testing of survey instruments is a good way used to increase the likelihood of face validity. Content validity the use of expert opinions, literature searches, and pretest open-ended questions helped to establish content validity.

A pilot study was done to help improve face validity and content validity of the instrument. According to (Berg and Cooil,1989) validity of an instrument is improved through expert judgment, for this study the researcher discussed with colleagues and the supervisor in order to help improve validity of the instrument. Also the questionnaires were administered to stakeholders, beneficiary and employees of Kisumu Medical &Education Trust who are not in the main study. This will help the researcher to identify items that are ambiguous and difficult to answer and later modified them to improve the quality of the instrument and its validity.

3.5.4 Reliability of Instruments

Reliability is a measure of the degree to which a research instrument yields consistent results or data after repeated trials. Reliability refers to consistency of measurement; the more reliable an instrument is, the more consistent the measure. Reliability is influenced by random error. As random error increases, reliability decreases. Random error is the deviation from a true measurement due to factors that have not effectively been addressed by the researcher (Mugenda & Mugenda, 2003). The researcher will attempt to minimize random error and hence increase the reliability of the data collected by administering the same instrument twice to the same group of subjects. The aim is to assess the clarity of the questionnaires items. In order to improve the reliability of the instruments, the research employed the retest technique where by the questionnaires was administered twice to the respondents in the pilot sample. The researcher critically assess the consistency of the response and make judgment on their reliability. This was done using a statistical package for social sciences (SPSS).

3.6 Data Collection procedure

The researcher obtained a permit from National council for Science and Technology based on authorization letter from The University of Nairobi. The permission was requested to conduct the research in the study area. It is worth noting here that the replies were given to the officer in charge, it may took a long time, in some cases and therefore may required her to follow up with telephone calls and by paying visits.

The questionnaire was administered by the help research who was trained on how to handle research for one week before being released to the field. The questionnaire were used because it allowed the respondents to give their responses in a free environment and help the researcher get information that would not have been given out. The questionnaire were self-administered to all the respondents.

3.7 Data Analysis Techniques

The process of data analysis involved several stages: the completed questionnaires were edited for completeness and consistency, checked for errors and omissions and then coded to SPSS and analyzed qualitatively and quantitatively. Qualitatively the data was sought into themes, categories and patterns. This was to enable the researcher to make general statements in terms of the observed attributes hence conceptualization. According to Gay (1992), Quantitative analysis was employ both descriptive and inferential statistics. Data was then analysed using descriptive analysis such as descriptive statistics mean scores and standard deviations frequencies distributions and percentages. The results were presented in table and charts.

3.8 Ethical Considerations

The study was conducted in an ethical manner. The respondents were explained the purpose of the study and they will be assured that the information given will be treated as confidential and their names will not be divulged. Informed consent will be sought from all the participants that agree to participate. A research approval was sought. The researcher administered the questionnaire to the respondents.

Their confidential information was only be accessed by the researcher and the supervisor. They were not required to provide any identifying details and as such, transcripts and the final report will not reflect the subjects identifying information such as their names, in the case they are not comfortable with it. After the study was completed and a final report written, the tools used to collect data were destroyed.

3.9 Operationalization Table of variables

This section analyses the operational definition of variables on influence participation monitoring and evaluation on donor funded development projects in Caritas Kenya. Variable are given table 3.1 below.

Table 3.1: Operationalization of Table of variables

Objectives	Variable	Indicators	Measurement	Scale	Data collection methods	Tool of Analysis
To examine how awareness of safe abortion programmes influences male involvement programmes on safe abortion	Awareness	No. of programs Knowledge of safe abortion methods	Frequency Percentage Mean Standard deviation	Ordinal Nominal	Questioners Interview guide	regression
The examine how perceptions of abortion influences male involvement programmes on safe abortion	Perceptions	Importance/ Benefit Short-coming	Frequency Percentage Mean Standard deviation	Ordinal Nominal	Questioners Interview guide	regression
To investigate whether cultural beliefs influences male involvement programmes on safe abortion	cultural beliefs	Women business/ affair Women promiscuity	Frequency Percentage Mean Standard deviation	Ordinal Nominal	Questioners Interview guide	regression
To examine whether costs influences male involvement programmes on safe abortion	Costs	Monetary	Frequency Percentage Mean Standard deviation	Ordinal Nominal	Questioners Interview guide	regression

3.10 Summary

This chapter describes the research methodology and design that was used in the study. The chapter includes research design, area of the study and the target population, sample selection and sample size, research instrument, reliability and validity of the research instruments, data collection procedures, data analysis techniques and ethical consideration.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION OF THE FINDINGS

4.1 Introduction

This chapter provides an analysis, presentation and interpretation of data on influence of male involvement programmes on safe abortion. A case study of Male Involvement in Safe Abortion (MISA) Program in Kisumu Medical & Education Trust.

