CORRELATES OF STIGMA AND UNSAFE ABORTIONS IN REGIONS WITH HIGH AND LOW INCIDENCE OF UNSAFE ABORTIONS IN TWO COUNTIES IN KENYA

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Correlates of Stigma and Unsafe Abortions in Regions with High and Low Incidence of Unsafe Abortions in Two Counties in Kenya

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DECLARATION

This is my original work and has not been presented for a degree in any other University

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DEDICATION

To my beloved parents, my teachers, my sisters, brothers, my children Baraka, Belinda, Barbara, and my wife Caroline.

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LIST OF ABBREVIATIONS

APHRC	African Population Health Research Centre
CAC	Comprehensive Abortion Care
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CO	Clinical Officer
CRA	Commission for Revenue Allocation
D&C	Dilation and Curettage
EVA	Electronic Vacuum Aspirator
FHOK	Family Health Options Kenya
FGD	Focused group Discussions
ICPD	International Conference on Population and Development
IDI	In-Depth Interviews
ILAS	Individual Level Abortion Stigma
ISSR	Institutional and Structural Stigma Research
MDG	Millennium Development Goals
MO	Medical Officers
MoH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health
MVA	Manual Vacuum Aspiration
NCPD	National Council for Population and Development
PAC	Post-Abortion Care
RH	Reproductive Health
SABAS	Stigmatizing Attitudes, Beliefs and Actions Scale
UN	United Nations
UNFPA	United Nations Fund for Population Activities
VCAT	Values Clarification and Attitude Transformation
WHO	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Abortion: Termination of pregnancy whether spontaneous or induced by the removal or expulsion from the uterus of a fetus or embryo before viability

Unsafe abortion: Termination of pregnancy by people lacking the necessary skills, or in an environment lacking minimal medical standards, or both (For this study, an unsafe abortion refers to an extremely dangerous life-threatening procedure that is self-induced in unhygienic conditions, or it may refer to a much safer abortion performed by a medical practitioner who does not provide appropriate post-abortion attention)

Stigma: A negative attribute ascribed to women who seek to terminate or those that terminate a pregnancy that 'marks' them as inferior to ideals of womanhood

Labelling: Demeaning description of a woman who has procured abortion, their friends or health care provider assisting women to seek safe abortion service

The incidence of Unsafe abortion: Number of new abortion cases in a year divided by the number of women of reproductive age (For example, if a population initially comprises 1,000 women of reproductive age and 28 women are treated in a health facility for abortion- related complications in 2012, the incidence of unsafe abortion proportion is 28 cases per 1,000 women).

Stereotyping: Describing women or any person or place providing abortion services in a negative manner that degrades individuals involved.

ABSTRACT

The incidence of unsafe abortion has been on the rise over the last 10 years with Kenya reporting one of the highest rates of unsafe abortions in sub-Saharan Africa region. Due to controversy about abortion, anyone associated with abortion faces stigma in one way or another. This study investigated the association between abortion related stigma and unsafe abortions and factors associated with abortion-related stigma among individual women seeking abortion services and among general community members in Machakos and Trans Nzoia counties in Kenya. Specifically, the study was guided by the following objectives; to determine the level of abortion-related stigma among individual women receiving abortion care services and among general community members, establish association between abortion-related stigma and incidence of unsafe abortion and, examine factors associated with abortion-related stigma at personal and community level. The study adopted a mixed method cross sectional design comprising quantitative and qualitative methods. The target population was men and women of reproductive age (16 – 49 years) in the two counties. Multi-stage sampling method was used to sample respondents. At community level, out of 712 respondents were targeted in various categories, 712 respondents were received as valid representing 100% response rate. At the facility level, out of 762 women treated for abortion complications in selected facilities in the two counties, 759 respondents were received as valid, representing a respone rate of 99.6%. For qualitative methods, a total of 26 Focus group discussions was held and 26 indepth interviews held after reaching a point of saturation in both counties. Survey data from quantitative methods was collected by use of two separate structured questionnaires one at community level and the other at individual level. The questionnaires were pilot tested on 20 respondents drawn from the study sites. Reliability of the questions was done by use of Cronbach's alpha. Normality test was done for dependent variable to aid subsequent regression analysis. For qualitative methods, indepth interview guides and focus group guides were developed and piloted in two communities and changes on order of questions made. A thematic framework analysis was used. A code book comprising both deductive and inductive codes and their definitions was created. The transcripts from

all the IDIs and FGDs were then separately uploaded onto Atlas –ti version 7 software to code the data. IDI and FGD transcripts were analysed by first reading the interviews, familiarising with the data and noting the themes and concepts that emerged. This study established a relationship between incidence of unsafe abortions and levels of abortion stigma where respondents from a county with higher incidence of unsafe abortion reported higher stigma scores compared to those from a county with lower incidence of unsafe abortion. The study revealed that stigma was in form of self-stigma, from the community and from health providers. Due to stigma, women preferred to seek information on abortion only from trusted friends and close relatives, regardless of their reliability to keep their abortion confidential. Based on the study findings it can be concluded that abortion related stigma is a key contributor to unsafe abortion in Kenya. The study recommends that stigma reduction interventions require multidimensional approaches targeting players at all levels. The study makes significant contribution to the body of knowledge in that organizations focusing on addressing reducing maternal deaths will gain practical insights into abortion stigma as a main contributor to deaths that could be prevented by normalizing converations around abortion thereby enriching their knowledge on stigma reduction interventions. Future researchers may focus on individual and community knowledge and actions as it relates to how women seeking abortions will be treated by their community members exposed to abortion stigma reduction interventions.

CHAPTER ONE
INTRODUCTION

1.1 Background Information for the Study

Abortion has existed since time immemorial and is one of the most common and safest medical procedures performed for women of reproductive age (Jones, 2012; Mumah et al., 2014). Globally, unsafe termination of pregnancy remains a major public health problem, and World Health Organization (WHO) reports that 21.6 million unsafe abortions occurred in 2008 (Department of Reproductive Health and Research, 2011). Annually, an estimated 8.5 million women suffer from complications of unsafe abortion, resulting in 47,000 maternal deaths (Darroch & Singh, 2011; Organization, 2011). The majority of unsafe pregnancy terminations occur in the developing countries with the most severe morbidity and mortality occurring in sub-Saharan Africa (Department of Reproductive Health and Research, 2011). In a 2012 national survey in Kenya, it was estimated that 465,000 induced abortions occurred (48 per 1000 women of reproductive age) (APHRC, 2013).

Abortion stigma is a complex issue, and understanding its manifestation and perpetuation is challenging. Stigma was once conceptualized as an individual attribute of either the "stigmatized" or the "stigmatizer"; that is to say that it has been considered a process of what some individuals do to other individuals (Parker & Aggleton, 2003). Stigma theory has progressed from an individualistic focus toward recognition of stigma as a socially constructed process – one that occurs within a broad social, cultural, and political framework (Corrigan,

Markowitz, & Watson, 2004; Parker & Aggleton, 2003; Yang et al., 2007). Abortion stigma is hypothesized to affect negatively women's emotional and mental health after an abortion (Major & O'Brien, 2005). Stigma may also affect a woman's willingness to disclose her abortion intentions and/or experiences to partners, parents, friends or healthcare providers, endanger her health and future fertility (Shellenberg et al., 2011; Shellenberg & Tsui, 2012). In certain settings, stigma may determine whether a woman seeks a safe versus unsafe abortion or life-saving medical care when suffering post-abortion complications.

Abortion stigma has multiple domains, including perceived, experienced, enacted, and internalized stigma(Shellenberg & Tsui, 2012). Perceived stigma relates to an individual's perception of whether or not they will be discriminated against, looked down on, or treated differently, particularly negatively, by others if they had an abortion.(Cockrill, Upadhyay, Turan, & Greene Foster, 2013) Experienced stigma, on the other hand, refers to the overt experiences of stigmatization a person has as a direct result of having an abortion, such as rejection by family or friends, physical, verbal, or emotional abuse, or mistreatment in the home, community, or healthcare setting(Shellenberg et al., 2011). Internalized stigma is the internalization of others' stigmatizing attitudes about abortion and women who have an abortion. Internalized stigma can manifest as feelings of guilt, shame, anxiety, or secrecy (Shellenberg and Tsui, 2012). Enacted stigma describes stigmatizing actions towards people who have had an abortion or provide abortion services, such as discrimination, mistreatment, or social exclusion.

Unfortunately, the stigma surrounding abortion and anyone associated with it – women, providers, pharmacists, and advocates – contributes to the social, medical, and legal marginalization of abortion care around the world (Marlow, Shellenberg, & Yegon, 2014; Marlow, Wamugi, et al., 2014). Stigma shames and silences women seeking abortions and providers, and is a major contributor to unsafe abortion. Abortion stigma perpetuates unsafe abortion which is one of the five major causes of maternal death (Kumar, Hessini, & Mitchell, 2009).

Article 23 (4) of the Kenyan constitution provides for certain conditions where abortion is permitted. It explicitly permits that abortion can be provided if it is conducted if in the opinion from a trained health professional; if the case requires emergency treatment; if the life or health of the woman is in danger; or if it is permitted under any other written law. Article 46 of the constitution further states that a person cannot be denied emergency treatment for any condition and must be offered treatment in the nearest health facility first before considerations of payments are complete (BriefSeries; Guyo, Ogutu, Johnson, Ndavi, & Karanja, 2014). However, this constitutional provisions are yet to be fully operationalized, and most providers have not been trained to provide safe abortion. This means that many of the induced abortions taking place now are unsafe. Additionally, while most induced abortions follow unintended pregnancies, the unmet need for family planning remains high in many countries including Kenya (Demographic, 2015).

1.2 Statement of the Problem for the Study

The incidence of abortion in Kenya has significantly increased from 32 to 48 per 1000 women of reproductive age (15-49 years) over the last ten years (African Population and Health

Research Center, Ministry of health Kenya, Ipas, & Guttmacher Institute, 2013; Gebreselassie, Gallo, Monyo, & Johnson, 2005). When compared to sub-Saharan African countries incidence of unsafe abortion of 36 per 1000 women of reproductive age, Kenya's statistics on unsafe abortion is one of the highest in Africa. The severity of unsafe abortion cases has almost doubled during the same period (M. o. H. African Population and Health Research Center, Kenya, Ipas, and Guttmacher Institute, 2013). Factors contributing to this increase in incidence coupled with a doubling of the severity of cases need to be fully understood to come up with ways to reverse these trends. Regional statistics from the APHRC study indicated different abortion rates in different regions in Kenya (Mohamed et al., 2015). Rift Valley region reported the highest incidence of 48 per 1000 women of reproductive age whereas eastern province reported the least incidence of 6 per 1000 women of reproductive age. There exist high levels of abortion-related stigma at structural, institutional, and community levels in Kenya and anyone associated with the provision of abortion services i.e. health care providers, as well as abortion clients are highly stigmatized (Marlow, Wamugi, et al., 2014). High levels of stigma at community levels prevent women from accessing safe abortion services. However, the association between stigma and incidence of unsafe abortions in Kenya is not known. This study explored the link between incidence of abortion and abortion- related stigma and identified the contribution of abortion related stigma on maternal deaths and makes recommendations on how to address abortion stigma at community and health facility level to reduce deaths from unsafe abortion.

1.3 Study Justification

This study sought to explore and understand factors contributing to the ever increasing incidences of unsafe abortion in selected regions with high and low incidence of unsafe

abortion in Kenya, through examining the correlation between abortion-related stigma and incidence of unsafe abortion by comparing levels of stigma among general community members and women seeking abortions from two counties- one county located in a region with high incidence of unsafe abortion and the other located in a region with low incidence of unsafe abortion in Kenya. Findings from the study are useful in contributing to the body of knowledge in public health and can be used to guide the design of interventions to address abortion stigma as a major cause of unsafe abortion and prevent abortion-related deaths and disabilities. These findings provide insights in understanding community norms around stigma, unwanted pregnancy, unsafe abortion to informing program planners on abortion-related stigma in health-care facilities and at the individual/community level, and to guide the development of community-level interventions to mitigate abortion-related stigma.

1.4. Study Objectives

1.4.1 General Objective

To investigate the association between abortion related stigma and unsafe abortions and factors associated with abortion-related stigma among individual women seeking abortion services and among general community members in Machakos and Trans Nzoia counties in Kenya

1.4.2 Specific Objectives

This study had four specific objectives:

1. To determine the level of abortion-related stigma among individual women receiving abortion care services and among general community members in Trans Nzoia and Machakos counties

2. To establish association between abortion-related stigma and incidence of unsafe abortion in Trans Nzoia and Machakos counties
3. To examine factors associated with abortion-related stigma at personal and community level in Trans Nzoia and Machakos counties

1.5 Research Questions for the Study

This study sought to answer the following research questions.

1. What are the levels of abortion-related stigma at individual and community levels in Machakos and Tran Nzoia regions?
2. Do regions that report high incidences of unsafe abortion also have high levels of stigma?
3. What are the factors associated with abortion-related stigma at a personal level and community level in Machakos and Trans Nzoia Regions?

1.6 Study Hypothesis

This study sought to test the following hypothesis

a) Community level stigma

Ho: there is no association between stigma at community level and incidence of unsafe abortion in the two study counties.

H1: There is a significant association between abortion stigma at the community level and incidence of unsafe abortion in the study counties

b) Individual level stigma

c) Ho: there is no association between individual level stigmal and incidence of unsafe abortion among women treated for abortion related complications in the two study counties.

d) H1: There is a significant association between individual level stigmal and incidence of unsafe abortion among women treated for abortion related complications in the two study counties

1.7 Scope of the Study

The researcher interviewed general community members in their communities as they went through their day to day tasks in their farms, markets, community meetings and general community events. The researcher worked with County health department staff to identify areas where community members usually meet for their community activities, and community members were asked questions related to how women who are known to have had an abortion will be treated in their community. At the facility level, the researcherinterviewed women treated for abortion complication services, and specifically in public and private health facilitiesThis study focused on multiple domains of stigma including perceived, experienced, enacted, and internalized stigma and therefore study instruments had been designed to be able to capture these domains of stigma

1.8 Study Limitations

By mixing both quantitative and qualitative research and data, the study gained in breadth and depth of understanding and corroboration around abortion stigma, while offsetting the weaknesses inherent to using each approach by itself. We, however, note that given that the

study used qualitative methods (IDIs and FGDs) and its limitations related to validity and reliability given secretive nature and difficulty talking openly about abortion and therefore the difficulty in replicating these qualitative methods especially given the sensitivity around abortion. Despite the formative work to include items in both ILAS and SABAs scales it is possible the study may have inadvertently missed statements or items. While quantitative methods can be replicated in other regions of Kenya, respondents especially women seeking an abortion could understand how they feel about their abortion. Study results on multivariate analysis suggest that modeling abortion stigma is somewhat restricted, even with when considering wide sets of covariates, very few characteristics are correlated with significantly higher (or lower) levels of abortion stigma, suggesting that it could be explained by unobserved (perhaps intrinsic) characteristics of respondents.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Stigma has been linked to the rising cases of unsafe abortions in Kenya today, although no rigorous research has been done to ascertain this correlation. Anecdotal evidence from organizations implementing abortion-related programs has shown that as a result of stigma, women in need of abortion services keep away from expert services offered by qualified health professionals in health facilities for fear of discrimination. They instead choose to seek the services of traditional birth attendants, herbalists and in some cases inducing abortion themselves (APHRC 2013). This has contributed significantly to the high incidences of abortion-related maternal mortality and morbidity, currently standing at 35% (Hussain, 2012).

2.2 Theoretical Framework for the Study

This study is guided by the theory of stigma which is conceptualized as an individual attribute of either the "stigmatized" or the "stigmatiser"; that is to say that, it has been considered a process of what some individuals do to other individuals (Corrigan et al., 2004). This theory has progressed from an individualistic focus towards recognition of stigma as a socially constructed process – one that occurs within a broad social, cultural, and political framework (Corrigan et al., 2004; Parker & Aggleton, 2003; Yang et al., 2007). Figure 4 below graphically demonstrates the social process – i.e. the manifestation and perpetuation – of this theory when applied to abortion, with the end result often being discriminatory beliefs or practices towards women who seek to terminate or have terminated a pregnancy. The recognition that

stigmatization does not simply take place at the interpersonal level, but that it can take different forms and manifest at different levels of society - structural, institutional, community, and individual – requires exploration and investigation of the issue from multiple angles to understand adequately stigma and the process of stigmatization.

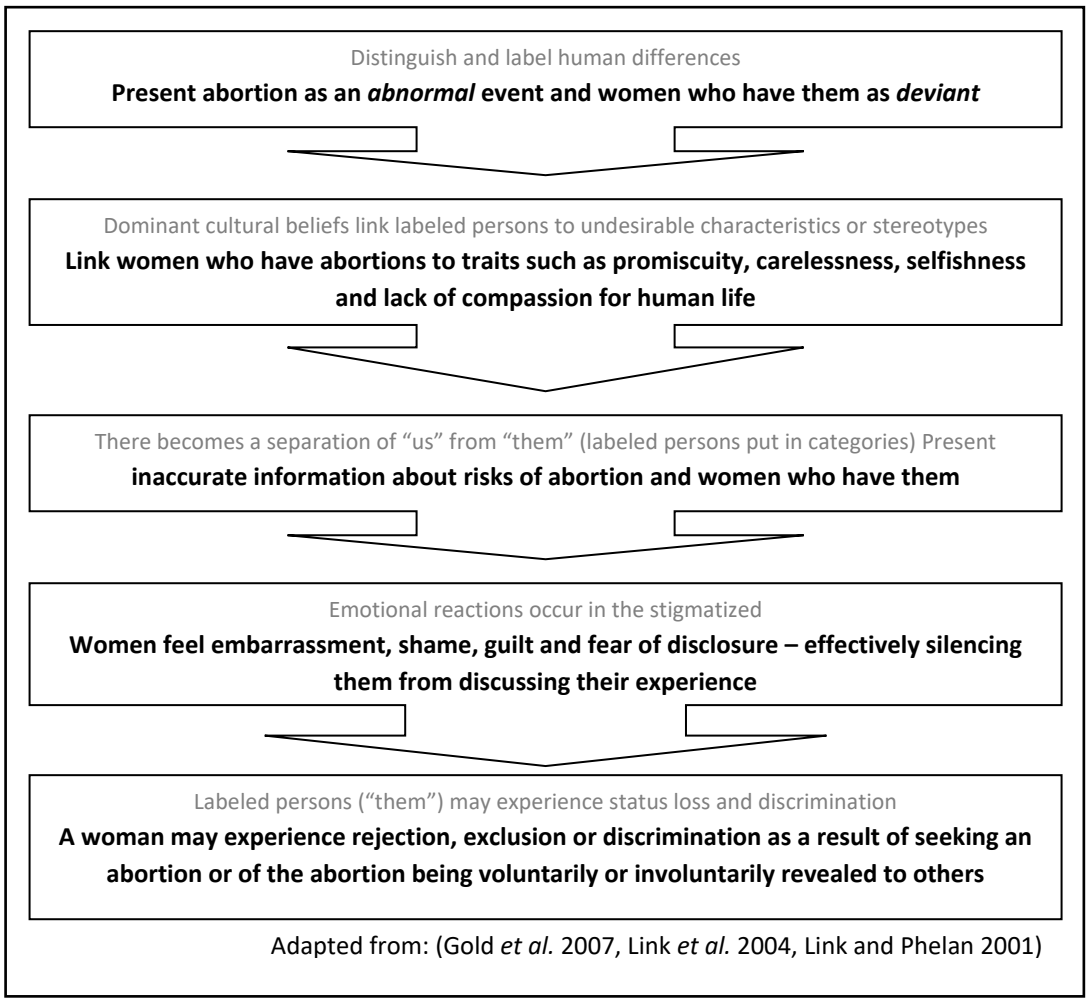


Figure 2.1 Social process of Abortion Stigma

To date, abortion stigma research has been focused on the individual and community levels. In 2011, Shellenberg et al. found that most participants in five different countries perceived

abortion to be a highly-stigmatized behavior. Study participants cited numerous social consequences of having an abortion, including harassment from family and friends and social exclusion. Marlow et al. found that in Kenya stigmatization of women who have an abortion is often dependent on the reason for the abortion, but participants also reported that women experience social exclusion if their abortion is made public(Marlow, Wamugi, et al., 2014). Several other studies have found similar results about high levels of abortion stigma at the individual and community levels (Sedgh et al., 2006; Shellenberg & Tsui, 2012; Singh, Moore, Bankole, Mirembe, & Wulf, 2006).

2.3 Critique of the Existing Literature Relevant to the Study

2.3.1 Overview of Unsafe Abortion

The World Health Organization (World Health Organization (WHO), 2011) defines unsafe abortion as the termination of a pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both. Currently, abortion accounts for 193,000 maternal deaths worldwide, with over 90% of these abortion-related maternal deaths occurring in developing countries (Say et al., 2014). Countless other women who undergo unsafe abortion suffer serious and life-threatening injuries (World Health Organization (WHO), 2011). Unless they can avoid unwanted pregnancies, 215 million women alive today in developing countries risk experiencing an unsafe abortion during their lives (Sedgh et al., 2012; Singh, Sedgh, & Hussain, 2010; World Health Organization (WHO), 2011). Women terminate pregnancies in countries where abortion is legally restricted and broadly permitted in equal measure, but deaths and injuries from unsafe abortions occur at much higher rates in

restrictive settings (Kinney et al., 2010; Organization, 2003). Almost all abortion-related deaths occur in developing countries, with the highest number occurring in Africa(Sedgh, Hussain, Bankole, & Singh, 2007). At least 95% of abortions in Africa and Latin America and about 60% in Asia (excluding Eastern Asia) are unsafe; 650 deaths occur per 100,000 unsafe abortions in Africa, compared to only 10 in industrialized countries (Organization, 2003; Shah & Ahman, 2009). Trends have shown that both Asia and Africa, with a high incidence of unsafe abortions, have more restrictive environments regarding abortion compared to more industrialized countries like Europe and America where the incidence of unsafe abortions are lower than those in Africa and Asia.

2.3.2 Abortion Stigma

Abortion stigma is defined as a shared understanding that abortion is morally wrong and/or socially unacceptable (Norris et al., 2011). Stigmatization is a deeply contextual, dynamic social process; it is related to the disgrace of an individual through a particular attribute he or she holds in violation of social expectations. Stigma has been described as "an attribute that is deeply discrediting," reducing the possessor "from a whole and usual person to a tainted, discounted one" (Goffman, 1963). Many have built on Goffman's definition over the past 45 years, but two components of stigmatization consistently appear across disciplines. In 2009, Kumar et al. proposed a definition of abortion stigma as: "A negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood" (Kumar et al., 2009). Building on this definition in 2013, Cockrill et al., acknowledge the role that stigma plays with abortion providers, systems of care, communities,

laws and policies and the media. The authors define abortion stigma as a "shared understanding that abortion is morally wrong and/or socially unacceptable".

In an effort to conceptualize stigma in general, Link and Phelan offer a four-component model to describe the social process of stigma, which can be applied to abortion stigma (Link & Phelan, 2001). These stages can roughly be described as labeling, stereotyping, separating, and discrimination (Shellenberg et al., 2011). As applied to abortion, this circular and non-hierarchical social process include;

i) Labeling: Abortion is an abnormal event. Women who have abortions and providers who offer abortion care are labeled as deviant. Behind these ideas is an oversimplification of pregnancy termination. Labeling abortion and those marked by it as abnormal hides how frequent and common abortion is.

ii) Stereotyping: Women who have abortions are linked to negative traits such as promiscuity, carelessness, selfishness, and having a lack of compassion for human life. Abortion providers stereotyped as cold, unfeeling, and motivated by greed or money.

iii) Separating: Women and providers are moved into a separate category, creating a false "us" versus "them" dichotomy. This separation serves to shame those marked by the stigma of abortion. Silence and fear of exclusion perpetuate this separation and participation in stereotyping.

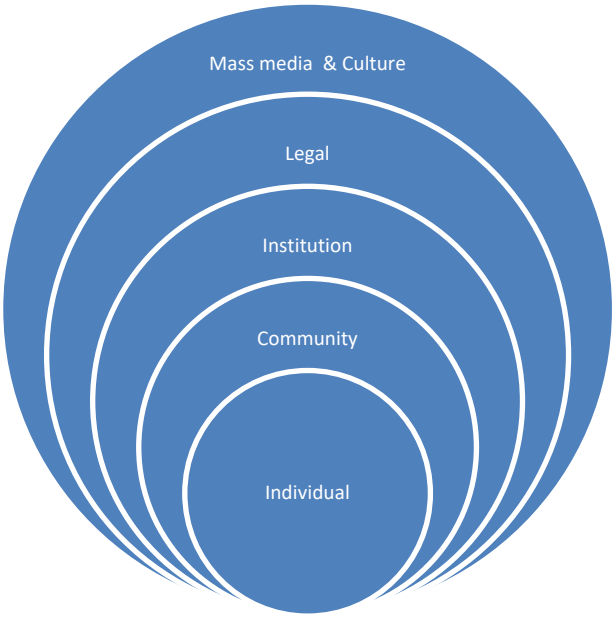
iv) Discrimination: This social process of stigma leads to overt discrimination or status loss for women and providers.

Based on an understanding of how stigma operates in other fields, such as HIV and AIDS and mental health, a group of experts from the fields of law, healthcare, and social sciences have advanced an ecological model (see Figure 5) of abortion stigma that illustrates the multiple levels at which stigma manifests (Hessini, 2014). This framework acknowledges that stigma manifests itself differently across geographic and cultural contexts.

The study retains this useful multi-level conceptualization, understanding stigma as created across all levels of human interaction: between individuals, in communities, in institutions, in law and government structures, and in framing discourses (Kumar et al., 2009). Abortion stigma is usually considered a "concealable" stigma: It is unknown to others unless disclosed (Quinn & Chaudior, 2009). Secrecy and disclosure of abortion often pertain to women who have had abortions, but may also apply to other groups - including abortion providers, partners of women who have had abortions, and others - who must also manage information about their relationship to abortion. As with women who have had abortions, none is fully in control of whether their status is revealed by - and to - others. Consequently, those stigmatized by abortion cope not only with the stigma once revealed but also with managing whether or not the stigma will be revealed (Quinn & Chaudoir, 2009). Other researchers have theorized that concealing abortion is part of a vicious cycle that reinforces the perpetuation of stigma(Kumar et al., 2009; Major & Gramzow, 1999). Abortion stigma has disastrous consequences around the world. People seeking abortions are bullied, shamed, marginalized, and sometimes even prevented by law or intimidation from seeking safe health care services. Abortion providers are harassed, dehumanized and targeted by regulation and anti-abortion advocates. Stigma leads to the social,

medical, and legal marginalization of abortion care around the world and is a barrier to access to high quality, safe abortion care.

It is with this model that the study explored the literature around abortion in this study.



What role does the popular media and its depiction of women, providers and the legal status of abortion play in abortion stigma?

What is the relationship between personal disclosure of abortion and abortion stigma?

How do community attitudes and actions related to abortion impact stigma or protect women against stigma?

What is the relationship between stigma and the way that abortion services are provided?

What is the relationship between laws and regulations and abortion stigma?

Figure 2.2 Ecological Model of Abortion Stigma

i) ***Individual level stigma*** is the experience (internalized, perceived and enacted) of stigma by individuals. Women who have abortions, people who support those women, and individuals involved in providing abortions all can experience individual level stigma.

ii) ***Community level stigma*** refers to the social and cultural norms, attitudes and behaviors towards abortion (women and providers) that exist in communities.

iii) ***Institutional level stigma*** refers to how policies and practices within health facilities, professional societies, and medical education institutions can have the effect of marginalizing abortion and the people who are involved in providing abortion care.

iv) ***Stigma at the legal level*** includes how barriers to abortion and reproductive health care are written into laws, and how policymakers and institutions interpret those laws in ways that discriminate.

v) ***Stigma at the mass media and cultural level*** includes how abortion care, providers and the people who have abortions are portrayed in the media, referred to in dominant discourse, and are made visible or invisible in popular culture.

2.3.4 Levels of Abortion Stigma

a) Individual Level

i) ***Secrecy and isolation.*** Among women who have abortions, experiences of secrecy and isolation were common throughout different cultural contexts. In a variety of countries throughout Africa, Asia and Latin America (Peru, Mexico, Pakistan, Nigeria, Kenya, Ghana, and Ethiopia), researchers found that women deliberately keep their decision-making and abortion experiences secret from peers, family members and partners for fear of damage to reputations. Secretiveness is one strategy that women use to avoid the social consequences of having peers and community members know about their abortions (Izugbara, Otsola, & Ezeh, 2009; Kebede, Hilden, & Middelthon, 2012; Tagoe-Darko, 2013).