4.2 Questionnaire Response Rate

A total of 45 questionnaires were distributed and 39 were collected having been filled completely. This constituted a response rate of 39(87.5%) which according to Mugenda and Mugenda (2003) a response rate of more than 80% is sufficient for a study.

4.3 Demographic Information

This section discusses the demographic characteristics of the respondents in the study .These include, distribution of respondents by their age, academic background, marital status and length of service.

4.3.1: Distribution of Respondents by Age

The respondents were asked to indicate their ages with the aim of establishing the age bracket.

Table 4.1 shows the age distribution of the respondents.

Table 4.2: Distribution of Respondents by Age

Age bracket	Frequency	Percent
Less than 30 years	13	34
31 – 40 years	18	46
41 – 50 years	6	14
Over 51 years	2	6
Total	39	100

From the table 4.1 13(34%) of the respondents were less than 30 years of age, those of the age between 31 – 40 years were the majority with 18(46%), those between 41 – 50 years were 6(14%), and those with aged over 50 years were 2(6%). This shows that there was a good representation of males according to different ages and therefore information on the influence of involvement of male on safe abortion will be obtained from all age groups.

4.3.2 Distribution of Respondents by Academic Background

The respondents were asked to indicate their academic background. Table 4.3 shows the study findings on the respondents' academic background.

Table 4.3: Distribution of Respondents by Academic Background

Level of education	Frequency	Percent
Certificate	2	6
Diploma	18	46
Undergraduate	11	29
Masters	8	20
Total	39	100

Table 4.3 shows that 18(46%) were diploma holders followed by 11 (29%) who had an undergraduate degree, 8(20%) were masters degree holders and finally 2 (6%) were certificate holders. This shows that respondents were well distributed in terms of education background and therefore would respond effectively.

4.3.3 Distribution of Respondents by Marital Status

The respondents were asked to indicate their marital status. Table 4.4 shows the study findings.

Table 4.4: Distribution of Respondents by Marital Status

Marital Status	Frequency	Percent
Married	20	51
Single	13	34
Divorced	4	9
Widower	2	6
Total	39	100

Table 4.4 shows that majority 20(51%) of the respondents were married, this was followed by those who were single at 13(34%), divorced were 4(9%) while 2(6%) were widowed.

4.3.4 Distribution of Respondents by Length of Service

The respondents were asked to indicate their length of service in the program. Table 4.4 shows the study findings

Table 4.5: Distribution of Respondents by Length of Service

Number of years	Frequency	Percent
Less than 3 months	13	34
3 to 6 months	17	43
7 to 12 months	5	14
1 year 6 months	4	9
Total	39	100

Table 4.5 shows that 17(43%) of the respondents had worked in the program for 3 to 6 years. 13(34%) had worked for less than 3 months, 5(14%) had worked for 7 to 12 months while 4(9%) had worked for one year and a half. This shows that the workers were aware of the study topic and therefore were in a position to respond effectively.

4.4 Community Awareness on Male Involvement in Safe Abortion

The researcher sought to address the first objective that looked at awareness of safe abortion programs.

4.4.1 Male Involvement Awareness of Abortion Programs

The respondents were asked to indicate whether there was awareness of male involvement safe abortion programs

Table 4.6: Male Involvement Awareness of Abortion Programs

Male awareness of abortion programs	Frequency	Percent
Yes	22	57
No	17	43
Total	39	100

The findings show that there was awareness of safe abortion programs for males as indicated by majority 57% while 43% were of the opinion that there was no awareness of male involvement safe abortion programs for males. Shostak (2008) reported that in a study conducted in 1999-2000, the results indicated that many men would have liked the opportunity to accompany their partners in the procedure room, to be there for them in the recovery room as well as the opportunity for counselling with their partners.

4.4.2 Ways in which program help create awareness to the male in the community

The respondents were asked to indicate ways in which program help create awareness to the male in the community. The study found that they mainly use seminars to create awareness of male involvement in safe abortion. Seminars are preferred they are the most effective way to conduct male reproductive health education. Seminars promote a sense of commonality and provide a venue where men can meet other men with the same interests, problems, and concerns regarding safe abortion; gain knowledge by listening to experts; and strengthen their motivation

to participate in male safe abortion programs. Other ways they use to create awareness are through Community forums like Chief’s baraza, community resource centers, men only community groups, traditional male games, Community outreach, Men-to-men strategy and targeting the youth and also targeting male schools.

4.4.3 Factors on male Awareness of Safe Abortion Program

The respondents were asked to rate the factors provided on male awareness of safe abortion programs. The table below shows the results.

Table 4.7: Factors on male Awareness of Safe Abortion Program

Factors Under Consideration	Mean score	Standard deviation
The program mainly uses community outreach using men-to-men for reproductive health teaching.	4.4029	0.6653
Men are aware that abortion at unregistered clinics are more harmful than at registered clinics	4.6658	0.8688
Providing a separate section for men in the health facility, offering privacy and having men attend to men is a way of encouraging and creating awareness for their participation	4.0517	0.7541
Offering male reproductive health services on special days is an option that attracts larger numbers of men to participate in safe abortion programs	4.2154	0.6857
Majority of the men do support their women to do safe abortion	2.1357	0.6648

From the respondents' perspective, it was strongly agreed that men are aware that abortion at unregistered clinics are more harmful than at registered clinics with a mean of 4.6658. The respondents agreed that the program mainly uses community outreach using men-to-men for reproductive health teaching with a mean of 4.4029. Offering male reproductive health services on special days is an option that attracts larger numbers of men to participate in safe abortion programs was agreed with a mean of 4.2154 and Providing a separate section for men in the health facility, offering privacy and having men attend to men is a way of encouraging and creating awareness for their participation was agreed with a mean of 4.0517. The respondents disagreed that majority of the men do support their women to do safe abortion with a mean of 2.1357. According to Reich (2008) men sometimes base their decision on their perception of their partner as a mother as well as whether or not they envision a future with their pregnant partner.

4.5 Community Perceptions on Male Involvement in Safe Abortion

The researcher sought to address the first objective that looked at men's perceptions of abortion

4.5.1 Level of perception of male involvement in safe abortion

The respondents were asked to indicate the level of perception of male involvement in safe abortion in the community. The table below shows the results

Table 4.8: Level of perception of male involvement in safe abortion

Level of perception of male involvement in safe abortion	Frequency	Percent
To a very high extent	4	10
High extent	6	16
Moderate extent	4	10
Low extent	18	46
Very low extent	7	18
Total	39	100

The results show that majority 18(46%) of the respondents indicated that there was low level of perception of male involvement in safe abortion, 7(18%) were of the opinion that there was very low level of perception of male involvement in safe abortion, 6(16%) were of the opinion that there was very high level of perception of male involvement in safe abortion while 4(10%) were of the opinion that there was very high level of perception of male involvement in safe abortion. . In Coyle (2007), in their investigation of how nine men experienced abortion (pregnancy termination), identified the following three themes: (1) powerlessness related to the abortion decision; (2) emotional turmoil due to the impact of abortion on both inter- and intrapersonal relationships; and (3) the use of defense mechanisms in response to stress.

4.5.2 Community Perceptions

The respondents were asked to indicate the kinds of perceptions available in the community about male involvement in safe abortion. It was found that community people think that a woman should always have the right to have an abortion in case of an unwanted pregnancy. They also indicated that the community think that men should not be involved in safe abortion programs. The man have not right to participate in women's decisions to abort since the body belongs to women and they are the ones who will undergo the procedure.

4.5.3 Factors on Community Perceptions

The respondents were asked to rate the factors on community perceptions. The table below shows the results.

Table 4.9: Factors on Community Perceptions

Factors Under Consideration	Mean score	Standard deviation
Men are often of the view that the decision to abort remains that of a woman	4.6544	0.7548
Current legal instruments support this notion as the final decision regarding abortion is regarded as the legal right of the woman	4.2651	0.3271
Men are powerlessness in matters related to the abortion decision	4.0257	0.4567
Men go through emotional turmoil due to the impact of abortion on both inter- and intrapersonal relationships	3.1779	0.8655

The found that majority of the respondents strongly agreed that men are often of the view that the decision to abort remains that of a woman with a mean of 4.6544. It was found that respondents agreed that current legal instruments support this notion as the final decision regarding abortion is regarded as the legal right of the woman with a mean 4.2651 and men are powerlessness in matters related to the abortion decision with a mean of 4.0257. The respondents that men go through emotional turmoil due to the impact of abortion on both inter- and intrapersonal relationships with a mean of 3.1779. Coyle (2007) indicates that men are often of the view that the decision to abort remains that of a woman as it is her body and she will be the one to carry the baby should it be carried to term. Current legal instruments support this notion as the final decision regarding abortion is regarded as the legal right of the woman.