Other researchers also found that abortion stigma affects women's disclosure of their experiences with abortion in the developed world, as well. In the United States and the United Kingdom, women also reported keeping their abortion experiences secret out of fear of social judgment (Astbury-Ward, 2015; Cockrill & Nack, 2013; Weitz & Cockrill, 2010). Such secrecy and social isolation can further distance women from needed social

and emotional support and can exacerbate feelings of guilt and shame. This can also lead to the paradox that something as common as abortion is seen as rare and deviant (Kumar et al., 2009). Providers also carefully manage how to and when to disclose that they provide abortions (Freedman, Landy, Darney, & Steinauer, 2010; Harris, Debbink, Martin, & Hassinger, 2011). In the United States, fear of violence and threats to professional-peer relationships drive Health providers to hide or minimize their work as abortion providers. Harris and colleagues posit that this leads to a "legitimacy paradox" The legitimacy paradox cycle works in this way: when abortion-providing health providers do not disclose their work in everyday encounters, their silence creates an impression that performing abortion work is unusual, non-standard, or non-normative (or at the very least their non-disclosure allows people to believe that nobody they know provides abortion care) (Harris et al., 2011). Abortion work comes to be seen as deviant or not the kind of work that a neighbor, friend or colleague would do. The social stereotype that legitimate, mainstream doctors don't do abortions is perpetuated. This stereotype contributes to the margin-alization of abortion providers, both inside and outside of medicine, and to the targeting of abortion providers for harassment and restrictive legislation. Providers reasonably come to fear stigmatization and harassment, which brings ongoing reluctance to disclose abortion work. Therefore, the cycle continues."

ii) **Guilt and shame**. Some studies across a diversity of region and culture found that women report feeling guilt and shame for having abortions, which was frequently articulated in the context of religion(Chiappetta-Swanson, 2005; Gipson, Hirz, & Avila, 2011; Hosseini-Chavoshi, Abbasi-Shavazi, Glazebrook, & McDonald, 2012; Palomino et al., 2011;

Shellenberg et al., 2011; Sorhaindo et al., 2014). In many countries, religious forces hold political and cultural power and shape the discourse that shapes how people understand abortion. In some studies, participants who report feelings of guilt and shame tied those feelings rarely to experiences of enacted stigma or discrimination. Rather, feelings of guilt were tied to beliefs that abortion is a sin (or that other would judge them as having sinned in the eyes of God) (Palomino et al., 2011; Shellenberg et al., 2011).

Some women who have internalized negative stereotypes about women who have abortions stigmatize other women by conjuring images of others as irresponsible, callous or promiscuous in order to distance themselves from feelings of guilt or shame. By judging other women having abortions, they created distance in order to view their own experience positively (Nickerson, Manski, & Dennis, 2014). Guilt and shame, however, are not correlated with regret. While some women express feelings of shame, they still remain firm that abortion was the best course of action (Orner, de Bruyn, & Cooper, 2011; Shellenberg et al., 2011).

b) Community level stigma

i) The centrality of motherhood. Community social norms around motherhood and the role of women, about the focus on and value of the fetus, about women's sexuality all impact the stigma attached to women who have abortions and the caregivers providing abortion. Where community norms center on the role that women are, first and foremost, mothers, the stigma surrounding abortion may be rooted in the shame of deviating from that role. The importance of motherhood arose as an important factor driving abortion stigma in

Mexico, Peru, Burkina Faso, Bangladesh, and Nepal (Hill, Tawiah-Agyemang, & Kirkwood, 2009; Payne et al., 2013; Shellenberg et al., 2011; Sorhaindo et al., 2014; Tagoe-Darko, 2013).

ii) ***Female sexuality.*** Social and community norms around women's sexuality are at the heart of the stigma surrounding abortion. In many settings, there is a strong stigma attached to sexual activity outside of marriage. In such cases, the fear of pregnancy serving as proof of sanctioned sexual activity may overwhelm the barriers to and stigma of accessing an abortion: abortion may be bad, but ill-timed pregnancy is worse (Dahlbäck, Maimbolwa, Kasonka, Bergström, & Ransjö-Arvidson, 2007; Hill et al., 2009; Kebede et al., 2012; Omo-Aghoja et al., 2009; Shellenberg et al., 2011). However, in other settings, no matter how stigmatized extramarital sex and unwanted pregnancy, abortion is seen as the more serious transgression (Gipson et al., 2011).

iii) ***Community attitudes towards women who have abortions:*** labeling and stereotyping. Violations of norms around the role of women as mothers and around socially-sanctioned sexuality lead to the labeling and stereotyping of women who have abortions. Social pressures have created a number of negative labels to apply to women who have abortions: being associated with sex work, being loose or selfish, and deserving future misfortune (Levandowski et al., 2012; Palomino et al., 2011; Shellenberg et al., 2011).

iv) ***Perceived consequences of abortion.*** In some studies, respondents framed any subsequent misfortune as perceived negative outcomes attributed to having an abortion. In Iran, misfortune after abortion is seen as punishment for the sin of abortion and is attributed to having had an abortion (Hosseini-Chavoshi et al., 2012). In Mexico,

Pakistan, Malawi, and Nepal, abortion was viewed as a threat to future fertility (Bhandari, Mo Hom, Rashid, & Theobald, 2008; Levandowski et al., 2012; Shellenberg et al., 2011). The shame and stigma of abortion are seen as contagious in Zambia, Pakistan, and Malawi. In Malawi, some believe that men will die if they have sex with a woman who has had an abortion (Levandowski et al., 2012). In Pakistan, some believe that a woman who has an abortion can make those around her sick (Shellenberg et al., 2011).

v) ***Community-enacted consequences of abortion.*** Perceived consequences of abortion can be linked to very real consequences. In many places, women may be shunned for seeking or having abortions, further perpetuating women's secrecy and isolation. In Ghana, young women might be thrown out of their homes (Tagoe-Darko, 2013). In one Antigua, providers note that "If their church finds out they have had an abortion, they'll be expelled from the church." (Cockrill & Nack, 2013; Gipson et al., 2011; Sorhaindo et al., 2014).

vi) ***Community attitudes towards abortion providers:*** labeling and stereotyping. As we've seen with women, abortion providers are also labeled and stereotyped. In Ghana and Kenya, some see abortion providers as motivated by money and greed (Harris et al., 2011; Izugbara et al., 2009; Martin, Debbink, Hassinger, Youatt, & Harris, 2014; Payne et al., 2013).

c) Institutional level

i) Barriers to providing abortions. Before addressing how stigma impacts the way abortion services are provided, it's important to note the multitude of barriers that have been put into place to delink abortion care from regular health care. In the United States, for example, there are system-level institutional policies and prohibitions on offering abortion care. Even individuals within those systems who support access to abortion may be relieved to avoid abortion provision. "The chief of my department told me, 'I think everybody's just very relieved that we don't have to worry about this ourselves.' And she's somebody who's actually a supporter, but she was relieved as the chief not to have to deal with who was going to do [abortions], who wasn't going to do them, and whether the department had to be all in agreement about providing the service." (Freedman et al., 2010). In Ethiopia, midwifery students report that religiously-based stigma surrounding abortion is a barrier to even becoming abortion providers (Holcombe, Berhe, & Cherie, 2015). In Kenya, Despite the new constitution providing that abortion can only be provided if in the opinion of a trained health care provider, when the Ministry of Health withdrew standards and guidelines relating to management of abortion in health facilities in Kenya, health providers interpreted this that abortion must not be provided in health facilities, and therefore, women who would otherwise receive safe services in public facilities are left to turn to traditional birth attendants and other quacks for terminating pregnancy and later presenting in a health facility while bleeding (E. K. Yegon, 2016; Gathura, 2014; Marlow, Wamugi, et al., 2014). Lack of access to training is also a very real barrier for individuals who may wish to become providers, as well as those who already provides abortion care.

For example, in Canada, a real lack of institutional support for nurses who manage pregnancy termination for fetal abnormality includes a lack of standardized procedures and training (Chiappetta-Swanson, 2005).

ii) Abortion stigma and quality of care. Abortion stigma can be linked to poor quality care both through institutional barriers such as training and obstructionist policies and procedures, as well as through individual stigmatizing attitudes and beliefs on the part of health-care professionals. In Ghana, nurse views on abortion are a significant barrier for providers in offering high-quality care. Some nurses refuse to set up the surgical cart and instruments (Payne et al., 2013). In Malawi, patients seeking post-abortion care may be "looked at as having done a bad thing and may be neglected" (Levandowski et al., 2012). In South Africa, studies find the inconsistent quality of care. One woman reported a surprising "lack of care received post-abortion immediately, expecting to be washed and her pain attended to, not '*chased out of the room because other people must come in*' " while others reported preferring their abortion provider for continuing family planning care because of high-quality experiences (Orner et al., 2011). In Bangladesh, provider judgments about their clients' characteristics shaped the quality of service that they provided (Bhandari et al., 2008). Health care professionals in settings where institutional policies are ambiguous can also serve as gatekeepers to care, either stigmatizing and discriminating against women or ensuring access in a complicated policy environment (Gipson et al., 2011; Orner et al., 2011; Payne et al., 2013)

d) Legal level

i) Legal abortion. Decriminalization and ensuring legal access to abortion is primary strategy of advocates for non-stigmatized abortion access. However, legal abortion is not sufficient to ensure non-stigmatized care, and law reform can lead to an increase in stigmatizing rhetoric and activism (Becker & Díaz Olavarrieta, 2013). In some settings, where abortion is both criminalized and heavily stigmatized socially, providers and advocates may not actually support efforts for decriminalization. The study considered the complicated environment of the Northeast Caribbean, where some islands have more liberal abortion laws, and others have a more legally restricted context (Pheterson & Azize, 2005): In Saint Maarten, abortion is illegal but tolerated: "Everyone knows it is done. It's an institutionalized toleration system. Safe abortions are available, also by gynecologists at the hospital. Health providers like to keep the situation illegal because then they could catch you. If anything goes wrong, they could prosecute. Meanwhile, South Africa boasts one of the most liberal abortion laws in the world. However, in practice, other researchers have observed a proliferation of unlicensed providers advertising and openly practicing. Additionally, Health providers in the public sector are mandated to provide services. Many seek conscientious objection avenues to avoid providing abortion (Harries, Gerdts, Momberg, & Greene Foster, 2015).

ii) Ambiguous legal environments. Environments where the laws and policies around abortion are unclear or ambiguous, providing abortion care can be a source of great stress and risk. The study considered the case of Ghana, where the law first states that abortion is illegal, but then goes on to lay out a number of exceptions such that in practice, it is a

liberal legal framework. However, that ambiguity has Health providers worried about fines and imprisonment for providing abortion that could be argued to fall outside of those criteria (Payne et al., 2013). The study concurs with L Martin et al. that the ambiguity of the law is both a manifestation of abortion stigma and a method by which such stigma is perpetuated. The legal code begins with a clear prohibition; it is only after that prohibition is crisply demarcated that the "extenuating circumstances" under which abortion is permitted can be listed (Martin et al., 2014).

iii) Restricted abortion settings. Where abortion is criminalized or restricted, the manifestations of stigma and discrimination may be conspicuous. Women only have clandestine avenues available to them, and the safety of those avenues is variable depending on the context and their access to quality information and drugs. In some settings, such as Burkina Faso, while there are providers willing to offer care, they only offer services to people that they can personally vouch for (Rossier, 2007). In such settings, women with means " go to private clinics and have it done by the doctors and you won't even hear about it' while "the girls and women who die from bad abortion are those who don't have money to go to proper doctors (Izugbara et al., 2009). It is not enough to simply liberalize laws. It is also critical shift the cultural context in which abortion provided and sought.

e) Mass Media and Culture Level

The study identified few studies which examined themes of abortion stigma at the level of mass media and identified four studies that employed discourse and narrative analysis methods to examine themes of abortion in the media. In Uganda, two discourse frames emerged: the

sanctity of life (a religious frame) and the fetal right to life (co-opting a human rights frame). Both discourses are in service to restricting access to abortion and have consequences for how women who access abortion are portrayed (Larsson et al., 2015). In Burkina Faso, themes around a public health frame (saving women's lives) and a rights-based frame (women's rights) were analyzed. Informants concluded that institutional and legal actors in Burkina Faso are resistant to a rights-based frame, though there was disagreement: "The issue of rights is actually a hindrance because many as soon as you mention a woman's rights they become completely closed up, and they don't want to have anything to do with it. But when you present it in terms of a public health issue, it's far more difficult for officials to ignore it." (Storeng & Ouattara, 2014). Both of these studies assessed the way abortion is portrayed in the news media.

In the United States and in the United Kingdom, researchers found narrative themes that emphasized abortion as a risk, as unsafe. In the UK, an analysis of Scottish and British newspapers found that abortion was consistently framed as negative: risky, unsafe, and immoral. The voices of women themselves were marginalized, creating a discourse that marked abortion as deviant and abortion stigma as inevitable (Purcell, Hilton, & McDaid, 2014). In the US, researchers analyzed all representations of pregnancy decision-making and abortion in American film and television from 1916 through January 2013. They found that abortion was fictionally linked to mortality at a much higher rate than in reality, contributing to a social understanding that abortion is risky and dangerous (Sisson & Kimport, 2014).The way abortion is characterized in the popular media, both the entertainment media and the news media, can influence the way abortion is understood.

f) Stigma at One Level May Impact How Stigma Manifests on Other Levels

In addition to exploring how stigma manifests at each of the five levels of the ecological model, the study also reviewed the complex interplay between levels.

i) ***The law/policy environment and institutional settings.*** For example, in some Caribbean islands, providers offer abortion extra-legally. As the study indicated in the case of St Maarten, Health providers fear that new laws "legalizing" abortion will restrict their provision more than the status quo. At the same time, regardless of the nature of a country's abortion laws, the impact of provider-level stigmatizing attitudes can be very powerful. Health providers hold a great deal of privilege and power and can determine who can have an abortion and when/why. "I try to discourage women from having an abortion unless they have heavy social reasons. If a woman has six or seven or eight children, okay, but if she has only two or three, then I don't do the abortion'' (Pheterson & Azize, 2005). The study also considered Burkina Faso, where there are very few indications for legal abortion: "Due to the difficult procedures involved in obtaining abortions for legal indications, individual doctors often arbitrate over women's access to 'therapeutic' abortion, often without consulting the legal system or medical colleagues. This is to avoid being accused of colluding with women, who are often suspected of lying about sexual assault to justify their abortion requests" (Storeng & Ouattara, 2014). Legal ambiguity can also have an impact on the quality of care provided in an institutional setting. In Ghana, for example, some private practices don't maintain any records (Payne et al., 2013). Finally, the legal and policy environment directly impacts how doctors

characterize their work with each other, with administrators and with the public. In Bolivia, doctors' discourse about the care they were providing was highly attuned to their audience, and they expressed compliance and adherence to law and policies even as their practice conflicted with established rules (Rance, 2005). Opaque and ambiguous legal and policy environments can have both a chilling effect on providers and health systems while also offering some opportunities for those providers to resist stigma and create avenues of access.

ii) ***Institutional, community, and individual***: Other researchers observed a paradox that where abortion is legal, and there have been concerted efforts to increase availability of health systems, women are still seeking an abortion outside of those legal avenues of care. This can be related how it is provided institutionally, including the quality of care or lack thereof, perceptions of confidentiality. When combined with stigmatizing community norms about abortion, pregnancy, and sexuality, the question arises: What does "safe" mean? Upon examination, it appears that "safe" can mean different things, depending on the social and cultural context of abortion. In Kenya, great efforts have been underway to train providers and to educate women about accessible abortion services. However, the social stigma of abortion is still pervasive. A public health framework for safety may seem unambiguous: evidence-based methods with trained providers in a health facility. Women, on the other hand, value privacy, cost, in some cases, the ability to maintain secrecy, and in other cases, services that are vouched for through social networks. This may lead women to seek

care in settings that public health practitioners would deem unsafe (Izugbara, Egesa, & Okelo, 2015). This theme is echoed in the United States, where women express a preference for abortion clinics over their own provider. Again, women value privacy, cost, and ability to control their image in their assessments of safe or appropriate services (Weitz & Cockrill, 2010). Other researchers in the United States also found that some abortion clinic processes could reinforce a community narrative that abortion is unsafe and lonely. When women experience clinical processes and interactions that are mandated by the realities of anti-abortion hostility, women can have individual negative experiences and the social myth that an abortion clinic is dangerous can be reinforced (Kimport, Cockrill, & Weitz, 2012; Kimport, Preskill, Cockrill, & Weitz, 2012). As providers, policymakers and programs seek to increase women's access to safe abortion, whether within a health-care setting or by increasing access to medications through other channels, an understanding of how women conceptualize safety and danger and how that is influenced by abortion stigma is critical.

g) Intersections: The Compounding Effect of Multiple Stigmas

The impact of stigma can be exacerbated among those who are marginalized due to other stigmatized identities. Two recurring themes emerged in the literature: Young women and HIV-positive women.

i) Youth and abortion stigma. Sexual activity among young unmarried women is highly penalized in many cultural settings. For example, in China, sexual activity

under the age of 16 is illegal regardless of consent: “By the threat of punishment of men to deter sexual intercourse, these laws have also increased teenage girls’ vulnerability to unsafe abortions or having babies at a young age.” This explicit law and cultural norm lead to girls hiding pregnancies and abortions to protect their partners. Laws that criminalize sexual activity among young people and that mandate parent consent create silence, shame, and increased access to poor quality and frequently expensive services instead of high quality, publicly available care in Hong Kong (Hung, 2010). In India, the social stigma surrounding young people’s sexuality is so pervasive that the fear of disclosing unplanned parenthood leads to delays in seeking abortion services (Sowmini, 2013) and in Zambia, the “double stigma” of social unacceptability is manifested by a young, unmarried woman’s pregnancy and abortion, which may even be coerced by her parents (Dahlbäck et al., 2007). The stigma of abortion that is rooted in community norms around women’s sexual agency is compounded for young people, who may have fewer resources at their disposal and even more barriers stopping them from accessing care.

ii) ***HIV stigma and abortion stigma.*** A series of studies in South Africa explored the impact of stigma among HIV-positive women who were pregnant and considering abortion. “The HIV-positive women in this study represent a triple-bind situation. They experience social disapproval if they become pregnant after knowing their HIV-positive status; they are often impeded in attempts to prevent pregnancy by uncooperative partners or experience difficulties in using contraception; they feel

even stronger social and internalized disapproval when they consider or have an abortion"(Orner et al., 2011).

iii) ***Some women perceive that abortion is even more taboo than HIV.*** Study participants in both Kenya and South Africa observed that more women disclose HIV status than experience with abortion. "In this country, HIV-infected people speak openly about their status and even attract sympathy and support. Abortion is the worst thing you can do as a woman. If you admit to it openly or if it is found out, you will lose every respect you have. People will call you bad names" (Izugbara et al., 2009; Orner et al., 2011).

2.3.5 Law and Abortion in Kenya

The legal framework for the sexual and reproductive health and rights (SRHR) of Kenyan women, including their ability to gain access to safe abortion improved dramatically with the overwhelming approval and promulgation of a new constitution in August 2010. This study concludes that the Kenyan constitution **does not permit** abortion but provides an exception to when an abortion can be provided. Article 26(4) of the Constitution of Kenya is explicit regarding exception where abortion may be permitted. *Abortion is not permitted unless, in the opinion of a trained health professional, there is a need for emergency treatment or the life or health of the mother is in danger, or if permitted by any other written law(Kramon & Posner, 2011).* Article 43 (1) (a) further widens access to reproductive health rights including access to safe abortion-*Every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive health care* (Kenya, 2010; Moses Mulumba, April 2010).

The Kenya Health Policy, 2012 – 2030 gives directions to ensure significant improvement in overall health status of Kenyans in line with Vision 2030, the Constitution of Kenya, 2010 and global commitments. It reaffirms Kenya's commitment to the realization of fundamental human rights as enshrined in the Constitution of Kenya, 2010 (MOH, 2012a, 2012b). The Reproductive Health (RH) Policy, 2007 aims to improve the reproductive health status of all people in Kenya by increasing equitable access and improving quality, efficiency and effectiveness of service delivery at all levels. The Adolescent Reproductive Health Development Policy acknowledges the contribution of unsafe abortion to maternal morbidity and mortality among the youth. The policy makes some recommendations to address unsafe abortion among the youth including effective advocacy and service provision, promotion of knowledge and adoption of appropriate attitudes towards abortion-related issues including adequate information, as well as improved access to contraceptive and postabortion care services.

In a study conducted in western Kenya, most community members reported that abortion was illegal. They were not aware that there are instances in which abortion services could be offered legally and would often turn to traditional birth attendants who provided unsafe abortion or private providers who charged very high costs for providing an abortion (Marlow, Wamugi, et al., 2014). Despite legal restrictions and the medical risks associated with unsafe abortion procedures, Kenyan women still obtain abortions services from a wide range of providers, including doctors at private clinics, midwives, traditional herbalists and other untrained providers; some women induce abortion themselves (Hussain, 2012).

2.3.6 Magnitude of Unsafe abortions in Kenya

In Kenya, unsafe abortion remains a major social and public health problem. Recent nationwide research in Kenya showed that about half a million induced abortions occurred in the country in 2012, corresponding to an induced abortion ratio of 30 abortions per 100 live births, and a rate of 48 abortions per 1000 women of reproductive age (African Population and Health Research Center et al., 2013). The study established that the bulk of unsafe abortion-related admissions in Kenya are managed in public health facilities (African Population and Health Research Center et al., 2013). The study also indicated that 77 percent of women who presented for post-abortion care (PAC) in Kenyan health facilities were treated for moderately severe and severe complications, such as sepsis, shock, or organ failure (African Population and Health Research Center et al., 2013). Unsafe abortion-related mortality is also common in Kenya (African Population and Health Research Center et al., 2013).

The management and treatment of complications of unsafe abortion exerts substantial toll on health systems resources(Shearer, Walker, & Vlassoff, 2010; Vlassoff et al., 2014). Many of these complications are emergencies and require extended hospital stays, intensive care, and attendance by highly-skilled health providers(Babigumira et al., 2011). In Kenya, unsafe abortion is a major cause of maternal morbidity and mortality with 35% of maternal deaths attributable to unsafe abortion(Hussain, 2012). Virtually all abortion-related deaths and health problems are preventable, as are most of the unintended pregnancies that lead to abortion. More than 40% of births in Kenya are unplanned, and one in four married women has an unmet need for contraceptives (Sedgh et al., 2007; Sedgh et al., 2012).

Nearly 465,000 induced abortions occurred in 2012, translating to a high national abortion rate of 48 per 1,000 women of reproductive age (15- 49 years) (Mohamed et al., 2015). This rate is comparable to Uganda's but much higher than other countries in Africa or elsewhere in the world (Rasch, 2011; Sedgh et al., 2012) The rate is highest in the Rift Valley and Nyanza/Western regions (64 and 63 per 1000 women of reproductive age, respectively). Nearly 120,000 women received care for complications resulting from unsafe abortions in health facilities in 2012. More than three-quarters of women who were treated for post-abortion care had moderate or severe complications, including high fever, sepsis, shock, or organ failure, which can require extensive treatment or hospitalization. Delays in seeking care and reporting to the provider that they interfered with the continuation of their pregnancy were highly associated with the severity of complications. Young women suffered disproportionately, as 45% of women aged 19 and younger who came to a health facility for post-abortion care, experienced severe complications (APHRC, 2013)

Kenya has a relatively high case-fatality rate of 266 deaths per 100,000 unsafe procedures (Eschenbach, 2015). These deaths are almost entirely preventable. The World Health Organization (WHO) estimates the case-fatality rate in developed regions to be 30 per 100,000, compared to an estimated 460 deaths per 100,000 unsafe abortions on the African continent. Women who have abortions in Kenya are diverse—educated and non-educated, urban and rural, Christian and Muslim, married and unmarried, old and young (Mohamed et al., 2015; Ziraba et al., 2015). More than 70% of women seeking post-abortion care were not using a method of contraception prior to becoming pregnant. Similarly, the results of the most recent Demographic and Health Survey in Kenya (2008-2009) found that 43% of births in the preceding five years

were reported by women as unwanted or mistimed, reflecting significant barriers to access and use of effective contraceptive methods (Demographic, 2015). For most women reaching health facilities, methods of post-abortion care and induced abortion recommended by the World Health Organization were available and provided by trained providers. Post-abortion care arising from unsafe abortion adds an extra strain on limited resources in an already overstretched healthcare system (M. o. H. African Population and Health Research Center, Kenya, Ipas, and Guttmacher Institute, 2013).

2.4 Research Gaps

Understanding and addressing abortion stigma is critical to ensuring women's access to safe, comprehensive abortion care and upholding women's basic human right to decide when and if to have children. While some studies have explored abortion stigma in the African context, from the literature review conducted in the study, no study have quantitatively measured individual and community-level stigma to inform stigma reduction strategies. It is also clear from literature examined in this study that unsafe abortion is a key driver to high maternal mortality in Kenya, contributing to 35% of all maternal deaths and disabilities. Several factors including restrictive policy and legal environment, beliefs and attitudes and lack of knowledge have been found to precipitate unsafe abortions. Despite the current constitutional and policy provisions that aim to promote women's reproductive rights, the socio-cultural environment, coupled with lack of information has limited the translation of these gains into real rights for women seeking abortion services, with literature showing that the incidence of unsafe abortion in Kenya has been on the rise in the last 10 years.

This study sought to examine the correlation between stigma with the incidence of unsafe abortion, with a specific focus on of two regions from regions with the high and low incidence of unsafe abortion respectively. Based on the findings, the study sought to draw inferences on the extent to which stigma levels influenced the incidence of unsafe abortion. The study collected data on perceptions of individuals and community members regarding abortion and extrapolated the perceptions to draw inferences.

CHAPTER THREE
METHODOLOGY

3.1 Study Area

This study was conducted in Trans Nzoia and Machakos regions located in regions with the high and low incidence of unsafe abortion respectively. The Kenya Demographic and Health Survey of 2008/09 estimates that the current maternal mortality ratio in Kenya stands at 488 per 100, 000 live births while Kenya Service Provision Assessment (KSPA) shows that maternal and newborn health indicators are still poor in health facilities across the country. According to the National Coordinating Agency for Population and Development, despite Trans Nzoia and Machakos regions having several health facilities, several sexual and reproductive health (SRH) issues persist in them (Agwanda, Khasakhala, & Kimani, 2009). These include among others: i) Incomplete immunization of children under 5 years; ii) Lack of awareness by the communities on what services are provided by MOH facilities; iii) Services, especially deliveries, provided by untrained personnel; iv) Low contraceptive acceptance rate; and iv) Inadequate post-abortion care services, including training of health workers in post-abortion care. However, abortion ratios are higher in Rift Valley- where Trans Nzoia is located, at 64 per 1000 live births and lowest in Eastern, where Machakos County is located in Eastern Region at 20 per 1000 live births as shown in Table 3.1. It is by these characteristics that the study focused on these two regions to establish the correlation between stigma and levels of unsafe abortion.

Table 3.1 National and Regional Induced Abortion Rates and Ratios, Kenya

	Number of women (in 000's) of reproductive age (15-49)	Induced Abortion Rate per 1,000 women of reproductive age	Induced Abortion Ratio per 100 live births
Total	9600	48	30
Central & Nairobi	2186	32	20
Coast & N. Eastern	1298	51	32
Eastern	1382	20	13
Nyanza & Western	2329	63	39
Rift Valley	2404	64	40

Adapted from, APHRC, 2013:(M. o. H. African Population and Health Research Center, Kenya, Ipas, and Guttmacher Institute, 2013)

3.1.1 About Trans Nzoia County

Located in the former Rift Valley Province, it borders the Republic of Uganda to the North West, and West Pokot County to North, Elgeyo Marakwet County to the East, Uasin Gishu County, and Kakamega County to the South, and Bungoma County to the West and South West. Tran's Nzoia county has its headquarters as Kitale, and it is divided into three administrative units Cherangany, Kwanza, and Sabot regions and has two local

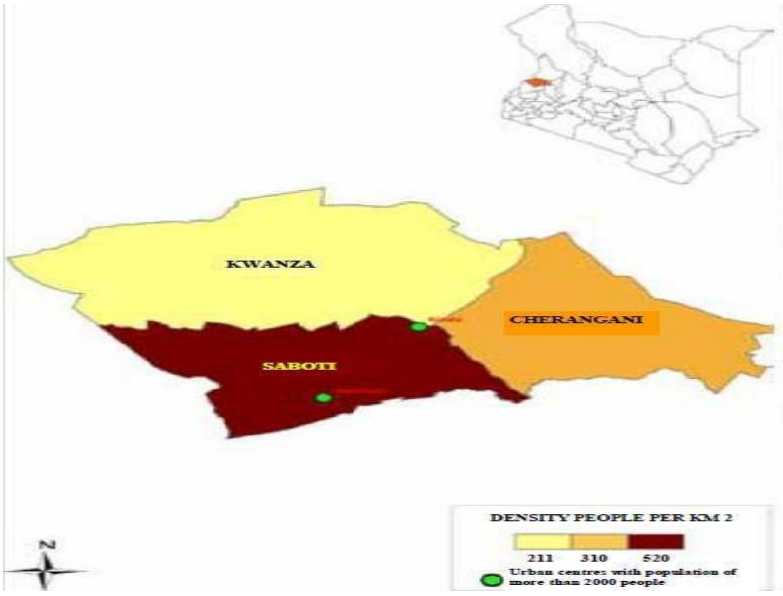


Figure 3.1 Map of Tran's nzoia County

authorities namely Nzoia County Council, Municipal Council of Kitale.

Trans Nzoia County is the 21st largest county by population in Kenya, with a total population of 804,081 (Male 49 %, Female 51 %) representing a population of 2.12 % of the national population, and a growth rate of 4.2% per annum. 50% of the population in the county are aged between 15- 64, with 47% of the population aged between 0-14, while 3% of the county population is aged above 65 (Cheserem, 2011).

1.8.2Machakos County:

Machakos County is in the former Eastern Province. Its capital town Machakos is cosmopolitan and is located 64 kilometers southeast of Nairobi. It borders Embu, Muranga, and Kiambu Regions to the North, Nairobi and Kajiado Regions to the West, Makueni County to the South and Kitui County to the East. The County has eight constituencies which are: Machakos Town, Masinga, Yatta, Kangundo, Matungulu, Kathiani, Mavoko and Mwala. The County covers 6,208 square km and has a population of 1,098,584 as per 2009 census (Male – 49%, Female – 51%); with an age distribution of

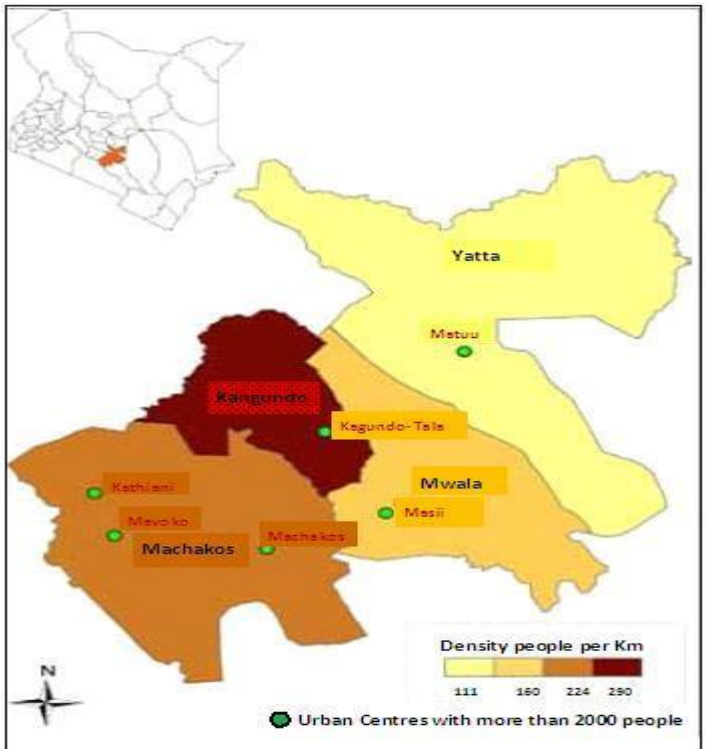


Figure 3.2 Map of Machakos County

0 to 14 years at 39%, 15 to 64 years at 56% and 5% above 65 years. Its population annual growth rate is 1.7% with a current estimate of 264,500 households of which only 17% is accessing electricity(Cheserem, 2011).

Regional statistics from the Ministry of Health Study on the Incidence of Unsafe Abortion in Kenya(M. o. H. African Population and Health Research Center, Kenya, Ipas, and Guttmacher Institute, 2013) indicate that different regions in Kenya have different abortion rates. Rift Valley Region, where Trans Nzoia County is located, reported the highest abortion incidence of 31 per 1000 women of reproductive age, whereas Eastern Region, where Machakos County is located, reported the lowest incidence of 6 per 1000 women of reproductive age. The study, therefore, assessed the link between abortion-related stigma and unsafe abortion, including whether regions with high abortion incidence have high rates of unsafe abortion and the factors that precipitate abortion-related stigma.

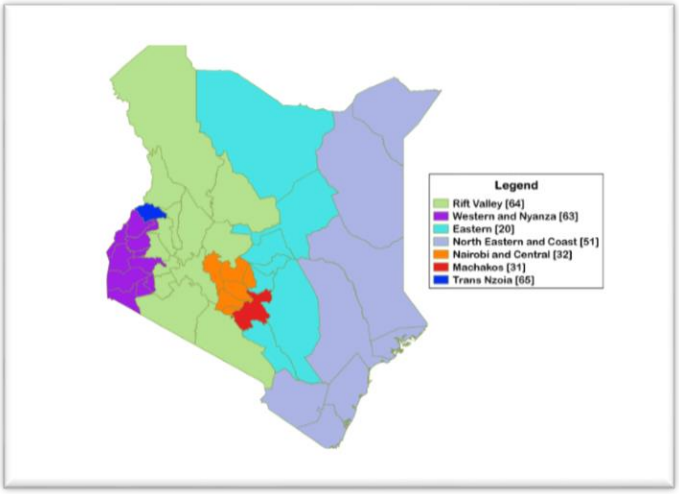


Figure 3.3 Incidence of Unsafe Abortion Map in Kenya

3.2 Overview of Study Methodology

This study employed mixed methods with the convergent parallel design. Mixed methods approach entailed combining both qualitative and quantitative data collection methods in a single study (Creswell, 2013).This was critical in helping to understand abortion-related stigma

given the sensitivities around the topic. Mixed methods were found important in providing more nuanced knowledge that is essential in informing theory and practice as well as adding insights into what could have been missed if only a single research method was used (Creswell, 2013; Tashakkori & Teddlie, 2010).

Mixing methods were considered vital in this study to provide avenues to generate exhaustively knowledge on the manifestation of abortion-related stigma among abortion clients and general community members where these clients came from, as well as investigating if there was any relationship between abortion-related stigma and incidence of unsafe abortion. This study applied a convergent parallel design as the data was collected and analyzed per method with the point of the interface in the two methods being a comparison of results from each method. This was followed by interpretation of data results from each method. After implementation of the model, studies were conducted to evaluate the proposed model using both quantitative and qualitative approaches. Qualitative methods explored factors associated with abortion stigma at personal and community level within the study site. The quantitative surveys informed on the magnitude of abortion-related stigma among individual women receiving abortion care services and among general community members and were used to determine the association between the incidence of unsafe abortions and abortion-related stigma in Trans Nzoia and Machakos Regions. Figure 6 below illustrates the design for this study.

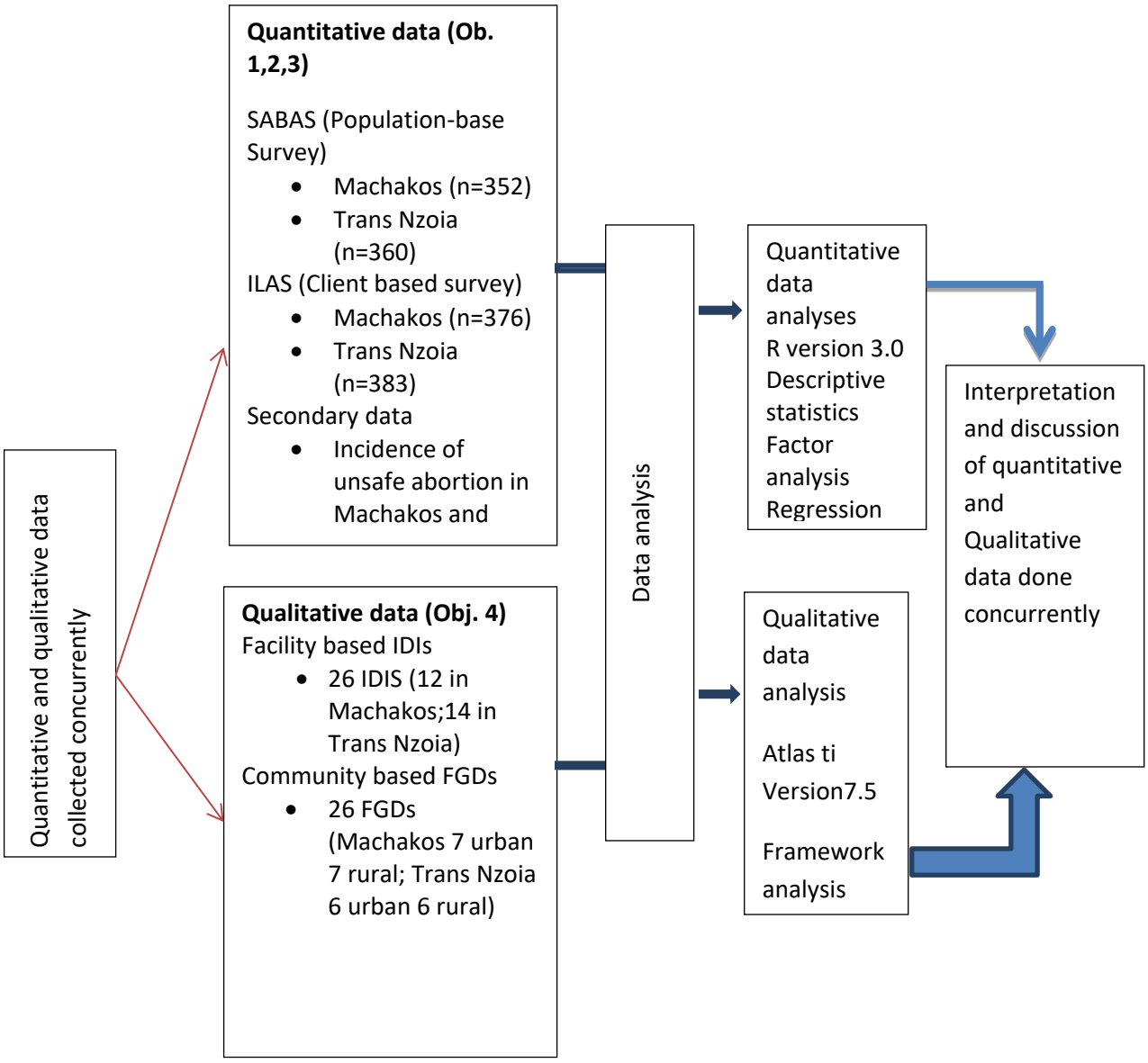


Figure 3.4 Study Design

3.2 Quantitative Methods

3.2.1 Individual Abortion Stigma Scale

3.2.1.1 Study Population

The study population comprised women of reproductive age (15-49 years) in Machakos and Trans Nzoia counties. To participate in the study, members of the study population had to meet the following criteria:

a) Criteria for inclusion of subjects

- For ILAS, any female client of reproductive age treated for abortion in selected health facilities in Trans Nzoia and Machakos counties

b) Criteria for the exclusion of subjects.

- Any respondents of reproductive age of unsound mind at the time of data collection
- Clients willing to participate in the study but were unstable or did not feel comfortable during the interview
- Clients who did not consent or those below 18 years without a guardian to consent on their behalf

3.2.1.2 Sampling for Individual Level Abortion-Related Stigma Scale

A multistage sampling method was used. To identify health facilities that participated in the study, a purposive sampling of health facilities that provide abortion care services was done. The facility was required to have a trained health provider, and to have been providing uterine evacuation services using either surgical or medical methods. Second-stage sampling involved a probability proportionate to size, where a list of all health facilities in the county providing CAC services over the last one year was generated. In order to reach the desired sample size,

health facilities that were seeing more clients compared to those seeing fewer clients were selected. In this case, a facility seeing an average of five clients per month was selected. All women seeking abortion care services during the one-month period in the selected health facilities in the two counties were considered as study respondents, but participation was purely on voluntary basis and upon receiving health care services. Women were approached by their health care provider or his/her delegate and asked if they would like to learn more about a simple study. This was only done after their care so that treatment could not be construed to be related to survey participation. Any woman who positively responded was read for information on the study and duly informed that her participation was voluntary. This was done in the language of their choice and asked to sign or mark to represent written informed consent to participate in the study.

i) Sample Size Determination and Sampling for Determining Levels of Stigma Among Induced Clients Compared to Spontaneous Clients

The study adopted a two-stage sampling where the first stage sampling involved sampling of health facilities in the two counties based on the levels of health services defined by the Kenya Essential Package for Health (KEPH). KEPH defined six levels of preventive and curative health services from level 1-6 as per the Ministry of Health Department of Health Management Information System (HMIS). Per the national health facility master-list, there are 8,014 health facilities in Kenya (at levels 2-6) and 329 facilities in Machakos County and 126 facilities in Trans Nzoia County. Using a list of health facilities that provide PAC services in the two

counties generated by the HMIS department, a total of 475 facilities formed the universe/sampling frame for this study.

A county representative stratified random sampling plan was employed to select the health facilities to be surveyed in each county. Stratification was done by the level of health facility, type of ownership (government or private/non-governmental) and geographical region. The sampling frame for the study was limited to all levels 2 to 6 health facilities that offer PAC but excluded health facilities belonging to armed forces and prisons as there are usually challenges in accessing data from such facilities. The study also excluded from the sampling frame blood banks, dental clinics, eye centers, laboratories, radiology units, rehabilitation centers, and VCT centers. Therefore, the sampling frame consisted of 257(172 in Machakos and 85 in Trans Nzoia) facilities at levels 2-6.

ii) **Sampling Strategy for Selecting Abortion Clients in Health Facilities Offering Abortion Care Services:**

Levels 5, 6, Marie Stopes International (MSI) and Family Health Options of Kenya (FHOK) facilities were included in the study. The sampling fraction was 1.0; level 4 health facilities at a sampling fraction of 0.21 to 0.44; level 3 health facilities at a fraction of 0.1 to 0.21; while level 2 facilities were represented at a fraction of 0.055 to 0.1. This depended on the number of health facilities in the county. The proportion assigned to each stratum or level reflected the importance of each facility type in the management or treatment of abortion-related complications in Kenya. Facilities that were more likely to treat large numbers of women with abortion complications (such as levels 5, 6, MSI and FHOK facilities) were assigned a higher probability of being sampled. In total, 42 health facilities were sampled using the above criteria

as shown in Table 2. An additional 20% of facilities at levels 2-4 (a total of 7 facilities) were added to cater for non-response, making the total /49 facilities sampled

Table 3.2 Sampling Strategy for Selection of Health Facilities

	Level 2	**level 3**	**Level 4**	**Level 5**	**MSI**	**FHOK**	**Total**
Machakos	4	5	8	1	1	0	19
Trans Nzoia	4	6	10	1	1	1	23
Total	8	11	18	2	2	1	42

A final list of facilities to be sampled was obtained in each county in consultation and participation of the County Department of Health based on health facility caseload of abortion and capacity in the provision of abortion care services. A simple random sampling of women who have received abortion care services done once a health facility was sampled.

For abortion clients, the sample size was estimated using formulae for estimating two proportions (Donner & Makuch, 1985). The sample size calculation in this survey was based on the key outcome indicator *"incidence of unsafe abortion in Eastern Province and Rift Valley province estimated at 13% [1](M. o. H. African Population and Health Research Center, Kenya, Ipas, and Guttmacher Institute, 2013)as baseline figure".*

$$n = \frac{\left\{Z_\alpha\sqrt{2P(1-P)} + Z_\beta\sqrt{P_1(1-P_1) + P_2(1-P_2)}\right\}^2}{(P_2 - P_1)^2}$$

Where:

Zα= the Z-score corresponding to the probability with which it was desired to be able to conclude that an observed change of size (P_2-P_1) would not have occurred by chance; set at 1.96

$P = (P_1 + P_2) / 2$

Zβ= the z-score corresponding to the degree of confidence with which it was desired to be certain of detecting a change of size (P_2-P_1) if one occurred. Set at 0.84 (average power value)

P1 = anticipated event rate among Machakos; "levels of abortion stigma in Kenya. This was unknown so the study assumed 50%*)*".

P2 = anticipated difference in stigma levels in the two study sites, such that the quantity (P_2-P_1) was the magnitude of change desired to be able to detect differences (This was also unknown, and we assumed there was a 20% difference between induced abortion clients and spontaneous abortion clients.

$$n = \frac{\left\{1.96\sqrt{0.0975(1-0.0975)} + 0.84\sqrt{0.13(1-0.13) + 0.065(1-0.065)}\right\}^2}{(0.065-0.13)^2}$$

n= 215 ≅ +10% non-response rate= 238

Total sample 238 x 2 (for high incidence and low incidence areas) = 476

3.2.1.3 Individual Level Abortion Stigma Scale

The Individual Level Abortion Stigma Scale (ILAS) is a theory-based, multidimensional, validated scale to measure stigma among women who have had abortions. Items were developed based on (Cockrill et al., 2013)conceptual framework for individual level abortion stigma and existing measures of other individual level stigmas (.e.g. HIV/AIDS (Turan et al., 2012) and sexual stigma (Major & Gramzow, 1999))**.**

The 20 items in ILAs scale were administered to women who had had an abortion. Once data was collected, factor analysis of the 4-factor model for individual-level abortion stigma; overall scale, worries about judgment sub-scale, isolation sub-scale, self-Judgment sub-scale and community condemnation sub-scales was conducted. Cronbach's alpha scores were computed to confirm if the final scale and factors (subscales) have high internal consistency and reliability. High scores on the ILAS scale and subscales indicate increased stigma. Seven of the items were reverse-coded (indicated with a *) because they measure positive behaviors or feelings and are therefore inversely correlated with the other 13 items on the scale. Scores for the full scale and subscales are calculated by summing the item scores and dividing by the number of items. Within the scales and sub-scales, there are no clear thresholds or cut-off points related to stigmatization, and this was determined during the study.

3.2.2 Measuring Community Level Stigma

3.2.2.1 Study Population

The study population comprised general members of the community and included both men and women of reproductive age (15-49 years) in Machakos and Trans Nzoia counties. To participate in the study, members of the study population had to meet the following criteria:

a) Criteria for inclusion of subjects

- Must be general community members living in the sampled community
- For women, their age should be between 15 – 49 Years
- For Men, their age should be above 18 Years

b) Criteria for the exclusion of subjects.

- Any respondents of reproductive age of unsound mind at the time of data collection

- Respondents who did not consent or those below 18 years without a guardian to consent on their behalf

3.2.2.2 Sampling Procedure for Selecting General Community Members

The surveys were designed to collect information from households within the two counties. A multistage sampling technique was used. First, purposive non-probability sampling was used to identify counties, sub-counties, locations and sub locations. At the sub-location level, a systematic sampling technique was used to select households to be interviewed.

A household survey was conducted with a target sample of 150 women and 75 men in each county, totaling to 716 respondents for SABAS as shown in Table 3. Respondents for the survey were men and women of reproductive age (i.e. between the ages 18 and 49). The sampling frame for the household survey comprised the divisional administrative units in each sub-county in the study sites. For each sub-county, the divisional administrative units were first stratified by population size, and approximately eight locations were selected from the divisions, based on the population distribution across the units. In each location, four sub-locations were selected randomly, giving about 32 sub-locations.

The final selection unit was the sub-location/community unit. In each of the 32 community units, 24 households were selected for an interview. Within each of these, approximately 16 women and eight men were sampled in order to reach the target sample sizes of 256 and 128 per district. Each sub-location had three enumerators (1 male and 2 female). The first household

to be sampled was taken as the 5th house from the center of the sub location; from then on every 5th household was sampled systematically until the appropriate sample size was achieved.

Table 3.3: SABAS Sampling Frame

Sampling unit	**Machakos County**	**Trans Nzoia County**	**Total**
Districts	4 districts	4 districts	8 districts
Divisions	1 division per district randomly selected	1 division was sampled per District randomly	8 divisions
Location	4 locations sampled per division	4 locations sampled per division	8 locations
Sublocation / Community Unit	4 sub locations/ CUs were sampled per location giving a total of 16 CUs	4sublocations/ CUse sampled per location giving a total of 16 CUs	32 sub locations /community units
Actual sample	In each of the CUs, 358HHs were sampled on a ratio of 2:1 for females and males respectively giving a total of 225 HHs (239 women, 119 men)	In each of the CUs, 358HHs were sampled on a ratio of 2:1 for females and males respectively giving a total of 225 HHs (239 women, 119 men)	32 sub locations
Total	**358**	**358**	**716HH respondents**

i) Sample Size Determination and Sampling for Determining Association Between Incidence of Unsafe Abortion and Abortion-Related Stigma

The sample size was estimated using formulae for estimating two proportions (Donner & Makuch, 1985). The sample size calculation in this survey was based on the key outcome indicator *"incidence of unsafe abortion in the former Eastern Province and Rift Valley province estimated at 13% (M. o. H. African Population and Health Research Center, Kenya, Ipas, and Guttmacher Institute, 2013; Ziraba et al., 2015) as baseline figure".*

$$n = \frac{\left\{Z_\alpha\sqrt{2P(1-P)} + Z_\beta\sqrt{P_1(1-P_1) + P_2(1-P_2)}\right\}^2}{(P_2 - P_1)^2}$$

Where:

Zα= the Z-score corresponding to the probability with which it was desired to be able to conclude that an observed change of size (P_2-P_1) would not have occurred by chance; set at 1.96

P = (P_1 + P_2) / 2

Zβ= the z-score corresponding to the degree of confidence with which it was desired to be certain of detecting a change of size (P_2-P_1) if one occurred. Set at 0.84 (average power value)

P1 = anticipated event rate among Machakos; "Incidence of Unsafe Abortion in Eastern province *at 13%).*"

P2 = anticipated incidence rate in Machakos such that the quantity (P_2-P_1) is the size of the magnitude of change desired to be able to detect differences (the study assumed that there is a 50% difference in levels of stigma in the two study sites i.e. 13% and 6.5%.

$$n = \frac{\left\{1.96\sqrt{0.0975(1-0.0975)} + 0.84\sqrt{0.13(1-0.13) + 0.065(1-0.065)}\right\}^2}{(0.065 - 0.13)^2}$$

n= 325 ≅ +10% non-response rate= 358

Total sample 358 x 2 (for high incidence and low incidence areas) = 716

3.2.2.3 Community Level Stigma Scale

The Stigmatising Attitudes, Beliefs, and Actions Scale (SABAS) is a tool designed to measure abortion-related stigma at the community level (Shellenberg et al., 2011). It is intended to

measure individuals' stigmatizing attitudes, beliefs and actions towards women who have abortions. SABAS captures three important dimensions of abortion stigma: negative stereotypes about men and women who are associated with abortion, discrimination/exclusion of women who have abortions, and fear of contagion as a result of coming in contact with a woman who has had an abortion.

The response categories for SABAS are set up on a Likert scale from "strongly disagree" to "strongly agree" with each response being assigned a value ranging from 1-5. SABAS is easy to score and can be scored in four different ways: total score, negative stereotyping sub-scale, exclusion and discrimination subscale, and fear of contagion subscale. There are items that are used in the total score and the exclusion and discrimination sub-scale and were reverse coded so that a higher score reflects a more stigmatizing attitude, i.e. strongly disagree=5, disagree=4, unsure=3, agree=2 and strongly agree=1). Regardless of whether you are looking at the total SABAS score or the score of individual sub-scales, a higher score represents more stigmatizing attitudes and beliefs about women who have an abortion. There are no predetermined cutoffs or thresholds for what represents stigma, and this was determined during this study.

3.2.3 Quantitative Procedures

In order to measure the levels of stigma among individual abortion clients and general community members, a cross-sectional study design was used. Individual Level Abortion Stigma Scale (ILAS) was employed among abortion clients in selected health facilities in the study sites. At the community level, Stigmatising Attitudes, Beliefs Action Scale (SABAS) was administered to general community members in selected locations within the study sites.

3.3 Qualitative Methods

3.3.1 Study Population

For in-depth interviews, study population comprised women of reproductive age in Machakos and Trans Nzoia counties. Focus group discussions population included men and women of reproductive age in the two counties. Men and women both married and unmarried were interviewed separately.

a) Criteria for inclusion of subjects

- For the focus group discussions- men and women of reproductive age resident in the two counties as confirmed by other men and women in that focus group discussants
- For client in-depth interviews- women who received abortion care services immediately in selected health facility in each region

b) Criteria for exclusion of subjects

- Any respondent of reproductive age who was of unsound at the time of the study
- Clients who were willing to participate in the study but were unstable or did not feel comfortable after uterine evacuation procedure during the interview
- Clients who did not consent or those below 18 years and were not accompanied by a guardian were excluded from this study

3.3.2 Qualitative Procedures with Women Who Have Received Abortion Care

In each county, two facilities were conveniently selected both from those that had reported serving the most number of women seeking abortion-related services in 2012. To be eligible, women had to have received either PAC or induced abortion in the selected facilities, be able

and consent to participate in the study. This strategy yielded 26 women accepting to be interviewed with nine declining from participating. The data collection team administered a semi-structured interview guide to collect information for the study. Data collection team comprised the principal investigator assisted by two nurses working in the same facility who had undergone two-day training on how to obtain informed consent, administering and safe keeping of data from IDIs. Each IDI lasted on average one and half hours.

3.3.3 Focus Group Discussions

Each county was disaggregated into three main regions: urban, semi –urban and rural. One FGD was conducted in each county targeting unmarried men and women and married men and women, each conducted separately. This strategy yielded a total of 26 FGDs in each county. Using four Community Health Volunteers (CHVs) as per MOH Community Health Strategy(Haines et al., 2007) in each county, community members were recruited from locations where they usually met for social functions. Such places included churches and water collection points, farms where women were cultivating and saloons. Unmarried men were recruited from venues of youth activities including video joints, sports events, while married men recruited from their favorite community clubs, in farms and men's meetings within the community. The FGD guides administered to this population covered the following topics: unwanted pregnancy; abortion; community attitudes toward women who have abortions; manifestation of stigma; community views on abortion stigma including women who have undergone an abortion; community views on providers of abortion care services; community perceptions on women's situation regarding abortion, sources of information regarding

abortion. Data collection team comprising the CHVs underwent a two-day training on how to obtain informed consent and in administering the interview guide including using recorders. The FGDs lasted on average two and half hours. All FGDs were recorded using a digital recorder and then transcribed; we then translated all transcriptions into English.

3.3.4 In-Depth Interviews

IDIs were conducted with abortion and post-abortion care (PAC) clients at each participating facility. All IDI respondents were 18 years or older and able to provide informed consent. An IDI guide was developed to elicit information on clients' opinions on their experience at the health-care facility and their thoughts/feelings about their abortion care. This comprised 17 questions seeking information on woman's background; how they learned that they were pregnant; their thoughts and feelings about the pregnancy; what led them to seek information about abortion; where they sought information about abortion; their experience before, during and after the abortion; and who accompanied them to the health facility. It also had questions on feelings about community attitudes toward women who had abortions; community perceptions on women's situation regarding abortion; sources of information regarding abortion and family planning experience. Data collection team comprised the first author assisted by two nurses from the selected facilities trained on how to obtain informed consent, administer and keep data from IDIs safe. Data was collected over a two-week period in August of 2014. Each IDI lasted on average one and half hours. All IDIs were conducted in Swahili and recorded using a digital recorder and then transcribed. These were then translated into English.

3.4 Pilot Testing the Study Tools

Both quantitative and qualitative tools were pretested in neighbouring counties (Embakasi sub-county, that neigbours Machakos and Bungoma town that neigbours Trans Nzia county) of the study counties to test the data collection approach was conducted before being administered. This was done to ensure that all data collectors had a similar understanding of the flow of questions and meaning of questions in the data collection tools. Pretesting was conducted during training of data collectors who pre-tested the tools and then shared their experiences. One round of Focus group discussions and two indepth interviews with pre- identified participants was conducted in each county before data collection, while for quantitative methods, 30 respondents were indentified during pilot each for SABAS and ILAS was conducted. Feedback from administering the study tools and research assistants were compiled and minor changes on the flow of questions noted. This feedback was then used to make minor changes on the data collection tools

3.5 Data Management

All study participants and facilities in this research were assigned unique study identifiers. No names were to appear on any study forms or materials. The datasets were stored in a computerized database and study documentation and materials (including informed consent forms) stored in locked file cabinets. Only investigators had access to this information. Audio-taped interviews were labeled with the study identifier, rather than with names. Both audio-taped interviews and informed consent forms will be retained for a two-year period, after which they will be destroyed. Data entry staff for this study was the only ones who had permission to

retrieve/place materials, with the authorization of the principal investigator and under the condition that the staff members understood and had signed the confidentiality agreement.

Completed questionnaires and recordings were sent to Ipas Africa Alliance head office where the principal investigator worked after every three days of data entry to update the database. Where data was missing, or obvious inconsistencies noted, the office editor informed the data manager who would then contact the field teams for clarifications and where the need arose, sent back queries to the field teams for completion of incomplete data or correction of the inconsistencies. Fairly clean data were exported for analysis to R version 3.0 (Team, 2014) for advanced cleaning and analysis.

3.6 Data Analysis

Analysis of both the qualitative and quantitative data collected took a period of 6-15 months. Data analysis commenced in August 2014 and was completed in December 2015.