4.6 Cultural Beliefs on Male Involvement in Safe Abortion

The researcher sought to address the third objective that looked at cultural beliefs.

4.6.1 Opinion on cultural beliefs in regards to men involvement to safe abortion

Participants pointed out that certain cultural practices in Kisumu Kenya impact male involvement in safe abortion. These include polygamy, naming of newborn children after relatives, preference of children of a certain sex over the other, and socialization of male children. Participants asserted that some of these practices are deeply rooted in culture and will take time to change. An example was given of men who come from families where polygamy has been practiced for generations. These men have no incentive to practice family planning because of pressures within their culture which dictate that a man should have many children. A woman who is in a polygamous marriage and wishes to stop giving birth most often has to take her own initiative and they mainly do unsafe abortion by hiding it from their men. Kumar et al (2009) posited that women who seek abortions challenge localized traditional social and cultural norms about the essential nature of women and womanhood. Men as partners also often alleviate or contribute to social costs when they support or create barriers to women who want to end a pregnancy

4.6.2 Factors on Cultural Beliefs

The respondents were asked to rate the factors on community perceptions. The table below shows the results.

Table 4.10: Factors on Cultural Beliefs

Factors Under Consideration	Mean score	Standard deviation
It is never appropriate to question or challenge a person's deeply held moral beliefs.	4.0002	0.5004
community norms determine individual childbearing preferences and sexual and reproductive behavior	3.0876	0.3334
Even if a woman is pregnant because she has been raped, abortion is still not morally right.	4.2667	0.3762
Community norms also prescribe how much autonomy individuals have in making abortion decisions	2.3231	0.3365

The study found that respondents agreed that even if a woman is pregnant because she has been raped, abortion is still not morally right with a mean 4.2667. They agreed that it is never appropriate to question or challenge a person's deeply held moral beliefs with a mean of 4.0002. The respondents moderately agreed that community norms determine individual childbearing preferences and sexual and reproductive behavior with a mean of 3.0876. The respondents disagreed that community norms also prescribe how much autonomy individuals have in making abortion decisions with a mean of 2.3231. Bosveld (1998) points out that most people's abortion decisions also reflect a range of outside influences. Social and cultural norms, gender roles, social networks, religion, and local beliefs influence peoples' choices.

4.7 Financial Resources on Male Involvement in Safe Abortion

The researcher sought to address the fourth objective that looked at whether costs of obtaining safe abortion affect male involvement in safe abortion.

4.7.1 Opinion on how does cost affect the decision for men to get involved in safe abortion

The study findings indicate that the costs of adding safe abortion services to existing health services are likely to be modest, relative to the costs to the health system of unsafe abortion and to gains for women's health. Others indicated that the provision of safe, legal abortion is considerably less costly than treating the complications of unsafe abortion. Decisions made about which abortion methods to offer and how to organize services directly influence the cost of providing services and their affordability.

4.7.2 Factors on how costs affect the decision for men to get involved in safe abortion

The respondents were asked to rate the factors on cost of safe abortion. The table below shows the results.

Table 4.11: Factors on how costs affect the decision for men to get involved in safe abortion

Factors Under Consideration	Mean score	Standard deviation
High costs prevent many poor women from obtaining safe abortions	4.7001	0.4701
The less skilled an abortion provider is, the lower the cost of the abortion	4.4234	0.5192
Cost is often a major barrier preventing poor women from being able to end unwanted pregnancies safely	4.2667	0.6798
Some private clinics and organisations are committed to safeguarding and promoting sexual and reproductive health	4.0333	0.5343

The findings show that respondents strongly agreed that high costs prevent many poor women from obtaining safe abortions with a mean of 4.7001. They agreed that the less skilled an abortion provider is, the lower the cost of the abortion with a mean of 4.4234 followed by those who agreed that cost is often a major barrier preventing poor women from being able to end unwanted pregnancies safely with a mean of 4.2667 while others agreed that some private clinics and organisations are committed to safeguarding and promoting sexual and reproductive health with a mean of 4.0333. a study done by WHO(2003) indicates that In low-income countries with restrictive abortion laws, cost is often a major barrier preventing poor women from being able to end unwanted pregnancies safely. In a very real sense, then, the ability to pay can buy women a greater chance of safety.