3.6.1 Quantitative Data Analysis

Quantitative data comprised data from general community members collected using SABAS scale and data collected from abortion clients using ILAS scale. Data entry screens were developed using EPI data version 3.02 (Association, 2005) which offers a replica of the questionnaire's in electronic format to facilitate entry. Logical check to ensure internal consistency of data was inbuilt in Epi data in order to reduce data entry errors. Once data was entered in EPI data screen, it was exported to Stata version 12 for preliminary exploratory data analysis and cleaning.

a) Analysis of Individual-Level Abortion Stigma (ILAS) Data

Descriptive statistics were computed– including frequencies and percentages for categorical data, and means and standard deviations for continuous data. Factor analysis of the 4-factor model for individual-level abortion-related stigma; overall scale, worries about judgment sub-scale, isolation sub-scale, self-judgment sub-scale and community condemnation sub-scale. Reliability was assessed using Cronbach's alpha, with an alpha of 0.7 or above being acceptable (J. A. Gliem & R. R. Gliem, 2003). Differences in socio-demographic characteristics across counties were tested using t-tests and chi-square. ILAS scores were calculated by summing all twenty items for the total score and then the appropriate items for each of the four subscales. Prior to computing scores, items in each category of ILAS scores were reverse coded. Missing responses for scale items were coded as zero and summed along with other items. For ILAS scores, the range, mean and standard deviation were computed for each county; differences in mean score between counties were tested using one-way analysis of variance. The minimum score possible was 20; while the maximum score was possible were 89.

Stratified multivariate linear regression was conducted to assess the relationship between respondents' demographic characteristics and ILAS scores for full scale and subscales for each county. The following covariates were included in the regression model: type of service sought (Induced/PAC), union status, highest educational attainment by the head of household- a proxy for socio-economic status, educational attainment, and religious affiliation. In order to explore the contribution of individual items to the overall scores, a binary variable was created for each item by collapsing strongly agree and agree to represent stigmatizing attitudes, and strongly disagree and disagree to represent non-stigmatizing attitudes; respondents who reported being

unsure about an item were excluded from these analyses. Differences between counties in the proportion of respondents agreeing or strongly agreeing with ILAS items were tested with chi-square. Statistically, significant relationships for all analyses were determined based on a p-value<0.05.

b) Analysis of Stigmatizing Attitudes, Believes and Action Scale (SABAS) Data

Descriptive statistics were computed, including frequencies and percentages for categorical data, and means and standard deviations for continuous data. Factor analysis was conducted on the 4-factor model for individual-level abortion stigma; overall scale worries about judgment sub-scale, isolation subscale, self-Judgment sub-scale and community condemnation sub-scales. Reliability was assessed using Cronbach's alpha with an alpha of 0.7 or above being acceptable (J. A. Gliem & R. R. Gliem, 2003). Differences in socio-demographic characteristics across counties were tested using t-tests and chi-square. SABAS scores were calculated by summing all twenty items for the total score and then the appropriate items for each of the four sub-scales. Prior to computing scores, items in each category of SABAS scores were reverse coded. Missing responses for scale items were coded as zero and summed along with other items. For SABAS scores, the range, mean and standard deviation were computed for each county; differences in mean score between counties were tested using one-way analysis of variance. The minimum score possible was 20, and the maximum score was possible was 89.

Stratified multivariate linear regression was conducted to assess the relationship between respondents' demographic characteristics and SABAS scores for full scale and subscales for each county. The following covariates were included in the regression model: type of service

sought (Induced/PAC), union status, highest educational attainment by the head of household- a proxy for SES, educational attainment, and religious affiliation. To explore the contribution of individual items to the overall scores, we created a binary variable for each item by collapsing agree and strongly agree to represent stigmatizing attitudes, and strongly disagree and disagree to represent non-stigmatizing attitudes; respondents who reported being unsure about an item were excluded from these analyses. Differences between counties in the proportion of respondents agreeing or strongly agreeing with SABAS items were tested with chi-square. Statistically, significant relationships for all analyses were determined based on a p-value<0.05.

3.6.2 Qualitative Data Analysis

The audio recordings from interviews were transcribed verbatim using standard transcription techniques. Transcriptions were done throughout the data collection process. Once all of the interviews were complete, Atlas –ti version 7 software (Friese, 2014) analysis program was used to assist in coding and analyzing the data. A "framework analysis" approach was used to summarize and analyze the data, and to assist in the development of a codebook and coding scheme(Ritchie, Lewis, Nicholls, & Ormston, 2013). An important benefit of using a thematic framework approach is that the analytical process and the interpretations derived from it can be viewed and examined by other people. Data was analyzed by first reading the full FGD and IDI transcripts, becoming familiar with the data and noting the themes and concepts that emerged. A thematic framework was developed from the identified themes and sub-themes, and this was then used to create codes and code the raw data. Some codes had been determined prior to data coding; any codes set a priori were well-grounded in stigma literature and were removed from

the codebook if they did not fit the data. Once all the data were appropriately coded, a matrix was created in Excel for each identified theme and the coded data transferred into the matrices. Once all the matrices were completed, analyses were conducted to assign meaning to emergent themes and concepts and to explore patterns of similarities and differences across interviews and between sites.

3.7 Ethical Considerations

Approval to conduct this study was granted by the Ethical Review Committee of Kenya Medical Research Institute (Scientific Steering Committee No. 2768). Additional approval to conduct the study was obtained from County Directors of Health and the Superintendent in charge of each facility. Participation in the study was purely voluntary as no one was coerced or induced to be a respondent. Measures as per KEMRI ESRC requirements and indicated in the questionnaires in appendices section were taken to safeguard the confidentiality of respondents who participated in the study. Such measures included, ensuring visual and audio privacy during data collection, not collecting any marks or information that would identify study respondents, keeping data in a password protected computers and limiting access of data to study team members who were required to have a valid Human subject's protection certification and using codes during data analysis and reporting.

CHAPTER FOUR
RESEARCH FINDINGS

4.1 Demographic Characteristics of Study Participants

4.1.1 Demographic characteristics of Respondents on Community-Level Stigma

A total of 712 respondents made up the total study population with 352 respondents from Machakos and 360 from Trans Nzoia County. Among the total respondents 50% (355) were married and 50% (357) were single, while 50%(358) of them were males and 50% (354) were females. 43% (308) of respondents were aged between 18-24 years, 30% (215) aged between 25-34 years and 27% (189) aged 35-46 years. 40% (288) of respondents had attained primary school, 33% (236) had not attended any school while 27% (188) had reached post-secondary school. On religious affiliations, 74% (529) of respondents reported that they were Protestant; 19%(138) as Catholics, 3% (24) as Muslims while another 3%(21) reported that they did not associate with any religious affiliation. Table 4.1 presents demographic characteristics of the study population per county.

Table 4.1 Demographic Characteristics of the Study Participants

	Machakos (352)	Trans Nzoia (n-360)	Total (n=712)	
Variable	**N (%)**	**N (%)**	**Total (%)**	**P- Value**
Gender				
Male	179 (51)	179 (50)	358 (50)	P=0.763
Female	173 (49)	181 (50)	354 (50)	
Age				
18-24	176 (50)	132 (37)	308 (43)	P=0.001
25-34	87 (25)	128 (36)	215 (30)	
35-49	89 (25)	100 (28)	189 (27)	
Highest Educational level				
None	122 (35)	114 (32)	236 (33)	P=0.625
Primary	140 (40)	148 (41)	288 (40)	
Post-Secondary	90 (25)	98 (27)	188 (26)	
Marital Status				
In Union	163 (46)	192 (53)	355 (50)	P=0.061
Not in any union	189 (54)	168 (47)	357 (50)	
Religious Background				
Protestant	275 (78)	254 (71)	529 (74)	
Catholic	62 (18)	76 (21)	138 (19)	P=0.143
Muslim	8 (2)	16 (4)	24 (3)	
Traditionalist	7 (2)	14 (4)	21 (4)	

4.1.2 Socio-demographic Characteristics of Women Treated for Abortion-Related Complications

The study surveyed a total of 759 women (383 in Trans Nzoia and 376 in Machakos) who presented in health facilities seeking termination of pregnancy, miscarriage or were bleeding

from pregnancy complications. In each county, 56% of women sought an elective abortion, whereas 44% were treated for PAC. Table 4.2 presents the characteristics of respondents by incidence region and overall. The findingsindicate a significant difference in respondents seeking abortion services in each county by age, marital status, the highest level of education attained by respondent, and SES at $P < 0.001$.

Table 4.2 Sociodemographic Characteristics of Respondents by County

Variables	Trans Nzoia		Machakos		Combined Sample		*P*
	CAC (*n*=214)	PAC (*n*=169)	CAC (*n*=210)	PAC (*n*=166)	CAC (*n*=424)	PAC (*n*=335)	
Age							
18–24	87 (44)	109(56)	80(40)	119(60)	167(42)	228(58)	0.001
25–34	97(65)	52(35)	101(71)	41(29)	198(68)	93(32)	
35–49	30(79)	8(21)	29(83)	6(17)	59(81)	14(19)	
Marital status							
In union	189(65)	104(35)	199(73)	74(27)	388(69)	178(31)	0.001
Not in union	25(28)	65(72)	11(11)	92(89)	36(19)	157(81)	
Highest level of education for household head (SES)							
Primary school	95(63)	57(38)	101(64)	58(36)	196(63)	115(37)	0.015
Secondary school	67(47)	77(53)	68(50)	68(50)	135(48)	145(52)	
Postsecondary school	52(60)	35(40)	41(51)	40(49)	93(55)	75(45)	
Highest level of education for respondent							
Primary school	136(56)	107(44)	141(59)	99(41)	277(57)	206(43)	0.033
Secondary school	50(49)	52(51)	50(48)	55(52)	100(48)	107(52)	
Postsecondary school	28(74)	10(26)	19(61)	12(39)	47(68)	22(32)	
Religious affiliation							
Muslim	0(0)	5(100)	0(0)	5(100)	0(0)	10(100)	0.031
Other religion	2(50)	2(50)	2(40)	3(60)	4(44)	5(56)	
Christian	212(57)	162(43)	208(57)	158(43)	420(57)	320(43)	
PAC=Post abortion care, CAC=Comprehensive abortion care, SES=Socioeconomic status							

4.1.3 Demographic characteristics for Focus Group Discussions

A total of 26 Focus group discussion sessions in rural and urban areas of the two counties were conducted. In each FGD there were 8-10 respondents. Table 4.3 provides characteristics of the Focus Group Discussions.

Table 4.3 Number and Characteristics of Focus Group Discussions

	Machakos		**Trans Nzoia**	
Timing	September 2014		October 2014	
Regions	Eastern region		Rift Valley region	
Sub-regions	Urban	Rural	Urban	Rural
	• Kathiani Sub County • Machakos Town Sub County • Kangundo Sub County •	• Masinga Sub County • Yatta Sub County • Matungulu Sub County Mwala Sub County	• Endebess Sub County • Kiminini Sub County	• Cherangani Sub County • Kwanza Sub County • Saboti Sub County
Number of groups	12		14	
Characteristics of Participants-Focus group discussions	2 urban & 2 rural 4 20 years or younger 4 above 25 years		4 urban & 4 rural 3 20 years or younger 3 Above 25 years	
Language of focus group discussion	8 Swahili Interviews and 4 Kamba interviews		4 Kalenjin, 4 Luhya, and 6 Swahili interviews	

4.1.4 Demographic Characteristics of Women Treated for Abortion-Related Complications.

The study conducted a total of 26 In-depth interviews with women treated for abortion-related complications (12 in Machakos County and 14 in Trans Nzoia County). 15 women sought induced abortion, while 11 women sought PAC. Six of those that sought PAC were aged above

25 while five were aged below 25, compared to nine and six of those that sought induced abortion who were aged above and below 25 respectively. Three-quarters of women less than 25 years who sought PAC had a self-induced abortion using local herbs. One woman in Machakos County and three in Trans-Nzoia County above 25 years who sought PAC services also had a self-induced abortion using a local herb. 10 women reported that they were married, while 16 women were not in any union. 12 women reported that they were still in school, 11 were in some formal employment, and two were commercial sex workers. Table 4.4 provides a demographic summary of interviews conducted.

Table 4.4 Demographic Information for Women Seeking Abortion Services

	Machakos	Trans Nzoia
Women interviewed	12	14
Type of services received	PAC- 6 Induced –6	PAC- 5 Induced - 9
Client Age	PAC:<25 years-3; >25 years-3 Induced: <25 years -3; > 25 years -3	PAC:<25 years-2; >25 years3 Induced: <25 years -3; > 25 years -6
Marital Status	Married - 4 Single – 8	Married – 6 Single -8
Socio-Economic Status	Student - 6 Formal - 5 Commercial sex workers -2	Student – 6 Formal – 6 Commercial sex worker-2

4.2 Reliability Analysis for Stigma Scales

4.2.1 Reliability Analysis for SABA Scale

Reliability was assessed using Cronbach's alpha. A high value for Cronbach's alpha indicates the good internal consistency of the items in the scale. Cronbach's alpha of 0.7 or above is acceptable(J. Gliem & R. Gliem, 2003) For the full item scale, a Cronbach's alpha of 0.86 was obtained for the combined sample, 0.90 and 0.78 Cronbach's alphas were obtained for the Trans Nzoia and Machakos samples respectively, providing evidence of internal consistency reliability for the full 18 item scale. The three subscales yielded Cronbach's alphas of 0.78 (negative stereotyping- 8 items), 0.76 (exclusion and discrimination- 7 items) and 0.65 (fear of contagion- 3 items) respectively. The results show that the internal consistency and reliability of fear of contagion sub-scale is questionable. Table 4.5 present reliability measurements by county and SABAS scales at full scale and sub scales.

Table 4.5 SABAS Scale Reliability Measurement by Sample Category

	Combined Sample (n=718)	**Trans Nzoia County (n=358)**	**Machakos County (n=360)**
Full scale (18 items)	**0.864**	**0.901**	**0.777**
Negative stereotyping (8 items)	0.786	0.837	0.694
Exclusion and discrimination (7 items)	0.758	0.815	0.650
Fear of contagion (3 items)	0.646	0.720	0.497

Exploratory Factor Analysis (EFA) for SABAS

Factor analysis was conducted to identify a factor structure for the negative stereotyping, exclusion/discrimination and fear of contagion subscales. Exploratory factor analyses were conducted on 18 items to identify a statistically and conceptually relevant scale. Items with

factor loadings >0.39 were retained. Exploratory factor analysis resulted in a 3-factor solution that explained 46% of the variance in a 16-item instrument. The subscales are: i) Negative stereotypes (8 items), ii) Discrimination and exclusion (5 items) and iii) Fear of contagion (3 items). Table 4.6 presents factor loadings for each item in SABAS scale.

Table 4.6 Rotated Factor Loadings and Unique Variances for SABAS Scores
Note: Factor loadings over .39 appear in bold

Variable	Factor1	Factor2	Factor3	Uniqueness
A woman who has an abortion is committing a sin	**0.6751**	-0.1000	0.1595	0.5088
Once a woman has one abortion, she will make it a habit	**0.4180**	**0.5307**	-0.1132	0.5308
A woman who has had an abortion cannot be trusted	**0.5890**	0.3069	0.0994	0.5490
A woman who has an abortion brings shame to her family	**0.7291**	0.1435	0.1505	0.4252
The health of a woman who has an abortion is never as good as it was before the abortion	**0.5807**	0.1514	-0.1407	0.6201
A woman who has had an abortion might encourage other women to get abortions	**0.4560**	0.3888	-0.0193	0.6405
A woman who has an abortion is a bad mother	**0.5401**	0.2115	0.3917	0.5101
A woman who has an abortion brings shame to her community	**0.6866**	0.1635	0.2264	0.4506
A woman who has had an abortion should be prohibited from going to religious services	0.1133	0.0394	**0.5898**	0.6378
I would tease a woman who has had an abortion so that she was ashamed about her decision	0.1385	**0.6803**	0.1439	0.4973
I would try to disgrace women in my community if I found out she'd had an abortion	0.1784	**0.5547**	0.2874	0.5779
A man should not marry a woman who has had an abortion because she may not be able to bear children	0.1045	0.3134	**0.5743**	0.5610
I would stop being friends with someone if I found out that she had an abortion	0.1865	**0.5044**	0.3907	0.5581
I would point my fingers at a woman who had an abortion so that other people would know what she has done	0.0907	**0.7218**	0.2349	0.4156
A woman who has an abortion should be treated the same as everyone else	0.0692	**0.4766**	0.3808	0.6231
A woman who has an abortion can make other people fall ill or get sick	0.2048	0.1911	**0.6070**	0.5531
A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion	0.1194	**0.4920**	**0.4603**	0.5319
If a man has sex with a woman who has had an abortion, he will become infected with a disease	0.1459	0.2184	**0.6352**	0.5275

The findings in Table 4.7 shows that the first factor (overall scale) is very strong with an Eigenvalue of 5.5 thereby explaining 95% of the variance among the 20 items. We do not have an explicit test of a single-factor solution, but the Eigenvalue of 5.5 is large enough to be reasonably confident that all items are tapping a single construct (Baik & Silverstein, 2006).

Table 4.7 Principal Component Factors – Unrotated

Factor	Eigenvalue	Difference	Proportion	Cumulative
Factor1	5.54472	3.84418	0.3080	0.3080
Factor2	1.70054	0.66414	0.0945	0.4025
Factor3	1.0364	0.10483	0.0576	0.4601
Factor4	0.93157	0.08931	0.0518	0.5118
Factor5	0.84226	0.01793	0.0468	0.5586
Factor6	0.82433	0.05735	0.0458	0.6044
Factor7	0.76698	0.01962	0.0426	0.6470
Factor8	0.74736	0.04657	0.0415	0.6886
Factor9	0.70079	0.03787	0.0389	0.7275
Factor10	0.66292	0.03138	0.0368	0.7643
Factor11	0.63154	0.01428	0.0351	0.7994
Factor12	0.61726	0.06802	0.0343	0.8337
Factor13	0.54925	0.01382	0.0305	0.8642
Factor14	0.53543	0.00679	0.0297	0.8940
Factor15	0.52864	0.02904	0.0294	0.9233
Factor16	0.4996	0.0273	0.0278	0.9511
Factor17	0.4723	0.06417	0.0262	0.9773
Factor18	0.40813	.	0.0227	1.0000
LR test: independent vs. saturated:	chi2(153) =	5492.93	Prob>chi2 =	0.0000

4.2.2 Reliability analysis for Individual Abortion Stigma Scale

The researcher tested the reliability of the ILAS tool using Cronbach's alpha and considered Cronbach's alpha of 0.7 or above acceptable. For the overall scale, a Cronbach's alpha of 0.92 was obtained for the combined sample; and 0.93 and 0.92 for Machakos and Trans Nzoia Regions, respectively, providing evidence of internal consistency for the overall 20 item scale

as shown in Table 4.8.

Table 4.8 ILAS Reliability for Overall Scale and Subscales

ILAS scale and subscales	Cronbach's alpha		
	Combined sample (*n*=759)	**Machakos (*n*=376)**	**Trans Nzoia county (*n*=383)**
Overall scale (20 items)	0.918	0.917	0.927
Worries about judgment (7 items)	0.985	0.984	0.985
Isolation (6 items)	0.692	0.734	0.735
Self-judgment (5 items)	0.843	0.843	0.825
Community condemnation (2 items)	0.399	0.422	0.341

The four subscales yielded Cronbach's alphas of 0.99 (Worries about judgment; 7 items), 0.70 (isolated; 6 items), 0.84 (self-judgment; 5 items), and 0.4 (community condemnation; 2 items), respectively.

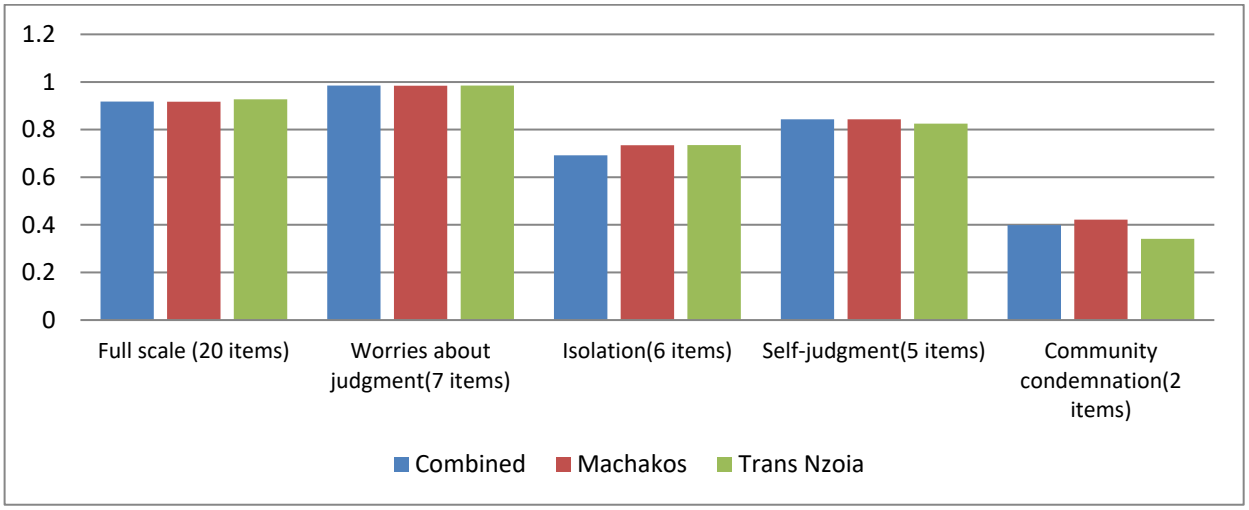


Figure 4.1 Reliability Coefficients for ILAS Scores

Figure 4.1 presents a comparison of reliability coefficients per county, showing that the internal consistency reliability for overall scale worries about judgment, isolation, and self-judgment was acceptable when community condemnation subscale's internal consistency is questionable. The researcher conducted exploratory factor analyses on the overall scale's items to identify a

conceptually relevant scale. Findings in Table 4.9 shows that the first factor (overall scale) is very strong with an Eigenvalue of 9.5 thereby explaining 95% of the variance among the 20 items. We do not have an explicit test of a single-factor solution, but the Eigenvalue of 9.5 is large enough to be reasonably confident that all items are tapping a single construct (Baik & Silverstein, 2006). Items with factor loadings >0.39 were retained in subsequent analyses (Hirschfeld, von Brachel, & Thielsch, 2014).

Table 4.9 Principal Component Factors for Individual-Level Abortion Stigma Scores

Factor	Eigenvalue	Difference	Proportion	Cumulative
Factor 1	9.50786	7.41243	0.4754	0.4754
Factor 2	2.09543	0.33806	0.1048	0.5802
Factor 3	1.75737	0.34781	0.0879	0.668
Factor 4	1.40956	0.11079	0.0705	0.7385
Factor 5	1.29877	0.3783	0.0649	0.8034
Factor 6	0.92047	0.11249	0.046	0.8495
Factor 7	0.80798	0.1074	0.0404	0.8899
Factor 8	0.70058	0.26363	0.035	0.9249
Factor 9	0.43695	0.21331	0.0218	0.9467
Factor 10	0.22364	0.01014	0.0112	0.9579
Factor 11	0.2135	0.06501	0.0107	0.9686
Factor 12	0.14849	0.04929	0.0074	0.976
Factor 13	0.0992	0.00555	0.005	0.981
Factor 14	0.09365	0.02195	0.0047	0.9857
Factor 15	0.0717	0.0112	0.0036	0.9893
Factor 16	0.0605	0.01038	0.003	0.9923
Factor 17	0.05011	0.00602	0.0025	0.9948
Factor 18	0.04409	0.00882	0.0022	0.997
Factor 19	0.03528	0.0104	0.0018	0.9988
Factor 20	0.02487		0.0012	1
Likelihood test - Independent versus saturated: χ^2 (190) =1.9e+04, $P>\chi^2$=0.0000				

4.3 Study findings by objectives

4.3.1 Level of Abortion-Related Stigma Among Individual Women Receiving Abortion Care Services and Among General Community Members

a) The level of Stigma Among General Community Members in Study Counties.

SABAS Scores by Incidence Region

Respondents in Trans Nzoia County reported the highest full-scale abortion stigma levels (μ=55.4) compared to those from Machakos County (μ=53.07) as shown in Table 4.10. On negative stereotyping subscale, the mean score for Trans Nzoia was 29.1 compared to 28.5 in Machakos. For the exclusion and discrimination subscale, the Trans Nzoia reported a mean score of 18.5 compared to 17.6, in Machakos, while on Fear of contagion; the mean score for Trans Nzoia was 7.3 compared to 7.0 in Machakos County. The mean differences in SABAS scores for all the four subscales were significant for Fear of contagion, exclusion and discrimination and Negative stereotyping (p-value <0.000).

Table 4.10 Descriptive Statistics for the SABAS Scores by County

		Combined Sample (n= 718)		**Trans Nzoia (n= 360)**		**Machakos (n=352)**		
	Score Range	Mean	SD	Mean	SD	Mean	SD	*p*value
Full scale (18 items)	21 - 86	54.2	11.08	55.4	10.34	53.07	11.66	0.106
Negative stereotyping (8 items)	8 - 40	29.1	5.41	29.7	4.96	28.5	5.75	0.085
Exclusion and discrimination (7 items)	7 - 35	18.0	5.46	18.5	5.11	17.6	5.78	0.000
Fear of contagion (3 items)	3 - 15	7.1	2.58	7.3	2.68	7.0	2.47	0.000

The researcher compared levels of stigma by the type of location and noted that in both counties as shown in Table 4.11. The researcher notes a similar trend in both counties in terms of the levels of stigma that were higher in more rural communities than in semi-urban and urban communities. However, the only scale that was statistically significant was exclusion and discrimination and fear of contagion (p<0.000).

Table 4.11 Descriptive Statistics for the SABAS Scores by location

	Trans Nzoia (N=360)						Machakos (N-352)						
	Urban		Semi- urban		Rural		Urban		Semi-urban		Rural		
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	*p*value
FS (18 items)	54.9	12.63	57.1	8.46	54.49	9.81	51.3	13.04	52.37	10.85	55.2	10.66	0.37
NS (8 items)	30.1	5.98	30.4	4.3	28.92	4.59	28.2	6.52	28.5	5.35	28.6	5.35	0.065
ED (7 items)	18.3	6.12	18.9	4.42	18.29	4.88	16.4	5.9	17.1	5.56	19.18	5.47	0
FC (3 items)	6.6	2.92	7.8	2.42	7.28	2.64	6.7	2.74	6.7	2.22	7.4	2.34	0

SABAS Scores by Gender

The researcher compared stigma scores per county and noted that respondent's in Machakos reported higher stigma scores than those in Trans Nzoia County. The differences in abortion stigma scores are significant (p-value <0.011). Across full scale and SABAs sub scales, males reported higher abortion stigma scores than female respondents. A comparison of gender per county indicates both genders in Trans Nzoia reported higher stigma scores than in Machakos County, as presented in Table 4.12. However, the difference in the abortion scores of the two groups is not significant (p-value 0.297).

Table 4.12 Descriptive statistics for the SABAS Scores by Gender

		Score Range	**Male (n= 354)**		**Female (n= 358)**		*p*value
			Mean	SD	Mean	SD	
Full scale (18 items)	Total	21 - 86	55.3	10.9	53.1	11.1	0.297
	Machakos	21 - 86	54.0	10.8	52.2	12.5	0.657
	Trans Nzoia	21 - 86	56.7	10.4	54.0	9.59	0.404
Negative stereotyping (8 items)	Total	8 - 40	29.7	5.0	28.4	5.69	0.156
	Machakos	8 - 40	27.9	6.3	27.9	6.34	0.644
	Trans Nzoia	8- 40	30.3	5.0	29.0	4.9	0.091
Exclusion and discrimination (7 items)	Total	7 - 35	18.4	5.6	17.7	5.3	0.645
	Machakos	7 - 34	17.9	5.6	17.4	5.82	0.585
	Trans Nzoia	7 - 35	18.9	5.4	18.0	4.73	0.776
Fear of contagion (3 items)	Total	3 - 15	7.3	2.7	6.9	2.49	0.052
	Machakos	3 - 15	7.1	2.6	6.8	2.4	0.571
	Trans Nzoia	3 - 15	7.5	2.8	7.1	2.60	0.214

SABAS Scores by Education Level

Respondents with no education/primary education recorded the highest levels of full-scale abortion stigma (μ=57.3), followed by those with secondary education (μ=54.3). The lowest abortion stigma scores were reported by the post-secondary group (μ=50.2). The differences in abortion stigma levels among the educational groups are statistically significant (p-value <0.000). A similar pattern is observed among the subscales, and Machakos and Trans Nzoia

counties as shown in Table 4.13. However, the educational wise variations of abortion stigma in the Machakos are statistically not significant. For full scale and stigma subscales, we note that stigma scores were significantly higher p-value <0.000). In Trans Nzoia compared to Machakos County (μ=53.6 and 51.6 for full scale; μ=25.1 and 24.3 for exclusion and discrimination; μ=19.9 and 17.71 for negative stereotyping; and μ=9.62 and 9.49 for fear of contagion respectively).

Table 4.13 Descriptive Statistics for the SABAS Scores by Level of Education

		Score Range	**No educ/primary (n= 234)**		**Secondary school (n= 288)**		**Post-secondary (n= 188)**		*P*value
			Mean	SD	Mean	SD	Mean	SD	
Full scale (18 items)	Total	21 – 86	57.3	10.8	54.3	10.1	50.2	11.7	0.000
	Machakos	21 - 86	57.6	11.7	52.5	10.5	48.8	11.7	0.020
	Trans Nzoia	24 - 86	57.0	9.7	56.2	9.4	55.4	10.3	0.070
Negative stereotyping (8 items)	Total	8 - 40	30.0	5.2	29.0	4.8	27.9	6.3	0.031
	Machakos	8 - 40	29.5	5.6	28.4	5.1	27.3	6.8	0.217
	Trans Nzoia	14 - 40	30.4	4.9	29.7	4.4	28.5	5.7	0.160
Exclusion and discrimination (7 items)	Total	7 -35	19.5	5.4	18.0	5.3	16.2	5.3	0.000
	Machakos	7 - 35	20.0	5.8	17.2	5.6	15.6	5.0	0.001
	Trans Nzoia	7 - 34	19.0	4.9	19.0	4.8	16.9	5.0	0.129
Fear of contagion (3 items)	Total	3 - 15	7.8	2.6	7.2	2.5	7.1	2.6	0.000
	Machakos	3 - 14	8.0	2.4	7.0	2.4	5.8	2.2	0.023
	Trans Nzoia	3 - 15	7.6	2.9	7.5	2.5	6.5	2.6	0.000

SABAS Scores by Age group

For the full scale, respondents aged 35-49 years and (18-24) age groups exhibited more stigma (μ=55.7 and μ=54.5) compared middle age group (25-34) (μ=53.3). However, the abortion stigma levels was not statistically significant across ages (p-value <0.087). Comparison of stigma by age group and incidence region shows that across all age groups Trans Nzoia reported higher stigma scores than in Machakos County. Table 4.14 presents the distribution of stigma by county and across stigma subscales.

Table 4.14 Descriptive statistics for the SABAS Scores by Age group

	Age Group		**18-24 (n= 307)**		**25-34 (n= 223)**		**35-49 (n= 189)**		
		Score Range	Mean	SD	Mean	SD	Mean	SD	*P*value
Full scale (18 items)	Total	21 - 86	54.5	10.7	52.3	11.6	55.7	11.1	0.087
	Machakos	21 - 86	53.7	10.6	53.7	12.4	51.5	12.0	0.524
	Trans Nzoia	24 - 86	55.11	10.77	55.03	10.32	56.16	9.54	0.124
Negative stereotyping (8 items)	Total	8 - 40	29.1	5.27	29.06	5.48	28.99	5.57	0.802
	Machakos	8 - 40	28.3	5.27	28.80	5.79	28.18	6.35	0.411
	Trans Nzoia	14 - 40	29.6	5.22	29.44	5.01	29.65	4.96	0.572
Exclusion and discrimination (7 items)	Total	7 - 35	18.5	5.5	18.9	5.8	17.5	5.1	0.341
	Machakos	7 - 35	18.4	5.6	17.7	6.2	16.7	5.2	0.703
	Trans Nzoia	7 - 34	18.6	5.4	18.2	5.1	18.5	4.7	0.548
Fear of contagion (3 items)	Total	3 - 15	6.9	2.5	7.4	2.7	7.1	2.6	0.052
	Machakos	3 - 15	7.0	2.3	7.3	2.7	6.6	2.4	0.132
	Trans Nzoia	3 - 15	6.9	2.7	7.4	2.7	7.8	2.7	0.101

SABAS Scores by Marital Status

Full-scale abortion stigma was not statistically significant between the single and married (p-value 0.713), though the married group exhibits higher abortion stigma levels (μ=53.4 and μ=54.6 for singles and married respectively 54.6 as shown in Table 4.15. There's a more marked variation by marital status in Machakos County compared to Trans Nzoia County across the full scale and sub scales. The variation in the negative stereotyping and exclusion & discrimination sub scales is statistically significant (p-value, 0.007).

Table 4.15 Descriptive statistics for the SABAS Scores by Marital Status

			Single (n= 357)		**Married/ in relationship (n= 355)**		
		Score Range	Mean	SD	Mean	SD	*p*value
Full scale (18 items)	Total	21 - 86	54.1	11.1	54.3	11.1	0.713
	Machakos	21 - 86	53.3	11.3	52.9	12.1	0.746
	Trans Nzoia	24 - 86	54.8	10.9	56.0	9.7	0.603
Negative stereotyping (8 items)	Total	8 - 40	29.1	5.5	29.7	5.3	0.696
	Machakos	8 - 40	28.5	5.7	28.4	5.8	0.412
	Trans Nzoia	14- 40	29.6	5.3	29.8	4.6	0.594
Exclusion and discrimination (7 items)	Total	7 - 35	18.1	5.5	18.6	5.4	0.007
	Machakos	7 - 35	17.8	5.6	17.5	5.9	0.112
	Trans Nzoia	7 - 34	18.3	5.4	18.6	4.8	0.083
Fear of contagion (3 items)	Total	3 - 15	7.0	2.6	7.3	2.6	0.249
	Machakos	3 - 15	7.0	2.5	7.0	2.5	0.384
	Trans Nzoia	3 - 15	7.0	2.7	7.6	2.7	0.283

SABAS scores by Religion

The study explored levels of stigma among religious groups in both counties. Majority of the respondents in both counties were protestant(n=529) followed by Catholics (n=138) Muslim (n=40 and other religions/no region group(n=14). The researcher notes that across the religious groupings, Muslims and other/no religion groups stigmatize women who have procured abortions more than their Catholic and Protestant counterparts (Muslim μ=57.9, other/no religion μ= 57.3, Catholic μ=53.8, Protestant μ=53.6). The study also notes that there were statistical differences in levels of stigma among religious groupings in Tran's Nzoia and Machakos for the full scale, Negative stereotyping subscale and exclusion and discrimination subscale. The researcher notes that across all the subscales, Trans Nzoia county reported higher stigma scores compared to respondents from Machakos as shown in Table 4.16.

Table 4.16 Descriptive statistics for the SABAS Scores by Religion

			Protestant (n= 529)		Catholic (n= 138)		Muslim (n= 40)		Other/no religion (n= 15)		
		Score Range	Mean	SD	Mean	SD	Mean	SD	Mean	SD	*p*value
FS (18 items)	Total	21 - 86	54.0	11.18	54.0	9.86	57.4	10.45	58.88	15.5	0.001
	Machakos	21 - 86	52.7	11.82	53.5	10.28	59.4	11.21	53.10	15.3	0.000
	Trans Nzoia	24 - 86	55.3	10.43	54.7	9.37	53.5	7.96	67.14	10.3	0.093
NS (8 items)	Total	8 - 40	29.0	5.39	29.3	5.40	28.6	4.92	29.53	6.7	0.010
	Machakos	8 - 40	28.3	5.76	29.4	5.06	28.0	4.50	32.57	5.5	0.038
	Trans Nzoia	8 - 40	29.0	5.39	29.3	5.40	28.6	4.92	29.53	6.7	0.264
ED (7 items)	Total	7 - 35	18.0	5.49	17.7	4.85	21.2	5.87	20.71	6.9	0.000
	Machakos	7 - 35	17.4	5.81	17.6	4.97	22.3	5.86	18.20	7.1	0.014
	Trans Nzoia	7 - 35	18.4	5.13	17.8	4.73	18.9	5.51	24.29	5.1	0.000
FC (3 items)	Total	3 – 15	7.1	2.61	7.1	2.37	7.7	2.37	8.65	3.0	0.208
	Machakos	3 – 15	7.0	2.54	6.6	2.16	8.2	2.26	7.50	2.5	0.800
	Trans Nzoia	3 – 15	7.1	2.68	7.6	2.52	6.6	2.39	10.29	3.2	0.030

4.3.2 Levels of Stigma Among Women Treated for Abortion

ILAS scores by County

Out of the 759 respondents, 50% (376) of respondents where from Trans Nzoia County and 50% (383) from Machakos county. Respondents in Trans Nzoia County reported a statistically significant difference ($p<0.001$) in the highest full-scale abortion stigma levels ($\mu=49.8$) compared to those from Machakos County ($\mu=47.6$) as shown in Table 4.17. On worries subscale, the mean score for Trans Nzoia was 13.7 compared to 12.8 in Machakos. For the worries subscale, Trans Nzoia reported a mean score of 13.7 compared to 13.4, in Machakos, while on Fear of judgment subscale; the mean score for Trans Nzoia was 13.04 compared to

12.05 in Machakos County. For community condemnation subscale Trans Nzoia reported a mean score of 9.3 compared to 9.2, in Machakos. The mean differences in ILAS scores were significant at full scale, isolation and self-judgement (p-value <0.000).

Table 4.17 Descriptive Statistics for ILAS Scores, by Incidence region

	Score Range	**Combined Sample (n= 759)**		**Trans Nzoia (n= 383)**		**Machakos (n=376)**		***p*value**
		Mean	SD	Mean	SD	Mean	SD	
Full scale (20 items)	20 – 74	48.68	10.5	49.8	10.8	47.6	9.9	**0.004**
Worries about Judgement (7 items)	7 – 28	13.28	8.2	13.72	8.4	12.8	7.9	0.858
Isolation (6 items)	6 – 22	13.6	3.8	13.73	3.6	13.4	4.0	**0.000**
Self Judgement (5 items)	5 – 24	12.6	4.1	13.05	4.4	12.25	3.7	**0.005**
Community Condemnation (2 items)	2 – 10	9.25	0.9	9.3	0.77	9.2	1	0.299

ILAS scores by Type of service

In both Counties 52% (424) of respondents were treated for Induced abortion while 46 % (335) were treated for Post Abortion Care. The study compared levels of stigma among women treated for abortion services and compared levels of stigma among women seeking Induced abortion and those seeking post abortion care. As shown in Table 4.18, the study notes that for full scale and sub scale, respondents treated for post abortion care reported statistically significant higher levels of stigma compared to those that came for induced abortion (p>0.000). Trans Nzoia county reported higher stigma levels that Machakos for the full scale and subscales.

Table 4.18 Descriptive Statistics for the ILAS Scores by Type of Service

		CAC (n=424)		PAC (n=335)		
		Mean	SD	Mean	SD	P-value
Full scale (20 items)	Trans Nzoia	45.69	9.34	55.72	11.67	0.002
	Machakos	45.16	7.48	49.99	10.09	0.000
	Total	45.43	8.46	52.84	11.26	0.000
Worries about Judgement (7 items)	Trans Nzoia	10.48	6.29	18.48	8.87	0.000
	Machakos	10.02	5.73	16.73	8.88	0.000
	Total	10.48	6.29	15.06	8.59	0.000
Isolation (6 items)	Trans Nzoia	14.53	3.54	12.85	4.09	0.000
	Machakos	13.87	3.78	12.74	3.44	0.000
	Total	14.2	3.67	12.8	3.78	0.000
Self Judgement (5 items)	Trans Nzoia	11.44	2.99	15.31	4.93	0.000
	Machakos	11.26	2.84	14.17	4.68	0.000
	Total	11.44	2.99	14.17	4.68	0.000
Community Condemnation (2 items)	Trans Nzoia	9.29	0.64	9.3	0.91	0.01
	Machakos	9.24	0.95	9.25	0.88	0.017
	Total	9.24	0.95	9.25	0.84	0.015

ILAS scores by Age

To understand the distribution of stigma by age group we obtained mean scores per age group per county. 52% of the respondents were aged 18-24 years, 38% aged 25-34 years and 10% aged 35-49 years. For the full scale, respondents aged 35-49 years and (18-24) age groups exhibited more stigma (μ=55.7 and 54.5) compared middle age group (25-34) (μ=53.3). However, the abortion stigma levels do not significantly differ across ages (p-value <0.087). Comparison of stigma by age group and incidence region shows that across all age groups Trans Nzoia reported higher stigma scores than in Machakos County. Table 4.19 presents the distribution of stigma by county and across stigma subscales.

Table 4.19 Descriptive Statistics for the ILAS Scores by Age

	Age Group		**18-24 (n= 395)**		**25-34 (n= 291)**		**35-49 (n= 73)**		
		Score Range	Mean	SD	Mean	SD	Mean	SD	*P*value
Full scale (18 items)	Total	20 – 74	52.06	10.92	44.37	8.22	47.5	9.29	0.000
	Machakos	20 – 74	50.59	9.92	43.57	8.56	47.60	10.03	0.000
	Trans Nzoia	34 – 74	53.52	11.66	45.20	8.04	47.43	8.56	0.000
Negative stereotyping (8 items)	Total	7 – 28	16.17	8.73	9.64	5.63	11.71	7.31	0.000
	Machakos	7 – 28	15.49	8.52	9.37	5.89	11.49	7.03	0.000
	Trans Nzoia	7 – 28	16.84	8.89	9.92	5.36	11.92	7.65	0.000
Self Judgement (5 items)	Total	7 – 28	12.17	6.63	5.64	3.53	7.71	5.21	0.000
	Machakos	7 – 28	11.49	6.42	5.37	3.79	7.49	4.93	0.000
	Trans Nzoia	7 – 28	12.84	6.79	5.92	3.26	7.92	5.55	0.000
Community Condemnation (2 items)	Total	3 – 15	6.9	2.5	7.4	2.7	7.1	2.6	0.052
	Machakos	3 – 15	7.0	2.3	7.3	2.7	6.6	2.4	0.132
	Trans Nzoia	3 – 15	6.9	2.7	7.4	2.7	7.8	2.7	0.101

ILAS scores by Highest level of Education of Household head (SES)

The study uses highest level of education of the head of household as a proxy for Socio-Economic Status (SES), where respondents with head of household levels who have completed post-secondary school having higher socio-economic status compared to those with no or completed primary school as having lower socio-economic status. Out of 759 respondents, 41% of respondents reported that their head of household has completed primary school, 37% of respondents completed secondary school while 22% completed post-secondary school. Table 4.20 presents levels of stigmatizing attitudes by respondent head of household highest level of education. The study notes that's respondents from Trans Nzoia county reported significantly higher stigmatizing attitudes at full scale and subscale compared to those from Machakos. The

study also notes in both counties, as the level of education increases then the levels of stigma at full scale and subscale is reducing.

Table 4.20 Descriptive Statistics for ILAS Scores SES

		Primary (n=311)		Secondary n (=280)		Post Primary (n=116)		
		Mean	SD	Mean	SD	Mean	SD	P-value
Full scale (20 items)	Trans Nzoia	51.39	11.79	48.77	10	49.2	10.88	0.000
	Machakos	50.52	11.39	47.71	9.81	47.54	9.64	0.000
	Total	49.69	10.98	46.6	9.53	45.91	8.04	0.000
Worries about Judgement (7 items)	Trans Nzoia	15.11	8.72	12.46	7.62	13.09	8.97	0.000
	Machakos	14.71	8.66	12.22	7.4	12.67	8.34	0.000
	Total	14.34	8.58	11.97	7.16	11.52	7.57	0.000
Isolation (6 items)	Trans Nzoia	13.11	3.5	14.41	3.94	12.83	3.66	0.000
	Machakos	13.02	3.23	14.82	3.72	12.82	3.72	0.000
	Total	13.19	3.74	13.98	4.13	12.83	3.88	0.000
Self Judgement (5 items)	Trans Nzoia	13.4	4.16	11.92	3.91	12.73	3.94	0.000
	Machakos	13.88	4.46	12.23	4.25	13.26	4.29	0.000
	Total	12.95	3.81	11.6	3.5	12.23	3.54	0.000
Community Condemnation (2 items)	Trans Nzoia	9.3	0.94	9.17	1.01	9.32	0.63	0.02
	Machakos	9.33	1	9.27	0.6	9.31	0.63	0.049
	Total	9.27	0.89	9.05	1.3	9.32	0.66	0.084

ILAS scores by Education level

Out of 759 respondents, 64% of respondents reported that they had completed primary school, 27% of respondents completed secondary school while 9% completed post-secondary school. Table 4.21 below presents levels of stigmatizing attitudes by respondent head of household highest level of education. The study notes that's respondents from Trans Nzoia county reported significantly higher stigmatizing attitudes at full scale and subscale compared to those from Machakos. The study also notes in both counties, as the level of education increases then the levels of stigma at full scale and subscale is reducing.

Table 4.21 Descriptive Statistics for ILAS Scores by Education level

		Primary (n=483)		Secondary (n=207)		Post-Secondary (n=69)		
		Mean	SD	Mean	SD	Mean	SD	**P-value**
Full scale (20 items)	Trans Nzoia	53.47	11.97	48.62	10.51	48.87	6.34	0.000
	Machakos	50.7	11.22	46.6	9.5	45.68	5.82	0.000
	Total	52.1	11.66	47.6	10.09	46.22	6.04	0.000
Worries about Judgement (7 items)	Trans Nzoia	16.58	9.3	12.83	7.9	11.06	6.72	0.000
	Machakos	14.9	8.86	12.25	7.53	10.18	6.01	0.000
	Total	15.75	9.1	12.54	7.7	10.58	6.31	0.000
Isolation (6 items)	Trans Nzoia	12.8	3.6	13.75	3.76	14.73	4.16	0.000
	Machakos	12.68	3.3	14.06	3.58	14.87	4.16	0.000
	Total	12.92	3.93	13.45	3.94	14.6	3.9	0.000
Self Judgement (5 items)	Trans Nzoia	14.97	4.4	12.42	4.29	11.39	2.8	0.000
	Machakos	13.79	3.8	11.75	3.56	11.32	2.76	0.000
	Total	14.39	4.15	12.0	3.95	11.35	2.76	0.000
Community Condemnation (2 items)	Trans Nzoia	9.37	0.64	9.15	1.04	9.56	0.49	0.003
	Machakos	9.36	0.64	9.23	0.84	9.55	0.05	0.226
	Total	9.36	0.52	9.07	1.2	9.57	0.05	0.36

4.3.3 Association of Abortion-Related Stigma and Incidence of Unsafe Abortion

a) SABAS Scale

Based on the probability tests conducted during descriptive analysis of SABAS scale data, we hypothesize that incidence region, education and religion variables are significantly associated with stigmatizing attitudes, beliefs, and actions in the communities surveyed. Four regression models were used to test whether individuals' region of residence (Machakos, Trans Nzoia site), age, education, marital status, religion, and gender had any association with stigmatizing attitudes, beliefs, and actions (SABA) in the community. The first regression model included all the 18 items of the SABA scale (full scale). In the second model, items relating to negative stereotyping (eight items) were included. The third regression model only considered exclusion

and discrimination items (seven items). The final regression model had three items on fear of contagion.

Age, education, and site (Trans Nzoia and Machakos), with education and site, treated as interaction terms were used to test whether stigma scores by age and education differed for Trans Nzoia and Machakos.

$$\textbf{\textit{SABAS Scale}} = \beta + \beta_1 Site + \beta_2 Age + \beta_3 Education + \beta_4 Marital\ status + \beta_5 Religion + \beta_6 Gender + \beta_7 Age*Site + \beta_8 Education*Site + \varepsilon$$

For all the predictor variables fed into the models, the first item was considered a reference category (coded 0). Table 4.22 represents results of linear regression models for Full-scale SABAS-18 items; Negative stereotyping-8 items; Exclusion and discrimination- 7 items and Fear of contagion-3 items. Partly consistent with our hypothesis, of all the variables fed into the four models, Incidence region and education were the only predictor variables significantly associated with stigmatizing attitudes, beliefs, and actions in the both the full scale and subscales. After the interaction, incidence region and education still showed a statistically significant association with the dependent variable in all the four models.

In the religion category, only Muslims were significantly associated with abortion stigma on three of the four models (full scale, exclusion and discrimination and fear of contagion. Respondents from Tran's Nzoia county were significantly more likely to perpetuate abortion stigma than those from Machakos County (coefficients: model1 -6.494***; model2-2.465***; model3 -1.976**; model4 -1.453***) as shown in Table 4.22. Respondents with a lower level of education were more likely to stigmatize women in their communities who have had an

abortion than their more educated counterparts. However, the interaction of education and study site yielded opposite results. Age had no significant relationship with a tendency to stigmatize women who have had an abortion, even after interaction with study site.

Table 4.22 Linear Regression Analysis for SABAS Full Scale and Subscales

	Full-scale SABAS	**Negative stereotyping**	**Exclusion and discrimination**	**Fear of contagion**
	Model1	Model2	Model3	Model4
Incidence Region-Trans Nzoia	-6.494*** (1.374)	-2.465*** (0.627)	-1.976** (0.728)	-1.453*** (0.337)
Age 25-34	-0.771 (1.221)	-0.536 (0.566)	-0.287 (0.594)	0.13 (0.271)
Age 35-39	0.988 (1.653)	0.146 (0.741)	0.481 (0.783)	0.509 (0.375)
Secondary	-8.037*** (1.208)	-3.043*** (0.554)	-2.982*** (0.576)	-1.710*** (0.274)
Post-secondary	-11.91*** (1.398)	-5.236*** (0.663)	-3.929*** (0.672)	-2.686*** (0.294)
Married	0.285 (0.796)	0.369 (0.376)	-0.0909 (0.393)	-0.0743 (0.182)
Catholic	0.313 (0.794)	-0.0718 (0.387)	0.268 (0.399)	0.165 (0.186)
Muslim	4.186* (1.676)	0.495 (0.754)	2.767*** (0.800)	0.805* (0.344)
Other/no religion	0.768 (1.997)	-0.197 (0.983)	0.453 (1.000)	0.223 (0.440)
Female	-1.136 (0.702)	-0.455 (0.340)	-0.569 (0.342)	-0.26 (0.157)
Age 25-34 x Trans Nzoia	-0.566 (1.505)	-0.364 (0.737)	0.092 (0.751)	-0.204 (0.347)
Age 35-39 x Trans Nzoia	-0.898 (1.958)	-1.26 (0.935)	0.181 (0.944)	-0.129 (0.453)
Secondary x Trans Nzoia	6.719*** (1.528)	2.511*** (0.744)	2.316** (0.760)	1.403*** (0.356)
Post-secondary x Trans Nzoia	7.211*** (1.778)	3.344*** (0.895)	1.959* (0.866)	1.619*** (0.397)
Constant	60.98*** (1.252)	32.51*** (0.546)	19.59*** (0.615)	8.599*** (0.289)
N	705	705	705	705
R-sq	0.099	0.083	0.088	0.37
adj. R-sq	0.081	0.065	0.070	0.018
Rmse	9.381	5.08	4.395	2.062

Standard errors in parentheses * p<0.05, ** p<0.01, *** p<0.001

Proportion of Respondents Agreeing with SABAS Items, by County

Negative stereotyping stigma scores ranged from 59% - 92% of respondents from Trans Nzoia reporting higher scores than those from Machakos and Tran's Nzoia regions. The highest scores were on statement related to a woman who is having an abortion is committing a sin where 92%

of respondents in these regions agreed with this statement while 58% of women in Trans Nzoia agreed that a woman seeking an abortion is a bad mother as shown in Table 4.23. With most respondents confirming views categorized as negative stereotyping, citing issues such as sin, shame, trustworthiness, and poor health as grounds of negative stereotyping. On the other hand, the proportions of respondents who confirmed that they would discriminate and exclude women who had procured abortion were moderate in both regions, but at different levels, with proportions being higher in Trans Nzoia compared to Machakos. 51% in Trans Nzoia compared to 35% in Machakos were of the view that a man should not marry a woman who had procured an abortion. However, the proportion of respondents who felt that a woman who procured abortion should be treated as everyone else was higher in Trans Nzoia at 39% compared to Machakos- at 27%. This is despite these regions all having confirmed to stereotype negatively, exclude and discriminate against women who had procured an abortion. These findings beg the question as to whether individuals' negative attitudes and beliefs about abortion translate into specific actions. Lastly, with regards to fear of contagion sub-scale, there were moderate to lower proportions of respondents confirming that they feared contamination from women who had procured an abortion. Under this category, the proportions were, however, different in the two regions, with Trans Nzoia reporting higher proportions of respondents who confirmed to fear contagion ranging from 51% to 45% across the reasons cited, compared to Machakos County.

Table 4.23 Proportion of Respondents Agreeing with SABAS Items, by County

Statements	Machakos	Trans Nzoia
Negative Stereotyping(NS)		
A woman who has an abortion is committing a sin. *	92	92
A woman who has had an abortion might encourage other women to get abortions. *	73	84
A woman who has an abortion brings shame to her family. *	84	84
A woman who has an abortion brings shame to her community. *	80	83
The health of a woman who has an abortion is never as good as it was before the abortion. *	86	77
A woman who has an abortion is a bad mother. *	58	76
A woman who has had an abortion cannot be trusted. *	64	74
Once a woman has one abortion, she will make it a habit. *	59	72
Exclusion and Discrimination(E&D)		
A man should not marry a woman who has had an abortion because she may not be able to bear children. *	35	51
I would tease a woman who has had an abortion so that she will be ashamed of her decision. *	31	48
A woman who has had an abortion should be prohibited from going to religious services. *	32	46
I would stop being friends with someone if I found out that she had an abortion. *	30	46
I would point my fingers at a woman who had an abortion so that other people would know what she has done. *	24	44
I would try to disgrace a woman in my community if I found out she'd had an abortion. *	31	41
A woman who has an abortion should be treated the same as everyone else. ^*	27	39
Fear of Contagion (FC)		
A woman who has an abortion can make other people fall ill or get sick. *	32	51
A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion. *	21	46
If a man has sex with a woman who has had an abortion, he will become infected with a disease. *	28	45

*Significant at p<0.001(Chi-square)' ; ^ Significant regional differences in incidence region at p-value at P<0.001

b) ILAS Scale

Five regression models were used to test whether the type of service sought, age, SES, respondent's level of education, marital status, religion, county, and interaction between type of abortion services received and county were associated with stigma. The first regression model included all 20 items of the ILAS scale, the second model included items from the worries about judgment subscale; the third model included items from the isolation subscale, the fourth model included items from the self-judgment subscale, and the fifth model included items from the community condemnation subscale. Table 4.24 presents adjusted linear regression results for the association between ILAS scores for overall scale, its subscales, and respondents' demographic characteristics.

Based on the probability tests conducted as part of the descriptive analysis of ILAS scale data, we hypothesized that county, the age of the respondent, marital status, SES, type of service sought and incidence region variables were significantly associated with ILAS. For all the predictor variables fed into the models, the first item was considered a reference category (coded 0).

Consistent with our hypothesis, age of respondent, type of respondent, SES, marital status, and incidence region were the only predictor variables from among all of the variables fed into the five models that were significantly associated with stigma both the overall scale and subscales except community condemnation subscale. For community condemnation subscale, the only significant predictors were religion and SES. After accounting for their interaction on the overall scale, county and education still showed a statistically significant association with the

dependent variable (abortion stigma) on all the four subscale models. The direction and type of association for the worries, isolated, self-judgment subscales followed a similar, and identical pattern to that of the overall scale. The effect of age on stigma noted that overall levels of stigma decreased with an increase in age of respondents, with respondents older than 25-year-old reporting lower levels of stigma. For clients aged 24–34 years, we noted that overall scale, worries, isolation, and judgment subscales scores decreased for every increase in respondents' age category ($b = -7.7$; -9.2; -6.4; -2.8 for each subscale, respectively). This trend is seen from clients aged above 35–49 years.

On SES, stigma scores increased for the overall scale, worries about judgment, isolated, and self-judgment subscales along with the level of education ($b = 2.97$, $P < 0.001$) for respondents whose head of household had reached or completed secondary school or beyond. Stigma scores for full scale, and 3 subscales also were significantly lower for respondents who were not married, compared to those who were ($b = -14.8$, $P < 0.001$). In terms of the county, stigma scores were lower for Machakos ($b = -2.23$, $P < 0.001$).

Respondents from Trans Nzoia reported significantly higher stigma scores for the overall scale and three of the subscales than those from Machakos (coefficients: overall model 10.56***; worries 8.40***; isolated −1.78**; self-judgment 4.05***; community condemnation 0.01). Interaction of type of abortion and county yielded a reduction in ILAS scores for every unit at overall scale, worries about judgment subscale, isolation subscale, judgment subscale, and community condemnation subscale ($b = -6.25$, $P < 0.001$; -4.28 women with no or completed; some primary level of education reported higher levels of stigma compared to those who had reached postsecondary level of education.