4.8 Discussions of Findings

The following are the discussions in line with the objectives

The study has establish that community awareness of male involvement in safe abortion influence safe abortion. The review by Coyle (2007) provided an examination of the literature from 1973 to 2006 and the author identified several common findings among the studies: men do not find abortion to be a benign experience.

The study found that Community perceptions of Male Involvement in Safe Abortion influences safe abortion. A study done by Tamang (2005) shows that male participation in reproductive health has proved to be challenging in countries where there are culturally defined gender roles and where manifestations of masculinity involve violence against women, alcohol consumption,

and high-risk sexual behavior. In most communities, men still have a dominant role in reproductive health-related issues. A number of decisions, such as sexual initiation, contraceptive use, whether to have an abortion, prevention and treatment of sexually transmitted infections (STIs) and HIV, and sexual coercion, still depend on men.

The study found in cultural beliefs are influenced by male involvement in safe abortion. Additionally, the traditional ways in which safe abortion programs are implemented play an important role in influencing not only the involvement of men but also their knowledge and appreciation of safe abortion issues. Although these findings are similar to those of other studies, which have found that certain cultural norms can affect male involvement in safe abortion issues, they are important for safe abortion programming in Kenya (Donnay, 2000).

The study found that financial resources do affect male involvement in safe abortion. A study done by WHO (2003) found that cost is often a major barrier preventing poor women from being able to end unwanted pregnancies safely. In a very real sense, then, the ability to pay can buy women a greater chance of safety. Cost of procuring safe abortion are high due to those costs associated with purchasing instruments and supplies that will need to be restocked regularly, such as cannulae and manual vacuum aspirators; antiseptic solutions and high-level disinfectants used for instrument processing; and drugs for pain management, infection prevention and medical abortion (Kero & Lalos, 2000).

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the study findings, conclusions and recommendations. It also makes suggestions for further research. The findings are summarized in line with the objectives of the study which was to examine the influence of male involvement programmes on safe abortion.

5.2 Summary of Findings

The first objective sought to examine how community awareness of Male Involvement in Safe Abortion influence safe abortion in Kisumu Region. It was found that majority of the males in the community are aware of the safe abortion program available. The program has been creating awareness mainly through seminars and also other ways like Chief's baraza, community resource centers, men only community groups, traditional male games, Community outreach, Men-to-men strategy and targeting the youth and also targeting male schools. It was found that men are aware that abortion at unregistered clinics are more harmful than at registered clinics and the program mainly uses community outreach using men-to-men for reproductive health teaching

The second objective was to investigate the influence of community perceptions of Male Involvement in Safe Abortion (MISA) on safe abortion in Kisumu Region. The study found that the level of community perceptions of Male Involvement in Safe Abortion is low. Since majority of men think that they should not be involved in the decision to procure an abortion. The community people think that a woman should always have the right to have an abortion in case of an unwanted pregnancy

Regarding the third objective which was to examine how cultural beliefs are influenced by Male Involvement in Safe Abortion, it was found that cultural beliefs do affect Male Involvement in Safe Abortion. The study found that men have no incentive to practice family planning because of pressures within their culture which dictate that a man should have many children. A woman who is in a polygamous marriage and wishes to stop giving birth most often has to take her own initiative and they mainly do unsafe abortion by hiding it from their men. Men's grief is often evaluated against social norms based on gender and because of this, men are often overlooked by caretakers at abortion clinics. Due to the neglect by caretakers and society in general regarding abortion, men may be more vulnerable than women.

The fourth objective was to examine how financial resources of Male Involvement in Safe Abortion. The study found that cost is a major hindrance to procuring safe abortion and men being involved. The study found that high costs prevent many poor women from obtaining safe abortions. It was found that the less skilled an abortion provider is, the lower the cost of the abortion and majority of women will go for the cheapest option.

5.3 Conclusion

There was adequate awareness of male involvement in safe abortion and its importance among men in Kisumu County. The program creates awareness through several programs and seminar is the one that is mainly used.