Table 4.24: Adjusted Linear Regression Sociodemographic Characteristics of Respondent's and ILAS Scale

Variables	Overall scale		Worries subscale		Isolated subscale		Judgement Subscale		Community condemnation	
	Estimate	**95% CI**	**Estimate**	**95% CI**	**Estimate**	**95% CI**	**Estimate**	**95% CI**	**Estimate**	**95% CI**
Age										
16–24 years (reference)										
25–34 years	−7.70***	−9.20, −6.20	−6.54***	−7.68, −5.39	2.22 ***	1.68, 2.77	−2.98***	−3.49, −2.34	−0.06	−0.19, 0.08
34–49 years	−4.55***	−7.01, −2.09	−4.46***	−6.35, −2.58	2.89***	1.98, 3.78	−2.72***	−3.67, −1.77	−0.10	−0.33, 0.13
Type of client										
Induced (reference)										
PAC	7.41***	6.00, 8.82	6.24***	5.16, 7.32	−1.40***	−1.93, −0.88	2.73***	2.18, 3.28	0.02	−0.16, 0.15
Highest education level of head of household (SES)										
Some or completed postsecondary school (reference)										
Some or completed primary school	0.17	−1.78, 2.12	−0.45	−1.97, 1.07	1.58	0.88, 2.27	−0.81**	−1.56, −0.05	−0.15	−0.32, 0.02
Some or completed secondary school	2.97***	0.98, 4.99	2.05***	0.5, 3.60	0.27***	−0.45, 0.99	0.67	−0.09, 1.44	−0.02	−0.19, 0.16
Highest education level of respondent										
Some or completed postsecondary school (reference)										
Some or completed primary school	1.38	−1.21, 3.98	1.96	−0.06, 3.98	−0.97	−1.92, −0.03	0.73	−0.26, 1.72	−0.41***	−0.64, −0.18
Some or completed secondary school	5.89	3.08, 8.69	5.17***	2.99, 7.35	−1.93***	−2.95 −0.91	3.04 ***	1.98, 4.11	−0.19	−0.45, 0.05
Marital status										
Not union (reference)										
In union	−14.83***	−16.17, −13.47	−12.49 ***	−13.49, −11.50	3.17***	2.59, 3.74	−5.34***	−5.89, −4.80	−0.06	−0.21, 0.09
Religion										
Muslim (reference)										
Christian	−4.86	−11.39	−6.84	−11.92 −1.76	3.04	0.69, 5.39	−3.31	−5.85, −0.78	2.56***	1.76, 3.35
Other religion	−6.06	−15.48	−7.44	−14.77, −0.11	1.17	−2.22, 4.57	−2.34	−5.99, 1.30	2.28***	1.72, 2.82
Incidence region										
High Incidence (reference)										
Low incidence region	−2.23**	−3.73 −0.75	−0.97	−2.13, 0.19	−0.32	−0.86, 0.22	−0.79**	−1.37 −0.22	−0.09	−0.23, 0.03

Client type and incidence region interaction										
Induced (reference)										
PAC	10.56***	8.58, 12.53	8.40***	6.88, 9.92	−1.78***	−2.55, −1.03	4.05***	3.28, 4.81	0.01	−0.18, 0.19
Low incidence region	0.53	−1.32, 2.36	0.92	−0.50, 2.34	−0.65	−1.36, 0.05	0.36	−0.36, 1.07	−0.10	−0.28, 0.07
PAC* low incidence region	−6.25***	−9.03 −3.47	−4.28***	−6.42, −2.14	0.76	−0.30, 1.83	−2.61	−3.69, −1.53	0.01	−0.25, 0.28
***P<0.001, **P<0.01, *P<0.05, CI=Confidence interval, PAC=Post abortion care, SES=Socioeconomic status										

Proportion of Respondents Who Agreed with ILAS Statements Per County

Table 4.25 presents the proportion of respondents who strongly agreed or agreed with ILAS items as a way of identifying which items were contributing the most to scores in each county. Respondents reported the highest stigma scores on the community condemnation subscale followed by self-judgment and worries about judgment subscales. For the community condemnation subscale, 98% of respondent's agreed with statements that abortion is wrong or the same as murder. In the combined sample, 78% of respondents seeking PAC agreed with statements about fear of being isolated from community members if it were to be known that they had an abortion. Other important findings include that 65% of respondents were worried about being judged, whereas 35% of respondents reported being concerned about self-judgments.

Overall, respondents from Trans Nzoia were more likely to agree with statements on being stigmatized compared to women in Machakos. We compared Trans Nzoia and Machakos and noted significant differences in proportions that agreed or strongly agreed on two subscales: isolation and self-judgment.

We also compared the proportion of respondents who strongly agreed or agreed with statements on stigma. We noted that respondents who sought PAC services in Trans Nzoia reported higher proportions of agreement for specific items compared to those in Machakos, and those differences were statistically significant ($P < 0.005$) for 12 items as shown in Table 4.25.

Table 4.25 Proportion of Respondents Agreeing with ILAS Scale

Statement	Machakos		Trans-Nzoia	
	Respondents seeking CAC (*n*=210)	Respondents seeking PAC (*n*=166)	Respondents seeking CAC (*n*=214)	Respondents seeking PAC (*n*=169)
Worries about judgment				
Other people might find out about my abortion**	15	52	20	34
My abortion would negatively affect my relationship with someone I love**	13	57	19	39
I would disappoint someone I love**	12	57	16	40
I would be humiliated	13	58	19	41
People would gossip about me**	14	57	18	37
I would be rejected by someone I love	13	47	17	30
People would judge me negatively**	12	54	18	36
Isolation				
I have had a conversation with someone I am close with my abortion	62	80	64	79
I was open with someone that I am close with about my feelings about my abortion	62	81	64	80
I felt the support of someone that I am close with at the time of my abortion**	61	83	63	79
I can talk to the people I am close with about my abortion^, **	58	72	61	60
I can trust the people I am close to with information about my abortion	52	70	55	60
When I had my abortion, I felt supported by the people I was close with^, **	55	50	63	79
Self-judgment				
I felt like a bad person	7	27	10	20
I felt confident I had made the right decision	62	58	63	59
I felt ashamed about my abortion^, **	13	54	17	31
I felt selfish^, **	12	52	12	33

I felt guilty**	12	54	16	37

^ *Significant regional differences in incidence region at p-value at P<0.001*
*** Significant regional differences among respondents seeking PAC at p- value p<0.005*

4.3.4 Factors Associated with Abortion-Related Stigma.

In order to examine factors associated with abortion-related stigma at a personal level and community level in Machakos and Tran Nzoia regions, the study conducted focus group discussions and in-depth Interviews. Sections 4.3.4.1 and 4.3.4.2 below present findings from focus group discussions and in-depth interviews respectively.

4.3.4.1 Focus Group Discussion Results

a) Community Perceptions of Women and Abortions

When asked how the community would treat a woman known or perceived to have had an abortion, men, and women in all the focus groups in both regions cited countless ways women are isolated, labeled, and stigmatized. Women who have had abortions are labeled as killers and are perceived to be a bad influence on other women, especially young women. Additionally, women are isolated by their peers and considered 'poor candidates' for marriage. A young woman in Machakos County illustrated this point when she described how women who had procured abortions were perceived by others in the community. She noted:

> *"They see them as girls with bad habits; they neglect them. Some even say that if you associate with them, they will teach you bad habits. But the one of being neglected make them feel that even the community does not want them because they never liked what she did." (Young woman, Trans Nzoia County)*

Due to the fear of being stigmatized, women avoid going to the hospital or clinic to seek expert services because of fear information being leaked that they had had an abortion. As a result, women seek abortion from less skilled providers, predisposing them to complications and even death. A young woman in Machakos County noted why women opt for these unskilled methods:

> *"Somebody thinks that if I go to the hospital, they will monitor me that now what has this person came to do here, so many people go for the traditional way so that no one knows. It becomes a secret such that you can't tell what happened to the person (woman, Machakos County."*

One man from Trans Nzoia County pointed out how the public stigmatization of women who have abortions drives them to seek unskilled procedures that in some cases lead to death:

> *"We still go after these girls calling them names like, she is useless she is terrible, and this makes the girl hate herself, that's why they hide and even die while aborting."*

Many respondents reiterated the health risks associated with complications due to unsafe induced abortions, noting that women should keep their pregnancies. This further served to stigmatize the practice. One woman in Trans Nzoia County said:

> *"If one is pregnant, she should keep the baby. Abortion is associated with many problems, one can get an infection, and the uterus gets damaged, this means you cannot have any other child."*

b) Perceptions On Abortion and Knowledge of the Law

When community members were asked how a woman believed to have had an abortion would be treated in their communities, they noted that women would be ostracized, labeled and stigmatized. Women known to have had an abortion are socially isolated, labeled as killers or murderers, are perceived to be a bad influence, are called prostitutes and accused of being unfaithful, while younger women are perceived to be poor candidates for marriage. A married woman from Machakos County explained:

> *"[The woman who aborted] is deemed not to have morals. She is bad company and [the community] will advise [others] not to interact with [her]."* (Married woman, Machakos)

Because of the fear of social isolation, women try to keep the abortion secret and limit the number of people they tell. As such, women avoid seeking abortion services from skilled providers in health facilities near them, preferring instead to induce secretly by themselves or seek services from health facilities away from their communities, sometimes dying in the process. One old woman reported:

> *My son is a soldier in Somalia. Given that he was away for a year; my daughter-in-law became pregnant with another man. She tried to get rid of the pregnancy secretly. She went to Matisi health center to terminate the pregnancy so that no one finds out. She died on her way. If we had known, we would have taken her to Weonia Health Centre, which is just behind here. It was a shame on all of us that we could not assist her (married woman Trans Nzoia)*

Most community members either believed that abortion was illegal or was not sure. In Machakos, County women thought that abortion was not available in public hospitals, but

that doctors from public hospitals could provide abortions in private settings if women agreed to keep it secret because of the illegal nature of the procedure. One woman explained:

> *"[Abortion] services are not legal. If you go to a health facility for abortion, they will tell you 'we don't do that.' And if they have to do it for you, it's just back door. And the blame is on you."* (Young woman, Machakos County)

This perception that abortion is illegal or lack of knowledge on the legal status of abortion in Kenya leads to secrecy around the procedure, perpetuating unsafe abortion practices endangering the lives of women.

c) Quality of Care at Public Health Facilities

In several of the focus group discussions, respondents cited poor treatment of women seeking abortion- related services at health facilities as well as a lack of youth-friendly services as factors preventing women from seeking expert abortion services. Poor treatment included provider hostility and lack of privacy and confidentiality. Young women reported feeling discouraged and reluctant to go to health facilities because of fear of poor treatment due to their age. One young woman describes this:

> "*They do insult patients. You can go to the hospital and then the doctors' start talking ill about you, so this discourages you so much, and you decide to leave." (Young woman, Machakos)*

This perception was higher in Trans Nzoia County, with eight focus group discussions, citing poor treatment of women seeking abortion by providers in public health facilities, compared in Machakos County where respondents of only three out of twelve focus group discussions expressed this view.

Negative attitudes by health care worker were cited to prevent women from seeking skilled abortion-related services at health facilities. Both male and female focus group discussion participants shared stories about young women who had been insulted and chastised for being pregnant and seeking abortion services. Providers were said to in some cases deny young women induced abortion procedures altogether. One woman in Trans Nzoia County said:

> *"If you are a teenager less than 15 years [old] who is pregnant and have decided to carry out abortion, the midwife will not accept an abortion procedure for you."*

d) Perceptions That No Abortion Is Safe

In both regions, both male and female focus group discussants reported that they did not believe there were any safe abortion methods, and all methods were risky and could lead to death. This perception was higher in Trans Nzoia County, where participants of six out of 12 focus group discussions compared with two out of 12 in Machakos County reported to believe that all abortions were unsafe. A young woman explained:

"*When you look at all the local means used to abort at home, you may end up dying. [It's] the same thing when you go to the hospital, those processes may bring you complications. There are no safe means of abortion."*

In Trans Nzoia County, women reported that they would be turned back by traditional birth attendants to return later when they thought the "medicine" would work better, mainly when the pregnancy had advanced. The TBAs argued that when the medicine was taken earlier in the pregnancy, it would lead to death. This practice greatly endangered the lives of women who relied on them for abortion services as it is riskier to procure an abortion at a more advanced stage. A respondent noted:

*My friend who had taken her daughter was advised by the Mkunga (TBA) to come back later since it is too early for the medicine to work. It is better when the "thing" has formed. It is dangerous when it is too early and also too late. You need the right time, (*Married woman, Machakos County*)*

These perceptions regarding abortion further aggravated stigma towards women seeking abortion services as the often associated it with death and/or disability.

e) Effects of Withdrawal of Abortion Standard and Guidelines by Ministry of Health

Women in Trans Nzoia County noted that there was a program addressing sexual and reproductive rights in the community. This program enabled community members to seek SRH services, including abortion care services. However, there seemed to be a change of heart in the roll-out of these services like health facilities that used to provide services

ceased offering these services following the withdrawal by the Ministry of health standards and guidelines on provision of abortion services.

> *"Over the last one few months, Community health workers used to refer women for services in the facilities. However, this later changed and it is now very hard to obtain these services. I wonder why the change of heart. They used to be very friendly not anymore. We are forced to go back to the Wakunga [Traditional Birth Attendants] for help. They are not as good, but they help anyway (Young unmarried woman, Trans Nzoia)."*

However, women in Machakos County were not aware of these standards and guidelines. The withdrawal of these standards and guidelines further heightened abortion- related stigmas facilities were no longer comfortably to provide the services, choosing to advise women to seek services elsewhere.

f) The Cost of Abortion Care

The cost of the abortion from any provider was ambiguous and in many instances negotiable and depended on the gestational age of the pregnancy. Secrecy, perceived illegality, higher costs of safer methods and general lack of knowledge about safe abortion methods were found to drive women to unskilled providers with lower costs. In both regions, it was widely reported that young and poor women had the greatest difficulty accessing the resources necessary to pay for a procedure and had to rely on boyfriends' other friends and mothers, while those with social support from parents, or husbands had greater ability to access or mobilize resources. One woman from Machakos County reported:

"*For someone to visit the hospital, they get intimidated and can be charged about Ksh.10, 000 and beyond. A young teenage school girl may choose to use herbal medicine*" (Married woman, Machakos).

The perceived high cost of health services was also seen as a barrier to safe abortion. Women also reported not being able to afford the cost accessing drugs for abortion and post-abortion care. Husbands who are heads of household resources were perceived to be generally unsupportive of abortions as well. One woman who was out of school explained:

"If you don't have KShs. 3,000 to start the service, then you are ignored. If the pregnancy is still young, the cost is between KShs. 5,000 and KShs.8, 000, but to [get service] you need to know [the provider's] name." (Married women, Trans Nzoia).

The high cost of abortion services was found to be as a result of stigma associated with abortion as women are not able to negotiate for fair prices given that abortion was viewed as an illegal health service and providers would do attend to women in secret and therefore charge women in secret.

4.3.4.2 In-depth Interview Results

a) *Reasons for Seeking Abortion*

Eight women reported their main reason for terminating their pregnancy as due to economic reasons. Women seeking induced abortion in both regions narrated similar reasons. One woman said:

"I thought of my background. I have a single mother; I am the first born, and we are two in the university, I am enrolled as parallel [privately sponsored student].

What if she found out I am pregnant yet in the third year? And am still in parallel? She wouldn't feel good. And still want to go on with my education; I did not want to burden her (Trans Nzoia PAC, unmarried with no child, in college)

You know my husband is out of the country finalizing his studies, and I have been seeing a friend. I thought I was using contraceptives, and I think I mistimed. I don't want to have a baby outside wedlock and embarrass my husband (Machakos, PAC, Married with two children, housewife).

b) Knowledge About Availability of Abortion Services at Health Facility

The majority of women in both regions sought induced abortion services from private facilities while those who went to public facilities sought PAC services. Women's perceptions of the existence of abortion services in private facilities were similar in both regions. The preference of private compared to public facilities was found to be due to high levels of stigma towards women seeking abortion services in public facilities compared to private facilities. One woman described:

"I came to this clinic [Private] after my friend told me that if you go to a government facility, they will ask too many questions and may even call the police to arrest you. In this clinic they don't judge you, my friend said her boyfriend took her to a private clinic and was assisted. No one knew anything had happened (Unmarried woman Machakos County)."

Women seeking abortion-related services preferred to self-induce abortion before presenting at the health facility. Six women seeking PAC, in public facilities had self-

induced and presented at the facility while bleeding and did not disclose that they had self-induced. They found it easier to access PAC services in public facilities than induced abortion. This view is exemplified by a respondent below:

> *"I am still in school, a nurse who is close to my mum said it is illegal to provide abortion in government facilities, …, I tried omo [detergent] and it did not work, I tried some jivu [ash] given by an old woman, and it also did not work, so when I used mwarubaini I started bleeding, and when I came here, the nurse saw me bleeding and I was rushed to the theatre. That is when I was helped* **(**unmarried, below 18 years, in school Trans Nzoia).

Due to stigma and secrecy around abortion-related issues, most of the respondents interviewed reported that they preferred to obtain information about where abortion services are provided from people close to them and were likely to keep their issues confidential- preferably friends and relatives- while some simply chose not to ask because they did not trust anyone. More than two-thirds of women reported that they learned that abortion services were provided in the health facilities through their friends or relatives, while others suspected that they could be helped in the hospital, and therefore did not ask anybody one woman reported:

> *I did not want anybody other than my close friend who could offer help to know that I came to this clinic [private]. They would spread rumors about me to my parents who are Christians, and this might give them a bad name* (Unmarried with No Child, Induced, Machakos).

On the reasons why they chose a particular facility, two-thirds of women who sought services in public facilities reported that they chose them because they referral hospitals for public sites, while more than three-quarters of women treated in private facilities reported better treatment, especially when they were referred when it was impossible to be assisted in a public facility. One woman from a Public facility said:

> *While it is cheaper being treated here, in the private facility you were overcharged, and I do not have the money. Here there is a doctor who will examine and take care of you in order to stop the bleeding,* (married, PAC in a Private facility Machakos).

While those who sought abortion-related services in private facilities reported that they opted for private because providers were caring and more welcoming, attend to clients faster and had a positive attitude towards them, in addition to the privacy and confidentiality, those who sought services in public health facilities gave the main reason for lower cost compared to the private facilities. This implies that there are lower levels of abortion-related stigma in private facilities compared to public facilities, encouraging more women to access safe abortion services.

c) Feelings About Their Abortion Experience

Half of the women interviewed reported that they felt bad about their abortion. Four women from Machakos County and seven women Trans Nzoia reported that, though they felt bad about having aborted, they had to do it and were more worried about the labeling and discrimination that would be directed at them if discovered by relatives and community members. One woman described her feeling as follows:

*"Of course, there is that feeling that you are doing something bad but on the other side, you see it has to be done. I said this is my decision, and even God knows that it's not intentional. I don't think I have done any wrong", (*PAC Married no children, Trans Nzoia, Public).

"Sometimes I think about it; I know what I have done was bad I often pray to God to forgive me. I didn't want to do what I did but the situation I was in, forced me into it," (Induced, married with a child, Machakos Public).

A quarter of women who underwent elective abortion reported that they felt guilty about their decisions and felt helpless that they could not reverse the decision.

*"After going through the process, I felt guilty about it. I condemned myself about the decision. I knew I could not reverse the action. I decided to move on since I made the decision myself***,**" (Induced Single, Trans Nzoia, Public).

Generally, women felt bad about having aborted. While those women who had sought post-abortion care expected that they could have been helped in the health facility to keep the pregnancy; they felt bad that they had lost the pregnancy while those that had induced the abortion felt they had done something bad.

d) Coping Mechanisms for Women as a Result of Fear of Being Stigmatized

18 women who sought induced abortion (eight) and PAC (ten) were cautious to disclose information about their abortion and had to lie, while others confined in very close friends, relatives or a trusted person for fear of divulging information as some reported:

"*Since abortion is not allowed here in Kenya, it's not easy to go asking others on how you can do it. You will be seen as a sinful person. I was very cautious about the people I consulted. I made sure I told friends I trusted would not tell others (*Married with two children, Induced, Private Clinic Machakos).

Nine out of fifteen women seeking induced abortion services were not accompanied as they did not want any family member to know that they had sought abortion services in order to maintain secrecy and confidentiality, and avoid rumors that would end into negative perception towards them. However, their boyfriends were aware and had organized with someone at the health facilities to offer the services. Some women openly explained why they did not want to accompany to the facility as they said thus:

"*I came to seek the service alone. I did not even want my closest friend to know about it. This is a very personal decision as I do not want anyone to know what I went through,"* (Single, Unmarried, Trans Nzoia County).

The only people who knew were my boyfriend and I. I did not tell anyone else to know. With time, we would even ask ourselves why we decided this; we regretted as we thought it was not right but we had to encourage ourselves

[But do you think it is good to be accompanied?] It may be good to have an accompaniment. This person is likely to support you walk back home in case you were weakened by the process. But the challenge is on confidentiality. How would you ensure he/she does not disclose to the other people whatever happened on that day," (Single woman Machakos)?

Most of the younger women would have liked to involve their parent especially the mother, but they feared that they would have been stopped from seeking abortion:

> *"I took the decision on my own because if I involved my parents, they would have felt very bad about it and probably, they would have stopped me from terminating the pregnancy and for me I feel it is important to remove it at this point in my life,*" Single woman in Machakos.

Younger women that involved their parents while seeking services reported that their parents were very supportive, and they helped them in either identifying a provider and also keeping confidentiality of the entire process:

> *"My mom sought information from people, but she did it indirectly. She did not tell them that she was seeking the service for me. She lied to them that one of her nieces was pregnant and was looking for a good service provider. When we got information about a service provider, I came here," (*A student in Trans Nzoia).

e) Knowledge of Law and Abortion as Per Kenya's Constitution.

More than three-quarters of women reported that they were not clear whether abortion was legal or illegal in Kenya, with majority reporting that it was illegal. Because of this understanding, most women who had induced their abortion denied that they had done something to initiate their abortion so as to access abortion-related services in health facilities.

> *"...more so, abortion is illegal in the country, you cannot just go anywhere and ask for the service"* **(PAC, Unmarried with child, Machakos)**

> *"….. I know it is not accepted to carry out abortions in Kenya. The private clinics do it secretly. But the government should understand there are people out there who carry out abortions not by choice but unbearable circumstances...* **"(Induced, unmarried Trans Nzoia).**

More than half of women in Trans Nzoia reported that there were some organizations working in their communities to sensitize community members about provisions of the new constitution as it relates to abortion, informing them that they could be referred to public facilities for abortion-related services. However, this was different in Machakos County as women reported that there were no organizations in their communities talking about abortion, and most of the organizations working there were mainly working on HIV and family planning programming:

> *I know [organization A] have been educating community members on what the new constitution says. There is a lot of confusion, but every Thursday there is a play in west FM that educates women that they can seek safe services in the District Hospital. The problem is that when you go to the district hospital, it is difficult to identify a provider who can help you and since this is a sensitive subject you want to be careful* **(Unmarried, with no child, PAC Trans Nzoia)**
>
> *The only organizations here work in HIV and family planning, the law is not clear on abortion, I wish we could be educated about it* **(married with two children, PAC Machakos).**

f) Providers Attitudes

Nearly all women who sought services from private health facilities reported better treatment by health providers compared to those in public facilities. In public facilities, women who were married and sought PAC reported better treatment compared to unmarried women:

> *She asked me why am I complaining when I should not have had sex before, and went ahead to assist another older woman who had a similar condition like I had. It's like she was punishing me and going to help the most mature woman* **(Unmarried no child, PAC Trans Nzoia)**

Half of the women that had sought PAC services and had signs of self-induction reported several instances of being coerced and threatened by the providers because they refused to disclose what they did to induce. Women in Trans Nzoia reported that some providers reached a level of threatening not to attend to them if they completely refused to disclose that they had induced abortion:

> *"The nurse was the first person I contacted. She asked me what was wrong with me; I narrated to her. At first, she looked angry; she rebuked me on why I had terminated it yet she had stopped me from carrying it out"* **(unmarried no child Induced, Public, Machakos)**
>
> "*They only difficult situation was to face the same people who had stopped me from aborting, and there I was…… the nurses still talked to me although they rebuked me about my hideous decision"* **(unmarried woman with child, Induced Public, Trans Nzoia)**

"*To be sincere, I was not comfortable with the discussion I had with the provider…. I knew I was seeking for a service that is illegal in Kenya."* **(Married, with children, Induced Public, Machakos).**

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This study had three specific objectives. In this section, the study reviews study results for each method discussed in the results section and discusses the results for each study objective.

5.1. Discussion of Research Findings

5.1.1 Level of Abortion-Related Stigma Among General Community Members

The study findings indicate varying levels of stigmatizing attitudes, beliefs and actions towards women who had abortions in Machakos and Tran's Nzoia regions. Given the full

SABAS score ranges for the two regions, average full-scale SABAS scores of 54.2 (overall), 55.4(Trans Nzoia) and 53.07(Machakos) represent moderate to moderately high levels of stigmatizing attitudes, beliefs and actions among the study populations. Interestingly, the pattern of increasing full and sub-scale SABAS scores starting with Trans Nzoia and Machakos corresponds to the nature and interpretation of the level of incidence of unsafe abortion in regions where the regions are located(M. o. H. African Population and Health Research Center, Kenya, Ipas, and Guttmacher Institute, 2013), with Trans Nzoia located in Rift Valley region with the highest incidence and Machakos from Eastern region with lowest Incidence of unsafe abortion. These findings provide evidence on the link between abortion incidence and levels of abortion-related stigma, meaning that areas with high levels of abortion-related stigma are likely to register high unsafe abortion incidence and Vis-Versa. As such, to address incidence of unsafe abortions to reduce maternal mortality and morbidity, interventions need to be targeted at addressing abortion- related stigma

The extent of the agreement by respondents with individual SABAS items provide insight into the types of messages and/or information that could be incorporated into stigma reduction interventions in these regions. With very high proportions of respondents across the two regions agreeing with Negative Stereotyping (NS) items such as sin, shame, trustworthiness, and poor health, these should be given priority in efforts aimed at reducing abortion- related stigma. This should also apply to Exclusion and Discrimination (E&D) sub-scale, even though the proportion of agreement among respondents with its

items was moderate in both regions, but higher in Trans Nzoia compared to Machakos. However, nearly one-third of respondents in Machakos reported that a man should not marry a woman who has had an abortion and that they would try to shame a woman who had an abortion – two issues on to abortion-related stigma that is worth exploring further at the community and individual levels. The findings for the item in the E&D sub-scale about treating a woman who has had an abortion the same as everyone else warrants further discussion. Most individuals in both regions agreed that women who have had an abortion should be treated the same as everyone else yet these regions all had a high agreement for negative stereotyping and other exclusion and discrimination items. This is an area of the abortion-related stigma that needs further research and exploration fully to understand the relationship between attitudes and actions. Lastly, the fear of contagion items had moderate to a high agreement for Trans Nzoia, indicating that stigma reduction efforts in this region should likely include these issues in their interventions. As with the exclusion and discrimination items, the fear of contagion (FC) items had limited agreement in the context of both regions and did not necessarily needed to be incorporated into stigma reduction efforts at the community level.

5.1.2 Level of Abortion-Related Stigma Among Women Receiving Abortion Care

The findings further suggest a high level of stigma across all the population sub-groups such as whether the respondent sought induced or post-abortion care, marital status, education level, socio-economic status, and age. These help us understand how women who abort are perceived and sometimes treated at the community level by the different

population groups. The most important finding from this study is that self-perceived stigma is associated with abortion-seeking behaviors for women who would wish to terminate a pregnancy. As Marlow *et al.*(Marlow, Wamugi, et al., 2014) noted, women in Kenya face a lot of stigmas when seeking to terminate the pregnancy. Respondents from high incidence regions reported higher stigma scores compared to those in the low incidence of unsafe abortion region. Stigma scores increased for women seeking post-abortion care compared to those seeking induced services. This could be explained by the fact that, abortion being highly stigmatized, those who seek induced abortion do so from private health facilities, while women seeking post-abortion care services do so from public health facilities, which were found to have high stigma levels, after self-inducing and suffering complications. These findings imply that existence of stigma among women seeking abortion services remains a major factor in influencing the decisions of women intending to terminate a pregnancy(Puri, Ingham, & Matthews, 2007; Steinauer et al., 2008). Since women fear to be blamed, shamed, silenced, labeled, excluded or prosecuted for procuring an abortion, they continue to seek care in secrecy ending up in unsafe settings that increase their risks of suffering complications. This partly explains the increasing incidence of unsafe abortion in Kenya.

5.1.3 Association of Abortion-Related Stigma and Incidence of Unsafe Abortions

Results from the multivariate analyses indicate that site and educational attainment are the two personal characteristics most strongly associated with stigmatizing views about abortion. Findings indicate that respondents from Trans Nzoia County hold higher

stigmatizing attitudes, beliefs and actions than those from Machakos County. This implied that understanding county dynamics and differences in terms of socio-cultural and other variables will be critical aspects to take into consideration in any stigma reduction initiatives. Similarly, the findings that indicate that stigmatizing attitudes are stronger among individuals with lower levels of educational attainment highlight the need to engage out-of-school youth, as well as individuals who have not had the opportunity to attend secondary school (or beyond) to equip them with information regarding abortion.

Although religious affiliation did not emerge strongly as a characteristic significantly associated with the full SABAS score, it did show significant association with the E&D sub-scale. Specifically, individuals in the "Muslim" group held more exclusionary and discriminatory views than their Protestant counterparts – this is important finding that could be considered when partnering with religious leaders and groups for stigma reduction activities. A note of caution though is, this statistically significant finding should not overshadow the fact that a majority of respondents across all four countries categorized themselves as Protestant or Catholic, and many of these individuals hold very stigmatizing views about abortion. This indicates that organizations and group working to reduce stigma need to engage with all types of religious groups.