The level of community perceptions of Male Involvement in Safe Abortion is low. Majority of men think that they should not be involved in the decision to procure an abortion. The community people think that a woman should always have the right to have an abortion in case of an unwanted pregnancy

The study found that cultural beliefs affect men involvement in safe abortion. Men have no incentive in the practice of abortion since it is the woman's body. High costs of procuring a safe abortion has been a barrier for men to be involved in safe abortion. The less skilled an abortion provider is, the lower the cost of the abortion and majority of women will go for the cheapest option

5.4 Recommendations

Strategies to create awareness on male involvement in safe abortion issues should be given priority at the clinical and community levels, with the aim of establishing a large number of adopters of male involvement in safe abortion. Approaches may include seminars and media (mass media, print and mobile phones). Men will be found at the community forums like chief's barazas, churches, and village markets, and at the traditional male games. The youth are an important group that should not be overlooked. While these strategies are being implemented, interveners and other partners need to start discussions with relevant ministry of health departments for an explicit policy on male sexual and reproductive health in the country.

Providers seeking to promote sexual and reproductive health for men in Kenya should be sensitive to the fact that if men are not taking full responsibility for their sexual and reproductive

behavior, the reason may be that they are acting within a set of cultural norms that determine gender relations. For reproductive health programs to benefit both men and women, they should be based on a better understanding of gender dynamics in the region

New policy and programme interventions should be guided by evidence-based best practices. Much of the evidence for abortion policies and programmes is reflected in the recommendations presented in this guidance document. However, programme managers often want to be assured through local evidence of the feasibility, effectiveness, acceptability and cost of the introduction of changes in policy and programme design, or service-delivery practices, prior to committing resources for their implementation on a larger scale. Even when interventions are based on accepted international best practices, some evidence of the capacity for local implementation and acceptability among community members is likely to be necessary to facilitate scaling-up.

As for any other health intervention, abortion training programmes should be competency based and conducted in facilities that have sufficient patient flow to provide all trainees with the requisite practice, including practice in managing abortion complications. In addition, training should address health-care provider attitudes and beliefs about sexual and reproductive health, including induced abortion, safeguarding privacy and confidentiality, treating all women with dignity and respect, and attending the special needs of adolescents, women who have been raped, and those who may be vulnerable for other health or socioeconomic reasons.

5.5 Recommendation for Further Research

The study was about the influence of male involvement programmes on safe abortion focused in Kisumu Medical & Education Trust. The scope of the study was limited to investigating issues such as, awareness, cultural beliefs perceptions and costs. In light of the finding, the study recommends the following areas for further study.

1. Since the study was conducted in Kisumu County, the researcher would like the same study on Factors influencing male participation in safe abortion programs in Kenya to be rolled out to all parts of the country and the result compared since some of the factors may differ in different parts of the counties.
2. The role of Health workers in influencing male participation in safe abortion programs.
3. A study should be carried out involving a wider population including other stakeholders especially women.

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APPENDICES

Appendix I: Letter of Introduction

Dear Respondent,

REF: TO WHOM IT MAY CONCERN

I am a master's student at the University of Nairobi pursuing a Master of Arts in Project Planning and Management. I am expected to undertake a research on the influence of male involvement programmes on safe abortion. A case study of Male Involvement in Safe Abortion (MISA) Program in Kisumu Medical & Education Trust. Your cooperation and assistance are required to enable me complete the exercise. This information will be strictly used for the intended academic purpose and will be treated with utmost confidentiality.

Thanking you in advance.

Yours faithfully

MURIITHI PETER KIMARU

L50/69378/2013

Appendix II: Introduction Letter From The University



UNIVERSITY OF NAIROBI
COLLEGE OF EDUCATION AND EXTERNAL STUDIES
SCHOOL OF CONTINUING AND DISTANCE EDUCATION
DEPARTMENT OF EXTRA-MURAL STUDIES
NAIROBI EXTRA-MURAL CENTRE

Your Ref:

Main Campus
Gandhi Wing, Ground Floor
P.O. Box 30197
NAIROBI

Our Ref:

Telephone: 318262 Ext. 120

7th July, 2015

REF: UON/CEES//NEMC/22/079


TO WHOM IT MAY CONCERN

RE: MURIITHI PETER KIMARU - L50/69378/2013

This is to confirm that the above named is a student at the University of Nairobi, College of Education and External Studies, School of Continuing and Distance Education, Department of Extra- Mural Studies pursuing Master of Arts in Project Planning and Management.

He is proceeding for research entitled "**influence of male involvement programmes on safe abortion**". A Case Study of Male Involvement in Safe Abortion (MISA) Program in Kisumu Medical & Education Trust.

Any assistance given to him will be appreciated.


CAREN AWILLY
CENTRE ORGANIZER
NAIROBI EXTRA MURAL CENTRE



Appendix III: Questionnaire

This questionnaire is to collect data for purely academic purposes. All information will be treated with strict confidence. Do not put any name or identification on this questionnaire. *Answer all questions as indicated by either filling in the blank or ticking the option that applies.*

SECTION A: PERSONAL INFORMATION

- 1) What is your age (tick one)
20 to 30 years () 30 to 40 years () 40 years and above ()
- 2) What is your academic background
Certificate [] diploma [] undergraduate [] postgraduate []
- 3) What is your marital status?
Married [] Single [] Divorced [] Widower [] Separated []
- 4) How long have you been working in your present capacity?
Less than 3 years () 3 to 5 years () 5 to 7 years () Over 7 years ()

SECTION B: AWARENESS OF SAFE ABORTION PROGRAMS

- 5) Are the male aware of abortion programs available in the health centers ?

Yes () No ()
- 6) How does the program help create awareness to the male in the community?
.....
.....
- 7) Kindly rate the following factors by indicating 1= strongly disagree 2= disagree
3=moderate 4=agree 5=strongly disagree

Description	Strongly disagree	disagree	neutral	agree	Strongly disagree
The program mainly uses community outreach using men-to-men for reproductive health teaching.					
Men are aware that abortion at unregistered clinics are more harmful than at registered clinics					
Providing a separate section for men in the health facility, offering privacy and having men attend to men is a way of encouraging and creating awareness for their participation					
Offering male reproductive health services on special days is an option that attracts larger numbers of men to participate in safe abortion programs					
Majority of the men do support their women to do safe abortion					

SECTION C: PERCEPTIONS OF ABORTION

8) What is the level of perception of male involvement in safe abortion in the community?

To a very high extent

- High extent
- Low extent
- Very low extent

9) In your own words what kinds of perceptions are available in the community about male involvement in safe abortion?

.....

.....

10) Kindly rate the following factors by indicating 1= strongly disagree 2= disagree 3=moderate 4=agree 5=strongly disagree

Description	Strongly disagree	disagree	neutral	agree	Strongly disagree
Men are often of the view that the decision to abort remains that of a woman					
Current legal instruments support this notion as the final decision regarding abortion is regarded as the legal right of the woman					
Men are powerlessness in matters related to the abortion decision					
Men go through emotional turmoil due to the impact of abortion on both inter- and intrapersonal relationships					

SECTION D: CULTURAL BELIEFS

11) What are the cultural believes in regards to men involvement to safe abortion?

.....

.....

12) To what extent does culture affect the decision for men to get involved in safe abortion?

To a very high extent

High extent

Low extent

Very low extent

13) Kindly rate the following factors by indicating 1= strongly disagree 2= disagree
3=moderate 4=agree 5=strongly disagree

Description	Strongly disagree	disagree	neutral	agree	Strongly disagree
It is never appropriate to question or challenge a person's deeply held moral beliefs.					
community norms determine individual childbearing preferences and sexual and reproductive behavior					
Even if a woman is pregnant because she has been raped, abortion is still not morally right.					
Community norms also prescribe how much autonomy individuals have in making abortion decisions					

SECTION E : COSTS

14) To what extent do costs affect the decision for men to get involved in safe abortion?

To a very high extent

High extent

Low extent

Very low extent

15) In your own opinion how does cost affect the decision for men to get involved in safe abortion?

.....

.....

16) Kindly rate the following factors by indicating 1= strongly disagree 2= disagree 3=moderate 4=agree 5=strongly disagree

Description	Strongly disagree	disagree	neutral	agree	Strongly disagree
High costs prevent many poor women from obtaining safe abortions					
the less skilled an abortion provider is, the lower the cost of the abortion					
cost is often a major barrier preventing poor women from being able to end unwanted pregnancies safely					
Some private clinics and organisations are committed to safeguarding and promoting sexual and reproductive health					

Appendix IV: Table for Determining Sample Size for a Given Population

Table for Determining Sample Size for a Given Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size
"S" is sample size.

Source: Krejcie & Morgan, 1970