5.1.4 Factors Associated with Abortion-Related Stigma

The study sought to determine if women from the two regions experienced similar levels of stigma and explore factors associated with abortion-related stigma among women seeking abortion services. In order to determine this, the study examined the reasons

people sought abortion services, knowledge about the availability of services, provider attitudes, perceptions on laws on abortion, their own feelings about abortion among others and how these impacted abortion services are seeking behavior. Information about abortion was relatively available in the community, although it is secretly shared because of people's perception towards abortion. Similar to findings by Marlow et al. in Uganda, the study found that women mostly preferred receiving information and support from people that they trusted and who would keep their abortion confidential (Marlow, Shellenberg, et al., 2014).

One of the questions that the study was very keen to answer was if the manifestation of abortion-related stigma was different in regions with the high and low incidence of unsafe abortion. In both regions, the same barriers to safe abortion were shared again and again – fear of being arrested or ostracized for seeking abortion-related information, fear of maltreatment at health facilities and a lack of knowledge that allows for informed decision-making. In examining perceptions and knowledge among women and men about the change in Kenya's abortion law, it is clear that there are misconceptions or mixed perceptions regarding the legality of abortion. These factors have led to abortion often being procured in secrecy, outside of the public purview, with the help of untrained providers at lower costs. Women are also reluctant to seek safer services at public health facilities because of the poor treatment and quality of care. This is perpetuated by the common belief that there is no safe abortion. Barriers, including costs of abortion services in health facilities settings and the stigmatization of abortion, create additional obstacles for women seeking safe abortion services. As noted earlier, poverty is also a key driver of

unsafe abortion due to its strong association with transactional sex and unwanted pregnancies.

Consequently, women primarily resort to ‘chemists’ and use of traditional medicines, which are associated with increased risk of severe complications and death. Since many of these women do not want their families and friends to know they are suffering from the effects of unsafe abortion, they delay going to health facilities. When women die at health facilities because of this delay, men and women perceive abortion care and services as just as risky as traditional medicine. Unfortunately, if women believe that there is no "safe" option for abortion and perceive the risks to be the same, women will ultimately choose traditional medicine over going to a hospital. This is primarily due to cost and confidentiality issues.

While there is a host of other issues potentially at play, the community members who participated in the study suggested abortion-related stigma and how this impacts negatively on dissemination and seeking of abortion-related information as a key driver to unsafe abortions. While the newly liberalized abortion laws in Kenya allow women to access safe abortion services, these structural and cultural factors that perpetuate stigma continue to foster a sense of secrecy and fear among women, preventing them from seeking safe abortion services. Providing youth-friendly services and adapting messages to address local beliefs and their perceived risks of abortion have been found to be

effective measures to dealing with abortion-related stigma and promoting safe abortion services.

A clear start to addressing these barriers is the provision of accurate medical and legal information on safe abortion directed at women, especially as part of reproductive health campaigns(Cook, Dickens, & Horga, 2004). Additionally, information needs to be presented and packaged in a way that is simple and clear to a variety of women at different levels of literacy. Separating, family planning and abortion information further stigmatizes abortion, increases the likelihood that women will make an uninformed and unsafe choice, and makes existing efforts to provide women with reproductive health knowledge as a missed opportunity for saving the lives of the 47,000 women who die of unsafe abortion each year (Department of Reproductive Health and Research, 2011).

In each county, women said they wanted to receive information about abortion from the same people who explain their family planning options – for most of these women the person delivering this information was a Community Health Volunteer (Marlow, Wamugi, et al., 2014). At a minimum, they need to know that safe abortion and unsafe abortion are very different things and under what circumstances abortion is legal and available in their country. Equipped with this knowledge, they have a reason to seek out one kind of abortion over another and the knowledge that while asking about abortion may cost them status in their community it will not mean that they go to jail. If CHVs and

providers in facilities simply had the correct information on abortion and shared without shaming those who ask for it, it would be a huge step in the right direction.

When MOH issued a circular withdrawing standards and guidelines for the provision of abortion services, this was generally interpreted to mean that abortion services should not be provided and this further increased stigmatization of abortion. Community members reported that health providers were afraid of offering them services and therefore referred them to seek services outside of health facilities as they did not want to be associated with abortion.

The study sought to determine if women from the two regions experienced similar levels of stigma and explore factors associated with abortion-related stigma among women seeking abortion services. In order to determine this, the study examined the reasons people sought abortion services, knowledge about the availability of services, provider attitudes, perceptions on laws on abortion, their own feelings about abortion among others and how these impacted abortion services are seeking behavior. Information about abortion was relatively available in the community, although it is secretly shared because of people's perception towards abortion. Similar to findings by Marlow in Uganda, the study found that women mostly preferred receiving information and support from people that they trusted and who would keep their abortion confidential (Marlow, Shellenberg, et al., 2014). Knowledge levels of availability of abortion services were similar in both regions. Women in Machakos reported that they were aware abortion services were only available in private clinics while those in Trans Nzoia were aware that services were

available in both private and public health facilities, but they needed to know a health provider to help maneuver challenges of seeking an abortion.

The study also established that women less than 25 years who were unmarried were more stigmatized in health facilities compared to married women when seeking abortion-related services. Women that were accompanied to the health facility by their trusted friends and relatives reported less stigma compared to those that were not accompanied. The study found high levels of secrecy and concealment of information among women seeking abortion services, an indication that no person wants to be associated with abortion. This is a clear indication of very high levels of stigma around abortion-related issues, impacting abortion services seeking behavior. Other studies reported similar findings that in various settings, women who had terminated pregnancy were reluctant to disclose their abortion for fear of stigma (Shellenberg et al., 2011). These results imply that continued existence of stigma among women negatively impacts their decisions to seek skilled abortion – related services. More women seek services where they are guaranteed confidentiality and if health facilities do not guarantee this, women will continue to seek unsafe abortion services. This partly explains the ever-increasing number of death arising from an unsafe abortion not only in Kenya but also in other developing countries.

Women from Trans Nzoia County reported that they were aware of community groups educating members of the community on the law and how they could access abortion services in health facilities. However, the information available in health facilities and

communities about abortion services seemed to differ. This could be informed by the fact that MOH rolled out standards and guidelines for the provision of abortion services and community-based groups had partnered with communities in Tran's Nzoia county to sensitize and mobilize community members on the need to reduce unsafe abortions in the county (MOH, 2013; Services, September 2012). However these guidelines were withdrawn by MOH, and this left a gap in the provision of services(Otieno, 2014), with this gap further stigmatizing women seeking abortion services. Women in Machakos County noted that community-based organizations were only reaching educating community members about HIV and family planning, and they would like the organizations to include information on provisions of the new constitution on abortion. While Kenyan constitution offers a health provider a chance to use their opinion on whether or not to provide an abortion(Hussain, 2012), lack of standards and guidelines that protect the provider on how to provide this services limits provider options and only leads to further stigmatization of women especially when the provider knows that they could be arrested for offering an abortion(Rights, 2015).

5.2 Conclusions

This study measured community-level stigma in two regions with the high and low incidence of unsafe abortion and provided empirical evidence upon which stigma reduction interventions can be developed and implemented. This study makes the following conclusions;

a) The study concludes that abortion related stigma is a key contributor to unsafe abortions and therefore maternal deaths as evidenced by the fact that respondents from a county located in a region with high incidence of unsafe abortion (Trans Nzoia) reported significantly higher stigma scores than respondents from a located in a region with low incidence of unsafe abortions (Machakos) that reported lower stigma scores. Age, marital status, and educational attainment were all significantly associated with stigmatizing attitudes. Respondents in the 35-49 age groups showed more stigmatizing attitudes than younger respondents. On marital status, it was found that respondents that are married reported higher SABAS scores at full scale and subscales compared to respondents who were single. The study noted a significant and inverse relationship between stigmatizing attitudes beliefs and actions both at community and individual level and educational attainment where Stigma scores go down as education level goes up.

b) Young women seeking abortion services reported higher levels of stigma directed at them compared to older married women. They reported having been treated badly ostensibly to teach them a lesson. Women seeking post-abortion care

reported higher levels of stigma compared to those that presented for induced abortion.

c) There is a lack of knowledge on the legality of abortion in Kenya. This perpetuated stigma and prevented women from seeking safe abortion services for fear of being arrested. Due to this lack of knowledge, they preferred to speak to as few trusted people as possible to seek information on where to get abortion services, hence encountering barriers related to cost, being turned away by providers in the health facility. Thus, women who could not afford private facilities chose to self-induce and present in a health facility while bleeding as the only way to access services.

d) . It was clear from the findings that, At the same time, efforts aimed at educating people on abortion were said to reduce stigma as these helped to dispel myths and misconceptions about abortion on which stigma thrives. The study further found that the withdrawal of standards and guidelines on abortion by the Ministry of Health send mixed signals about abortion, heightening stigma around it, with facilities advising women not to seek services in health facilities anymore.

e) Majority of community members regard abortion as a bad thing with women who have had abortion perceived negatively and even treated badly by general community members. Men and women in both regions revealed the various ways women are isolated, labeled, and stigmatized. Women who procured abortion were labeled as killers and perceived to be a bad influence on women especially young women; and abortion considered illegal. These, coupled with high costs, fear of social isolation, poor treatment by health workers and perceptions that there were

no safe abortion options resulted in women across the two regions choosing to procure abortions secretly, in most cases avoiding health facilities, thus ending up in unsafe conditions.

5.3 Recommendations

Based on these findings, interventions aimed at addressing abortion-related stigma must be multidimensional in approach, targeting all players at all levels, while considering contextual factors precipitating abortion-related stigma. The study makes the following recommendations.

i. Following findings that regions with higher incidence of unsafe abortion reported higher levels of stigma with rural areas reporting highest stigma compared to urban and semi urban areas, we recommend that initiatives to reduce abortion related stigma should be implemented at both health facility level and community level to combat the problem of unsafe abortion. At the community level focus, should target towards normalizing conversations around sexual and reproductive health and not naming and shaming women who have sought an abortion. There is need to clarify provisions of the law so that women can understand instances where abortion can be provided safely in a health facility to avoid deaths resulting from abortion. At facility level intervention, should focus on addressing health care provider attitudes on how they handle and communicate with women seeking abortion. Health providers should adopt youth friendly way of interacting with clients and offer them services before they conduct self-indication and later present

at facility to be assisted when they are already bleeding. Interventions at the community level should focus on discouraging women from seeking an unsafe abortion but from trained health professional in a health facility, where a woman will be counseled and given a choice of whether to keep the pregnancy. This will be in a supportive environment both at community and health facility level, where the woman will also be offered contraceptives to prevent repeat unwanted pregnancies.

ii. Addressing gaps in sexual and reproductive health programs and debunking myths and misconception about contraception to promote use to prevent unwanted pregnancies that create the need for abortion. This should include promotion of abstinence and appropriate use of long-term contraceptive methods among women to prevent unwanted pregnancies and involvement of young people in design of the programs to ensure that they are responsive and address their unique needs

iii. Facilitating dialogue at the community to discuss sexual and reproductive health issues affecting the community members and identify solutions to them. This would ensure ownership of interventions and help in debunking some of the myths and misconceptions around SRH issues such as abortion that perpetuate stigma

iv. The study found a relationship between levels of stigma and incidence of unsafe abortion. to reduce the incidence of unsafe abortions, interventions aimed at reducing maternal mortality should also address reducing abortion stigma both at community and individual level. As indicated in the ecological model, there is a relationship between interrelationship on abortion stigma across, individual,

community, legal, institutional level and therefore, stigma reduction programs should address all levels of stigma.

v. Most individuals in both regions agreed that women who have had an abortion should be treated the same as everyone else yet these regions all had a high agreement for negative stereotyping and other exclusion and discrimination stigma scores. This is an area of the abortion-related stigma that needs further research and exploration fully to understand the relationship between attitudes and actions.

vi. Advocacy for the supportive legal environment to facilitate access to SRH services, including safe abortion, contraception, as well as protect SRHRs. This should include working with policy and lawmakers to formulate laws and policies that promote and protect reproductive rights of women, including fighting abortion-related stigma.

REFERENCES

African Population and Health Research Center, Ministry of health Kenya, Ipas, & Guttmacher Institute. (2013). *Incidence and Complications of Unsafe Abortion in Kenya: Key Findings of a National Study*. Retrieved from Nairobi, Kenya:

African Population and Health Research Center, M. o. H., Kenya, Ipas, and Guttmacher Institute. (2013). Incidence and Complications of Unsafe Abortion in Kenya: Key Findings of a National Study (Vol. 1, pp. 36). Nairobi, Kenya: Ministry of Health.

Agwanda, A., Khasakhala, A., & Kimani, M. (2009). *Assessment of family planning services in Kenya: Evidence from the 2004 Kenya Service Provision Assessment survey*. Retrieved from Calverton, Maryland, USA: http://dhsprogram.com/pubs/pdf/WPK4/WPK4.pdf

APHRC, I. (2013). Incidence and Complications of Unsafe Abortion in Kenya: Key findings of a national Study (Vol. 1).

Association, E. (2005). Epi Data Version 3.1 [Computer software]. *Odense, Denmark*.

Astbury-Ward, E. (2015). Abortion 'on the NHS': the National Health Service and abortion stigma. *Journal of Family Planning and Reproductive Health Care, 41*(3), 168-169.

Babigumira, J. B., Stergachis, A., Veenstra, D. L., Gardner, J. S., Ngonzi, J., Mukasa-Kivunike, P., & Garrison, L. P. (2011). Estimating the costs of induced abortion in Uganda: a model-based analysis. *BMC Public Health, 11*(1), 904.

Baik, J., & Silverstein, J. W. (2006). Eigenvalues of large sample covariance matrices of spiked population models. *Journal of Multivariate Analysis, 97*(6), 1382-1408.

Becker, D., & Díaz Olavarrieta, C. (2013). Decriminalization of abortion in Mexico City: the effects on women's reproductive rights. *American journal of public health, 103*(4), 590-593.

Bhandari, A., Mo Hom, N., Rashid, S., & Theobald, S. (2008). Experiences of abortion in Nepal and menstrual regulation in Bangladesh: a gender analysis. *Gender & Development, 16*(2), 257-272.

BriefSeries, I. Abortion and Unintended Pregnancy in Kenya.

Cheserem, M. (2011). Kenya: County Fact Sheets. *Nairobi, Kenya: Commission on Revenue Allocation*.

Chiappetta-Swanson, C. (2005). Dignity and dirty work: Nurses' experiences in managing genetic termination for fetal anomaly. *Qualitative Sociology, 28*(1), 93-116.

Cockrill, K., & Nack, A. (2013). "I'm Not That Type of Person": Managing the Stigma of Having an Abortion. *Deviant Behavior, 34*(12), 973-990.

Cockrill, K., Upadhyay, U. D., Turan, J., & Greene Foster, D. (2013). The stigma of having an abortion: Development of a scale and characteristics of women experiencing abortion stigma. *Perspectives on sexual and reproductive health, 45*(2), 79-88.

Cook, R. J., Dickens, B., & Horga, M. (2004). Safe abortion: WHO technical and policy guidance. *International Journal of Gynecology & Obstetrics, 86*(1), 79-84.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin, 30*(3), 481-491.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*: Sage.

Dahlbäck, E., Maimbolwa, M., Kasonka, L., Bergström, S., & Ransjö-Arvidson, A.-B. (2007). Unsafe induced abortions among adolescent girls in Lusaka. *Health Care for Women International, 28*(7), 654-676.

Darroch, J. E., & Singh, S. (2011). Adding it up: the costs and benefits of investing in family planning and maternal and newborn health—estimation methodology. *New York: Guttmacher Institute*.

Demographic, K. (2015). Health Survey 2008–2009. 2010. *Nairobi: Kenya Service Provision Assessment*.

Department of Reproductive Health and Research, W. H. O. (2011). Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 (6th ed., pp. 56): World Health Organization.

Donner, B. A., & Makuch, R. (1985). Approaches to sample size estimation in the design of clinical trials—a review. *Statistics in medicine, 4*(2), 247-247.

E. K. Yegon, P. M. K., E. Echoka,J. Osur,. (2016). Abortion-Related Stigma and Unsafe Abortions: Perspectives of Women Seeking Abortion Care in Machakos and Trans-Nzoia Counties, Kenya. *East Africa Medical Journal, 93*(4), 105-110.

Eschenbach, D. A. (2015). Treating Spontaneous and Induced Septic Abortions. *Obstetrics & Gynecology, 125*(5), 1042-1048.

Freedman, L., Landy, U., Darney, P., & Steinauer, J. (2010). Obstacles to the integration of abortion into obstetrics and gynecology practice. *Perspectives on sexual and reproductive health, 42*(3), 146-151.

Friese, S. (2014). *Qualitative data analysis with ATLAS. ti*: Sage.

Gathura, G. (2014, 19 May 2014 00:39). Doctors in limbo as abortion rules withdrawn. *The Standard Newspaper*. Retrieved from http://www.standardmedia.co.ke/m/story.php?articleID=2000121617&story_title=Doctors-in-limbo-as-abortion-rules-withdrawn

Gebreselassie, H., Gallo, M. F., Monyo, A., & Johnson, B. R. (2005). The magnitude of abortion complications in Kenya. *BJOG: An International Journal of Obstetrics & Gynaecology, 112*(9), 1229-1235.

Gipson, J. D., Hirz, A. E., & Avila, J. L. (2011). Perceptions and practices of illegal abortion among urban young adults in the Philippines: a qualitative study. *Studies in Family Planning, 42*(4), 261-272.

Gliem, J., & Gliem, R. (2003). *Calculating, interpreting, and reporting Cronbach's alpha reliability coefficient for Likert-type scales*.

Gliem, J. A., & Gliem, R. R. (2003). *Calculating, interpreting, and reporting Cronbach's alpha reliability coefficient for Likert-type scales*.

Goffman, E. (1963). Stigma. Hammondsworth: Penguin.

Guyo, J., Ogutu, O., Johnson, A., Ndavi, P., & Karanja, J. (2014). Advocacy towards changes on laws governing access to safe abortion in Kenya.

Haines, A., Sanders, D., Lehmann, U., Rowe, A. K., Lawn, J. E., Jan, S., . . . Bhutta, Z. (2007). Achieving child survival goals: potential contribution of community health workers. *The Lancet, 369*(9579), 2121-2131.

Harries, J., Gerdts, C., Momberg, M., & Greene Foster, D. (2015). An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa. *Reprod Health, 12*, 21.

Harris, L. H., Debbink, M., Martin, L., & Hassinger, J. (2011). Dynamics of stigma in abortion work: findings from a pilot study of the Providers Share Workshop. *Social science & medicine, 73*(7), 1062-1070.

Hessini, L. (2014). A learning agenda for abortion stigma: recommendations from the Bellagio Expert Group Meeting. *Women & health, 54*(7), 617-621.

Hill, Z. E., Tawiah-Agyemang, C., & Kirkwood, B. (2009). The context of informal abortions in rural Ghana. *Journal of Women's Health, 18*(12), 2017-2022.

Hirschfeld, G., von Brachel, R., & Thielsch, M. (2014). Selecting items for Big Five questionnaires: At what sample size do factor loadings stabilize? *Journal of Research in Personality, 53*, 54-63.

Holcombe, S. J., Berhe, A., & Cherie, A. (2015). Personal Beliefs and Professional Responsibilities: Ethiopian Midwives' Attitudes toward Providing Abortion Services after Legal Reform. *Studies in Family Planning, 46*(1), 73-95.

Hosseini-Chavoshi, M., Abbasi-Shavazi, M. J., Glazebrook, D., & McDonald, P. (2012). Social and psychological consequences of abortion in Iran. *International Journal of Gynecology & Obstetrics, 118*, S172-S177.

Hung, S. L. (2010). Access to safe and legal abortion for teenage women from deprived backgrounds in Hong Kong. *Reproductive Health Matters, 18*(36), 102-110.

Hussain, R. (2012). Abortion and unintended pregnancy in Kenya. *Issues in brief (Alan Guttmacher Institute)*(2), 1-4.

Izugbara, C. O., Egesa, C., & Okelo, R. (2015). 'High profile health facilities can add to your trouble': Women, stigma and un/safe abortion in Kenya. *Social science & medicine, 141*, 9-18.

Izugbara, C. O., Otsola, K. J., & Ezeh, A. C. (2009). Men, women, and abortion in central Kenya: a study of lay narratives. *Medical Anthropology, 28*(4), 397-425.

Jones, G. W. (2012). Feedback Report on Status of Implementation of "The Call for the Elimination of Unmet Need for Family Planning'in Selected Countries in Southeast Asia. *Operationalizing the Call for the Elimination of Unmet Need for Family Planning*, 39.

Kebede, M. T., Hilden, P. K., & Middelthon, A.-L. (2012). The tale of the hearts: deciding on abortion in Ethiopia. *Culture, Health & Sexuality, 14*(4), 393-405.

Kenya, T. G. o. (2010). *The Constitution of Kenya,*. Nairobi, Kenya;: National Council for Law Reporting (NCLR).

Kimport, K., Cockrill, K., & Weitz, T. A. (2012). Analyzing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experience of abortion clinics. *Contraception, 85*(2), 204-210.

Kimport, K., Preskill, F., Cockrill, K., & Weitz, T. A. (2012). Women's perspectives on ultrasound viewing in the abortion care context. *Women's Health Issues, 22*(6), e513-e517.

Kinney, M. V., Kerber, K. J., Black, R. E., Cohen, B., Nkrumah, F., Coovadia, H., . . . Lawn, J. E. (2010). Sub-Saharan Africa's mothers, newborns, and children: where and why do they die? *PLoS medicine, 7*(6), e1000294.

Kramon, E., & Posner, D. N. (2011). Kenya's new constitution. *Journal of Democracy, 22*(2), 89-103.

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

Larsson, S., Eliasson, M., Allvin, M. K., Faxelid, E., Atuyambe, L., & Fritzell, S. (2015). The Discourses on Induced Abortion in Ugandan Daily Newspapers. *The European Journal of Public Health, 25*(suppl 3), ckv171. 002.

Levandowski, B. A., Kalilani-Phiri, L., Kachale, F., Awah, P., Kangaude, G., & Mhango, C. (2012). Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: the role of stigma. *International Journal of Gynecology & Obstetrics, 118*, S167-S171.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology*, 363-385.

Major, B., & Gramzow, R. H. (1999). Abortion as stigma: cognitive and emotional implications of concealment. *Journal of personality and social psychology, 77*(4), 735.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annu. Rev. Psychol., 56*, 393-421.

Marlow, H. M., Shellenberg, K., & Yegon, E. (2014). Abortion services for sex workers in Uganda: successful strategies in an urban clinic. *Culture, Health & Sexuality*(ahead-of-print), 1-13.

Marlow, H. M., Wamugi, S., Yegon, E., Fetters, T., Wanaswa, L., & Msipa-Ndebele, S. (2014). Women's perceptions about abortion in their communities: perspectives from western Kenya. *Reproductive Health Matters, 22*(43), 149-158.

Martin, L. A., Debbink, M., Hassinger, J., Youatt, E., & Harris, L. H. (2014). Abortion providers, stigma and professional quality of life. *Contraception, 90*(6), 581-587.

MOH, K. (2012a). *The Kenya Health Policy, 2012-2030*. Nairobi.

MOH, K. (2012b). *Reversing the trends: The second National Health Sector Strategic Plan of Kenya*. Nairobi.

MOH, K. (2013). *The Kenya National Patients rights Charter, 2013*. Nairobi: Ministry of Health.

Mohamed, S. F., Izugbara, C., Moore, A. M., Mutua, M., Kimani-Murage, E. W., Ziraba, A. K., . . . Egesa, C. (2015). The estimated incidence of induced abortion in Kenya: a cross-sectional study. *BMC Pregnancy and Childbirth, 15*(1), 185.

Moses Mulumba, D. K., Viola Nassuna. (April 2010). *Constitutional provisions for the right to health in east and southern Africa*. Retrieved from Harare:

Mumah, J., Kabiru, C., Mukiira, C., Brinton, J., Mutua, M., Izugbara, C., . . . Askew, I. (2014). *Unintended Pregnancies in Kenya: A Country Profile," STEP UP Research Report*. Retrieved from Nairobi:

Nickerson, A., Manski, R., & Dennis, A. (2014). A Qualitative Investigation of Low-Income Abortion Clients' Attitudes Toward Public Funding for Abortion. *Women & health, 54*(7), 672-686.

Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., De Zordo, S., & Becker, D. (2011). Abortion stigma: a reconceptualization of constituents, causes, and consequences. *Women's Health Issues, 21*(3), S49-S54.

Omo-Aghoja, L., Omo-Aghoja, W., Okonofua, F., Aghedo, O., Umueri, C., Otayohwo, R., . . . Esume, C. (2009). Perceptions and attitudes of a rural community to abortion in the Niger-delta region of Nigeria. *Nigerian journal of clinical practice, 12*(4).

Organization, W. H. (2003). *Safe abortion: Technical and policy guidelines for health systems*: World Health Organization.

Organization, W. H. (2011). Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2008.

Orner, P., de Bruyn, M., & Cooper, D. (2011). 'It hurts, but I don't have a choice, I'm not working and I'm sick': decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa. *Culture, Health & Sexuality, 13*(7), 781-795.

Otieno, J. (2014, Wednesday, July 23rd 2014 at 10:35). Clandestine abortions shoot up as practitioners suspend guidelines, Eve Woman article. *The Standard Newspaper*. Retrieved from http://www.standardmedia.co.ke/evewoman/article/2000129181/clandestine-abortions-shoot-up-as-practitioners-suspend-guidelines?pageNo=2

Palomino, N., Padilla, M. R., Talledo, B. D., Mazuelos, C. G., Carda, J., & Bayer, A. M. (2011). The social constructions of unwanted pregnancy and abortion in Lima, Peru. *Global Public Health, 6*(sup1), S73-S89.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social science & medicine, 57*(1), 13-24.

Payne, C. M., Debbink, M. P., Steele, E. A., Buck, C. T., Martin, L. A., Hassinger, J. A., & Harris, L. H. (2013). Why women are dying from unsafe abortion: narratives of Ghanaian abortion providers. *African Journal of Reproductive Health, 17*(2), 118-128.

Purcell, C., Hilton, S., & McDaid, L. (2014). The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010. *Culture, Health & Sexuality, 16*(9), 1141-1155.

Puri, M., Ingham, R., & Matthews, Z. (2007). Factors affecting abortion decisions among young couples in Nepal. *Journal of Adolescent Health, 40*(6), 535-542.

Quinn, D. M., & Chaudoir, S. R. (2009). Living with a concealable stigmatized identity: the impact of anticipated stigma, centrality, salience, and cultural stigma on psychological distress and health. *Journal of personality and social psychology, 97*(4), 634.

Rasch, V. (2011). Unsafe abortion and postabortion care–an overview. *Acta obstetricia et gynecologica scandinavica, 90*(7), 692-700.

Rights, C. f. R. (2015). Kenyan Women Denied Safe, Legal Abortion Services. Retrieved from http://www.reproductiverights.org/press-room/kenyan-women-denied-safe-legal-abortion-services

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*: Sage.

Rossier, C. (2007). Abortion: an open secret? Abortion and social network involvement in Burkina Faso. *Reproductive Health Matters, 15*(30), 230-238.

Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.-B., Daniels, J., . . . Alkema, L. (2014). Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health, 2*(6), e323-e333.

Sedgh, G., Bankole, A., Oye-Adeniran, B., Adewole, I. F., Singh, S., & Hussain, R. (2006). Unwanted pregnancy and associated factors among Nigerian women. *International Family Planning Perspectives*, 175-184.

Sedgh, G., Hussain, R., Bankole, A., & Singh, S. (2007). *Women with an unmet need for contraception in developing countries and their reasons for not using a method*: Alan Guttmacher Institute.

Sedgh, G., Singh, S., Shah, I. H., Åhman, E., Henshaw, S. K., & Bankole, A. (2012). Induced abortion: incidence and trends worldwide from 1995 to 2008. *The Lancet, 379*(9816), 625-632.

Services, M. o. M. (September 2012). *STANDARDS and GUIDELINES for reducing morbidity & mortality from unsafe abortion in Kenya*. Nairobi.

Shah, I., & Ahman, E. (2009). Unsafe abortion: global and regional incidence, trends, consequences, and challenges. *J Obstet Gynaecol Can, 31*(12), 1149-1158.

Shearer, J. C., Walker, D. G., & Vlassoff, M. (2010). Costs of post-abortion care in low- and middle-income countries. *International Journal of Gynecology & Obstetrics, 108*(2), 165-169.

Shellenberg, K. M., Moore, A. M., Bankole, A., Juarez, F., Omideyi, A. K., Palomino, N., . . . Tsui, A. O. (2011). Social stigma and disclosure about induced abortion: results from an exploratory study. *Global Public Health, 6*(sup1), S111-S125.

Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of perceived and internalized stigma among abortion patients in the USA: An exploration by race and Hispanic ethnicity. *International Journal of Gynecology & Obstetrics, 118*, S152-S159.

Singh, S., Moore, A., Bankole, A., Mirembe, F., & Wulf, D. (2006). Unintended pregnancy and induced abortion in Uganda: causes and consequences.

Singh, S., Sedgh, G., & Hussain, R. (2010). Unintended pregnancy: worldwide levels, trends, and outcomes. *Studies in family planning, 41*(4), 241-250.

Sisson, G., & Kimport, K. (2014). Telling stories about abortion: abortion-related plots in American film and television, 1916–2013. *Contraception, 89*(5), 413-418.

Sorhaindo, A. M., Juárez-Ramírez, C., Olavarrieta, C. D., Aldaz, E., Mejía Piñeros, M. C., & Garcia, S. (2014). Qualitative Evidence on Abortion Stigma from Mexico City and Five States in Mexico. *Women & health, 54*(7), 622-640.

Sowmini, C. (2013). Delay in termination of pregnancy among unmarried adolescents and young women attending a tertiary hospital abortion clinic in Trivandrum, Kerala, India. *Reproductive Health Matters, 21*(41), 243-250.

Steinauer, J., Landy, U., Filippone, H., Laube, D., Darney, P. D., & Jackson, R. A. (2008). Predictors of abortion provision among practicing obstetrician-gynecologists: a national survey. *American journal of obstetrics and gynecology, 198*(1), 39. e31-39. e36.

Storeng, K. T., & Ouattara, F. (2014). The politics of unsafe abortion in Burkina Faso: the interface of local norms and global public health practice. *Global Public Health, 9*(8), 946-959.

Tagoe-Darko, E. (2013). " Fear, Shame and Embarrassment": The Stigma Factor in Post Abortion Care at Komfo Anokye Teaching Hospital, Kumasi, Ghana. *Asian Social Science, 9*(10), 134.

Tashakkori, A., & Teddlie, C. (2010). *Sage handbook of mixed methods in social & behavioral research*: Sage.

Team, R. C. (2014). R: A language and environment for statistical computing. Vienna, Austria: R Foundation for Statistical Computing; 2014.

Turan, J. M., Hatcher, A. H., Medema-Wijnveen, J., Onono, M., Miller, S., Bukusi, E. A., . . . Cohen, C. R. (2012). The role of HIV-related stigma in utilization of skilled childbirth services in rural Kenya: a prospective mixed-methods study. *PLoS medicine, 9*(8), e1001295.

Vlassoff, M., Mugisha, F., Sundaram, A., Bankole, A., Singh, S., Amanya, L., . . . Mirembe, F. (2014). The health system cost of post-abortion care in Uganda. *Health Policy and Planning, 29*(1), 56-66.

Weitz, T. A., & Cockrill, K. (2010). Abortion clinic patients' opinions about obtaining abortions from general women's health care providers. *Patient education and counseling, 81*(3), 409-414.

World Health Organization (WHO). (2011). *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2008*. Retrieved from Geneva:

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: adding moral experience to stigma theory. *Social science & medicine, 64*(7), 1524-1535.

Ziraba, A. K., Izugbara, C., Levandowski, B. A., Gebreselassie, H., Mutua, M., Mohamed, S. F., . . . Kimani-Murage, E. W. (2015). Unsafe abortion in Kenya: a cross-sectional study of abortion complication severity and associated factors. *BMC Pregnancy and Childbirth, 15*(1), 34.

APPENDICES

Appendix 1: Certificate of Translation of Consent Forms and Tools

CERTIFICATE OF TRANSLATION

CERTIFICATE OF TRANSLATION

This is to certify that we have translated the following data collection isntruments from **ENGLISH** into **SWAHILI** and back **SWAHILI** back into **ENGLISH** without losing meaning,

1. Oral Consent form
2. Focused group discussion Guide
3. SABAS Scale
4. ILAS Scale
5. In-depth Interview guide from

We further confirm that the translations are true and accurate to the best of our abilities.

Sign: *Oscar Mutinda*

Acorn House, 97 James Gichuru Road, Lavington, P.O. Box 68230-00200 City Square, Nairobi, Tel: +254 (0) 20 3862721-33 | Mobile +254 722 667 615, Email Oscar.mutinda@ipsos.com. http://www.ipsos.com | http://www.ipsos.co.ke

Appendix 2: Informed consent for Quantitative Tools (English)

Instructions: *To be administered to selected clients receiving abortion related services in health facilities in Machakos and Trans Nzoia counties.*

Title: Abortion Related Stigma: Investigating Correlates of Stigma and Unsafe Abortions in high incidence and low incidence regions in Kenya Study

Introduction

I want to thank you for finding time to meet me today.

My name is _____, working with a team from this hospital on a study titled *"Abortion Related Stigma: Investigating Correlates of Stigma and Unsafe Abortions in high incidence and low incidence regions in Kenya".*

Objectives of the study: The main objective of this study is to investigate the association between unsafe abortions and abortion related stigma at individual and community level in two regions with high and low unsafe abortion incidences. This study hopes document how abortion stigma is a major contributor to the high rates of unsafe abortion. If this association is determined, then interventions targeting stigma can be prioritized in solving the problem of unsafe abortion

Procedures: We will ask you questions on how women who have sought abortion services are treated by friends, family members and general community members. All responses will be kept confidential. This means that your interview responses will only be shared with the research team and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you do not have to talk about anything you do not want to and you may end the interview at any time. The interview should take less than an hour. I will be noting your response on this data collection form.

Benefits: There are no direct benefits to you as a person related to this study. However, this study will provide information that can be used to determine the levels of abortion stigma at individual and community level and interventions to reduce the levels of stigma designed in order to address the problem of unsafe abortion.

Risks: There are no physical risks associated with this study.

Voluntarism: Participation in this study is voluntary. You do not have to talk about anything you do not want to and you may end the interview at any time.

Confidentiality: All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent.

Contact for PI in case you need any further clarification regarding your participation in this study, contact the Principal Investigator (Erick Kiprotich Yegon) on 0772234488.

Contact for KEMRI/ERC committee

In case you need to find out more about your rights to participation in this study, contact the KEMRI Ethical Review Committee (ERC) secretary on email at ercadmin@kemri.org or (P.O. BOX – 00200 or Tel: **+254 (0)20 2713349**2726300 Ext 44355.

Are there any questions about what I have just explained? Are you willing to participate in this interview? _____

Signature for participant and witness

_____	_____	_____
Interviewee	**Witness**	**Date**
_____	_____	_____
Interviewee	**Witness**	**Date**

Appendix 3: Informed Consent for Qualitative Tools (English)

Participant Unique ID_____

Consent for participation in a research study: Interview with women seeking abortion services and general community members

Introduction

Hello, my name is _____ working with a team from this hospital on a study titled *"Abortion Related Stigma: Investigating Correlates of Stigma and Unsafe Abortions in high incidence and low incidence regions in Kenya".* I would like to invite you to participate in a research study to better understand the quality of services provided at [INSERT FACILITY NAME] and women's decision-making around pregnancy and abortion.

This consent form will provide you with some information about the study. It may contain words that you do not understand. Please ask me to explain any words or information that you do not clearly understand as we go through the form.

Objectives of the study: The main objective of this study is to investigate the association between unsafe abortions and abortion related stigma at individual and community level in two regions (Trans nzoia and Machakos) with high and low unsafe abortion incidences. This study hopes document how abortion stigma is a major contributor to the high rates of unsafe abortion. If this association is determined, then interventions targeting stigma can be prioritized in solving the problem of unsafe abortion

Procedure

To be eligible to participate in this study, you must be at least 18 years of age. If you agree to participate in the study, an interviewer will speak with you privately in a private office here at the health facility. Before you begin, the interviewer will ask you to consent to participate and will give you the opportunity to ask any questions about the study. The interviewer will then ask you a series of questions related to abortion and the interview

will likely last about 1 hour – it may last a little longer or shorter depending on you and the interviewer. You will be asked some questions about yourself, your experience at this facility, and your thoughts and feelings having to do with this pregnancy and abortion. You do not have to answer any of the questions and you can stop the interview at any time. The interview will be recorded with a digital voice recorder and the interviewer will also be taking notes to ensure accurate documentation of the interview. At the end of the interview, the interviewer will give you the opportunity to ask any remaining questions that you might have. You will receive phone care valued at 200 shillings for your participation in the interview.

Risks

There is no known risk for you to participate in this study. However, some of the questions you will be asked in the interview might bring up feelings or make you feel uncomfortable. Your participation in the interview is entirely voluntary. You may refuse to answer any of the questions and you can stop the interview at any time.

Benefits

There is no direct benefit to you for participating in the interview. However, increased understanding of the reproductive health decisions among women who are choosing to have an abortion and a better understanding of the quality of services at this facility will help us to improve future health programs and women's health services at this facility.

Confidentiality

All your interview responses will be kept confidential. Your name will not be associated with any of your responses to the questions that you are asked during the interview. After the interview, we will write down what you have said in the recording. We will be sure to change any names or personal information that was recorded in the interview when we create the written version of the interview. We will keep the digital recording of the interview in a secure location and erase the recording within one year after the end of the project. None of the information you provide during the interview will affect the services

you receive here. Only members of the research team will have access to the information you share with us in this interview.

Contact for KEMRI/ERC committee

In case you need to find out more about your rights to participation in this study, contact the KEMRI Ethical Review Committee (ERC) secretary on email at info@kemri.org or (P.O. BOX – 00200 or Tel: **+254 (0)20 2713349**2726300 Ext 44355.

Are there any questions about what I have just explained? Are you willing to participate in this interview? _____

Signatures

_____	_____	_____
Participant Name	Participant Signature	Date
_____	_____	_____
Witness Name	Witness Signature	Date

Appendix 4: Informed Consent for Qualitative Tools (Swahili)

Participant Unique ID_____

Consent for participation in a research study: Interview with women seeking abortion services and general community members

Introduction

Habari, *ingependa kukushukuru kwa kupata wakati wa kukukutana na mimi leo. Jina langu ni_____na ninafanya na timu kutoka hospitali hii kwa utafiti uitwao "Unyanyapaa unaotokana na uavyaji mimba: Kuchunguza uhusiano kati ya Unyanyapaa na uavyaji mimba usio salama katika maeneo ya matukio ya juu na chini hapa nchini Kenya"*

Objectives of the study: *Lengo kuu la utafiti huu ni kuchunguza uhusiano kati ya uavyaji mimba usi salama na unyanyapaa utokanao na kuavya mimba kwenye ngazi za kibinafsi na za kijamii katika maeneo mawili yenye matukio ya juu na chini ya uavyaji mimba usio salama.Utafiti huu unalenga kunukuu jinsi unyanyapaa unaotokana na uavyaji mimba ni changio mkubwa kwa viwango vya juu cha uavyaji mimba usio salama.Ikiwa uhusiano huu utaamuliwa basi hatua zinazolenga unyanyapaa zitapewa kipaumbele katika kutatua tatizo la uavyaji mimba usio salama.*

Procedure

Tutakuuliza maswali kuhusu vile wanawake waliowahi kusaka huduma za uavyaji mimba walivyochuliwa na marafiki, familia na watu katika jamii kwa ujumla.Majibu yote yatawekwa siri. Majibu yote yatakuwa siri. Hii ina maana kwamba majibu yako ya mahojiano yatatumiwa tu na wanachama wa timu ya utafiti na tunakuhakikishia ya kwamba taarifa yoyote tutakayoijumlisha kwenyea ripoti yetu haitakutambulisha wewe kama mhojiwa.Kumbuka Sio lazima uongee kuhusu kitu chochote ambacho hukitaki na unaweza kusitisha mahojiano wakati wowote.Mahojiano haya yanafaa kuchukua muda

wa chini ya saa moja.Nitakuwa nikinukuu majibu yako katika fomu hii ya kuchukua majibu.

Risks

Hakuna hatari za kimwili zinazotokana a na utafiti huu. Kushiriki katika utafiti huu ni wa hiari. Sio lazima uongee kuhusu kitu chochote ambacho hukitaki na unaweza kusitisha mahojiano wakati wowote.

Benefits

Hakuna faida za moja kwa moja kwako kuhusiana na utafiti huu.Lakini,utafiti huu utapatiana habari inayoweza kutumiwa kuamua viwango vya unyanyapaa utokanao na uavyaji mimba katika ngazi za kibinafsi na kijamii na hatua za kupunguza viwango vya unyanyapaa vilivyoundwa ili kukabiliana na tatizo la uavyaji mimba usio salama.

Confidentiality

Majibu yote yatawekwa siri. Hii ina maana kuwa majibu yako kutokana na mahojiano yatatumiwa tu na wanachama wa timu ya utafiti na tunakuhakikishia ya kwamba taarifa yoyote tutakayoijumlisha kwenyea ripoti yetu, haitakutambulisha wewe kama mhojiwa.Tutaweka recodi ya mazungumzo yetu ili tutumie katika utafiti huu kwa muda wa mwaka mmoja halafu tutaharibu mazungumzo hayo.

Contact for PI/*Anwani ya mawasiliano ya mtafiti mkuu*

Ikiwa utahitaji ufafanuzi zaidi kuhusu kushiriki kwako katika utafiti huu, wasiliana na Mtafiti mkuu (Erick KiprotichYegon) kwenye namabari ya simu 0772234488.

Contact for KEMRI/ERC committee/*Anwani ya mawasiliano ya kamati ya* KEMRI/ERC

Ikiwa utahitaji kujua zaidi kuhusu haki zako za kushiriki katika utafiti huu, wasiliana na katibu wa kamati ya kimaadili ya KEMRI (ERC) kupitia kwa anwani ya barua pepe ercadmin@kemri.org au anwani ya posta (PO BOX - 00200 au Nambari ya simu: +254 (0) 20 27133492726300 Ext 44355.

Je, *una maswali yoyote kutokana na yale niliokuelezea? Je, uko tayari kushiriki katika mahojiano haya?* _____

Signature for participant and witness/*Sahihi ya mshiriki na shahidi*

_____ _____

_____

Interviewee/*Mhojiwa* **Witness /*Shahidi*** **Date/*Tarehe***

Language of Consent:_____

Appendix 5: Translated Informed Consents (Swahili)

Instructions: To be administered to selected clients receiving abortion related services in health facilities in Machakos and Trans Nzoia counties.

Jina : Unyanyapaa unaotokana na uavyaji mimba: Utafiti wa kuchunguza Uhusiano kati ya Unyanyapaa na uavyaji mimba usio salama katika maeneo ya matukio ya juu na chini hapa nchini Kenya

Utangulizi

Ningependa kukushukuru kwa kupata wakati wa kukukutana na mimi leo.

Jina langu ni_____na ninafanya na timu kutoka hospitali hii kwa utafiti uitwao "Unyanyapaa unaotokana na uavyaji mimba: Kuchunguza uhusiano kati ya Unyanyapaa na uavyaji mimba usio salama katika maeneo ya matukio ya juu na chini hapa nchini Kenya"

Lengo la utafiti:

Lengo kuu la utafiti huu ni kuchunguza uhusiano kati ya uavyaji mimba usi salama na unyanyapaa utokanao na kuavya mimba kwenye ngazi za kibinafsi na za kijamii katika maeneo mawili yenye matukio ya juu na chini ya uavyaji mimba usio salama.Utafiti huu unalenga kunukuu jinsi unyanyapaa unaotokana na uavyaji mimba ni changio mkubwa kwa viwango vya juu cha uavyaji mimba usio salama.Ikiwa uhusiano huu utaamuliwa basi hatua zinazolenga unyanyapaa zitapewa kipaumbele katika kutatua tatizo la uavyaji mimba usio salama.

Taratibu:

Tutakuuliza maswali kuhusu vile wanawake waliowahi kusaka huduma za uavyaji mimba walivyochuliwa na marafiki, familia na watu katika jamii kwa ujumla.Majibu yote yatawekwa siri. Majibu yote yatakuwa siri. Hii ina maana kwamba majibu yako ya mahojiano yatatumiwa tu na wanachama wa timu ya utafiti na tunakuhakikishia ya kwamba taarifa yoyote tutakayoijumlisha kwenyea ripoti yetu haitakutambulisha wewe

kama mhojiwa.Kumbuka Sio lazima uongee kuhusu kitu chochote ambacho hukitaki na unaweza kusitisha mahojiano wakati wowote.Mahojiano haya yanafaa kuchukua muda wa chini ya saa moja.Nitakuwa nikinukuu majibu yako katika fomu hii ya kuchukua majibu.

Nufaa/Faida ya kushiriki:

Hakuna faida za moja kwa moja kwako kuhusiana na utafiti huu.Lakini,utafiti huu utapatiana habari inayoweza kutumiwa kuamua viwango vya unyanyapaa utokanao na uavyaji mimba katika ngazi za kibinafsi na kijamii na hatua za kupunguza viwango vya unyanyapaa vilivyoundwa ili kukabiliana na tatizo la uavyaji mimba usio salama.

Hatari :

Hakuna hatari za kimwili zinazotokana a na utafiti huu.

Hiari:

Kushiriki katika utafiti huu ni wa hiari. Sio lazima uongee kuhusu kitu chochote ambacho hukitaki na unaweza kusitisha mahojiano wakati wowote.

Siri:

Majibu yote yatawekwa siri. Hii ina maana kuwa majibu yako kutokana na mahojiano yatatumiwa tu na wanachama wa timu ya utafiti na tunakuhakikishia ya kwamba taarifa yoyote tutakayoijumlisha kwenyea ripoti yetu, haitakutambulisha wewe kama mhojiwa.

Anwani ya mawasiliano ya mtafiti mkuu

Ikiwa utahitaji ufafanuzi zaidi kuhusu kushiriki kwako katika utafiti huu, wasiliana na Mtafiti mkuu (Erick KiprotichYegon) kwenye namabari ya simu 0772234488.

Anwani ya mawasiliano ya kamati ya KEMRI/ERC

Ikiwa utahitaji kujua zaidi kuhusu haki zako za kushiriki katika utafiti huu, wasiliana na katibu wa kamati ya kimaadili ya KEMRI (ERC) kupitia kwa anwani ya barua pepe ercadmin@kemri.org au anwani ya posta (PO BOX - 00200 au Nambari ya simu: +254 (0) 20 27133492726300 Ext 44355.

Je, una maswali yoyote kutokana na yale niliokuelezea? Je, uko tayari kushiriki katika mahojiano haya? _____

Sahihi ya mshiriki na shahidi

_____ _____

_____

Mhojiwa **Shahidi** **Tarehe**

Language of Consent:_____

Appendix 6. Individual Abortion Level Stigma Questionnaire

Instructions for interviewers: Please use this form to consent participants into the study. Please fill in today's date, your full name and the location where the interview is taking place. Read the participant the statement below to ensure that they agree to be interviewed. Have the participant sign and date the form.

Today's Date: __ __ / __ __ / __ __ __ __
dd / mm / year

Name of Facility: _____

Interviewer's Full Name: _____

Location of Interview: _____

INTERVIEWER, PLEASE READ THE FOLLOWING STATEMENT TO THE PARTICIPANT:

"Hello, my name is _____, and I am working with a team of researchers exploring differences in abortion stigma faced by clients who have sought abortion services in health facilities. I would like to ask you questions about your feelings about abortion. I will not write down your name on the data collection form. Everything you tell me will be kept strictly confidential. No one will be able to identify you from the information we collect. Your participation is completely voluntary and you do not have to answer questions that you do not want to answer. Based on previous experience, it should take us about 15 minutes to complete the questionnaire. Do I have your permission to continue? "

Participant Consent:
I have understood the information. I have had the opportunity to ask questions about this interview.

_____ I agree to participate
_____ I do not wish to be interviewed

_____ _____
Signature or mark of the respondent Date

Interviewer: Prior to starting interview, please ensure that the location of the interview has auditory privacy.
Interviewers: Please use this form to interview participants about their attitudes and beliefs about abortion. For the background information, please tick the appropriate box. For the abortion attitudes questions, please circle the number that corresponds to a respondent's answer. Instructions for interviewers embedded in the questionnaire are indicated with ***bold and italicized text.***

INTERVIEWER PLEASE READ THE FOLLOWING STATEMENT ALOUD TO THE PARTICIPANT PRIOR TO STARTING THE INTERVIEW:

"Thank you for allowing me to interview you today. First, I am going to ask you a few questions about yourself, and then I am going to read you a series of statements about abortion. After I read each statement, I'd like you to tell me if you strongly disagree, disagree, are unsure, agree or strongly agree with what I've read. If you do not understand anything that I read to you, please ask me to repeat it."

Section 0: Unique Identifier					
Item	**Month you were born**	**Last 3 digits of your cell phone number** (please enter 000 if respondent does not own a cell phone)			**How many brothers do you have?**
001					
002	Type of service received	☐ Spontaneous abortion ☐ Induced abortion			

The following survey is for women who have had an abortion. The purpose of this survey is to gain information about women's feelings and experiences around their abortions. Some women have had more than one abortion. To answer the questions, please think about your most recent abortion.

Section 1: Respondent Background Information		
Item	**Question**	**Response**
101	***Interviewer: Please write in today's date in the space provided.***	__ __ / __ __ / __ __ __ __(DD / MM/YYYY
102	How old were you on your last birthday, in years?	___ years
103	Can you tell me what the highest level of education is that has been completed by the head of your household?	☐ Completed or some primary school ☐ Completed or some secondary school ☐ Completed or some post-secondary school
104	What is your highest level of schooling that you have completed? ***Interviewer: Please read all answers aloud and mark the one that bet describes the interviewee's educational level.***	☐No formal education ☐Primary school ☐Secondary school ☐Technical school ☐College or University ☐Don't know/refused
105	What is your marital status? ***Interviewer: Please read all answers aloud and mark the one that best describes the interviewee's marital status.***	☐Married ☐Not married but has a steady partner ☐Single (no steady partner) ☐Separated/Divorced ☐Widowed ☐Don't know/refused
106	How do you identify your religious affiliation? ***Interviewer: Please read all answers aloud and mark the one that best describes the interviewee's religious affiliation.***	☐Christian ☐Catholic ☐Muslim ☐Hindu ☐Traditional ☐Other (please specify)_____ ☐No religious affiliation ☐Don't know/refused

Section B: Respondent's attitudes and beliefs about abortion

Worries about judgment: The following questions are about the things you worried about around the time of your abortion. Make the selection that best describes what you worried about.

Items	Answer options			
	Not worried	A little worried	Quite worried	Extremely worried
201. Other people might find out about my abortion.	1	2	3	4
202. My abortion would negatively affect my relationship with someone I love.	1	2	3	4
203. I would disappoint someone I love.	1	2	3	4
204. I would be humiliated.	1	2	3	4
205. People would gossip about me.	1	2	3	4
206. I would be rejected by someone I love.	1	2	3	4
207. People would judge me negatively.	1	2	3	4

Isolation: The following questions are about talking to your close friends and relationships about your abortion. Think about your most recent abortion. Make the selection that best describes your experience.

Items	Answer options			
* Item is reverse-coded	Never	Once	More than once	Many times
208. I have had a conversation with someone I am close with my abortion.*	1	2	3	4
209. I was open with someone that I am close with about my feelings about my abortion.*	1	2	3	4
210. I felt the support of someone that I am close with at the time of my abortion.*	1	2	3	4
211. I can talk to the people I am close with about my abortion.*	*Note: Questions #11-12 uses the five "strongly agree" to "strongly disagree" answer options used in next section.*			

212. I can trust the people I am close to with information about my abortion.*				
213. When I had my abortion, I felt supported by the people I was close with.*	1	2	3	4

Self-judgment: The following questions are about how you felt around the time of your abortion. Please make the selection that best describes your feelings.

Items	Answer options				
* Item is reverse-coded	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
214. I felt like a bad person.	1	2	3	4	5
215. I felt confident I had made the right decision.*	1	2	3	4	5
216. I felt ashamed about my abortion.	1	2	3	4	5
217. I felt selfish.	1	2	3	4	5
218. I felt guilty.	1	2	3	4	5

Community condemnation: The following questions are about the community you lived in around the time of your abortion. How many people in your community held the following beliefs?

Items	Answer options				
	No one	A few people	About half the people	Many people	Most people
219. Abortion is always wrong.	1	2	3	4	5
220. Abortion is the same as murder.	1	2	3	4	5

Appendix 7: Stigmatizing attitudes Believes and Action Scale (Community)

Stigmatizing attitudes, beliefs and Actions (SABAS) scale for general community members

Instructions for interviewers: Please use this form to consent participants into the study. Please fill in today's date, your full name and the location where the interview is taking place. Read the participant the statement below to ensure that they agree to be interviewed. Have the participant sign and date the form.

Today's Date: __ __ / __ __ / __ __ __ __
dd / mm / year

Name of Facility: _____

Interviewer's Full Name: _____

Location of Interview: _____

INTERVIEWER, PLEASE READ THE FOLLOWING STATEMENT TO THE PARTICIPANT:

"Hello, my name is _____, and I am working with a team of researchers exploring differences in abortion stigma faced by clients who have sought abortion services in health facilities. I would like to ask you questions about your feelings about abortion. I will not write down your name on the data collection form. Everything you tell me will be kept strictly confidential. No one will be able to identify you from the information we collect. Your participation is completely voluntary and you do not have to answer questions that you do not want to answer. Based on previous experience, it should take us about 15 minutes to complete the questionnaire. Do I have your permission to continue? '

Participant Consent:
I have understood the information. I have had the opportunity to ask questions about this interview.

_____ I agree to participate
_____ I do not wish to be interviewed

_____ _____
Signature or mark of the respondent Date

Language of Consent:_____

Interviewer: Prior to starting interview, please ensure that the location of the interview has auditory privacy.

Interviewers: Please use this form to interview participants about their attitudes and beliefs about abortion. For the background information, please tick the appropriate box. For the abortion attitudes questions, please circle the number that corresponds to a respondent's answer. Instructions for interviewers embedded in the questionnaire are indicated with ***bold and italicized text.***

INTERVIEWER PLEASE READ THE FOLLOWING STATEMENT ALOUD TO THE PARTICIPANT PRIOR TO STARTING THE INTERVIEW:

"Thank you for allowing me to interview you today. First, I am going to ask you a few questions about yourself, and then I am going to read you a series of statements about abortion. After I read each statement, I'd like you to tell me if you strongly disagree, disagree, are unsure, agree or strongly agree with what I've read. If you do not understand anything that I read to you, please ask me to repeat it."

Section 0: Unique Identifier					
Item	**Month you were born**	**Last 3 digits of your cell phone number** (please enter 000 if respondent does not own a cell phone)			**How many brothers do you have?**
001					

Section 1: Respondent Background Information		
Item	**Question**	**Response**
101	***Interviewer: Please write in today's date in the space provided.***	__ __ / __ __ / __ __ __ __ (DD/MM/YYYY)
102	***Interviewer: Please indicate whether respondent is male or female.***	☐Male ☐Female
103	How old were you on your last birthday, in years?	___ years
104	What is your highest level of schooling that you have completed? ***Interviewer: Please read all answers aloud and mark the one that bet describes the interviewee's educational level.***	☐No formal education ☐Primary school ☐Secondary school ☐Technical school ☐College or University ☐Don't know/refused
105	What is your marital status? ***Interviewer: Please read all answers aloud and mark the one that best describes the interviewee's marital status.***	☐Married ☐Not married but has a steady partner ☐Single (no steady partner) ☐Separated/Divorced ☐Widowed ☐Don't know/refused
106	How do you identify your religious affiliation? ***Interviewer: Please read all answers aloud and mark the one that best describes the interviewee's religious affiliation.***	☐Christian ☐Catholic ☐Muslim ☐Hindu ☐Traditional ☐Other (please specify)_____ ☐No religious affiliation ☐Don't know/refused

Section 2: Respondent's attitudes and beliefs about abortion						
Item		**Strongly Disagree**	**Disagree**	**Unsure**	**Agree**	**Strongly Agree**
201	A woman who has had an abortion should be prohibited from going to religious services.	1	2	3	4	5
202	A woman who has an abortion is committing a sin.	1	2	3	4	5
203	Once a woman has one abortion, she will make it a habit.	1	2	3	4	5
204	A woman who has had an abortion cannot be trusted.	1	2	3	4	5
205	I would tease a woman who has had an abortion so that she will be ashamed about her decision.	1	2	3	4	5
206	A woman who has an abortion brings shame to her family.	1	2	3	4	5

207	A woman who has an abortion can make other people fall ill or get sick.	1	2	3	4	5
208	I would try to disgrace a women in my community if I found out she'd had an abortion.	1	2	3	4	5
209	A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion.	1	2	3	4	5
210	The health of a woman who has an abortion is never as good as it was before the abortion.	1	2	3	4	5
211	A man should not marry a woman who has had an abortion because she may not be able to bear children.	1	2	3	4	5
212	I would stop being friends with someone if I found out that she had an abortion.	1	2	3	4	5
213	A woman who has had an abortion might encourage other women to get abortions.	1	2	3	4	5
214	If a man has sex with a woman who has had an abortion, he will become infected with a disease.	1	2	3	4	5
215	A woman who has an abortion is a bad mother.	1	2	3	4	5
216	A woman who has an abortion brings shame to her community.	1	2	3	4	5
217	I would point my fingers at a woman who had an abortion so that other people would know what she has done.	1	2	3	4	5
218	A woman who has an abortion should be treated the same as everyone else.	1	2	3	4	5

Appendix 8: Kipimo cha Mitazamo, Imani Inayo Nyanyapaza (SABAS)

Maelezo kwa wahoji: tafadhali tumia fomu hii kupata idhini ya washiriki. Jaza tarehe ya leo,jina lako,na eneo la mahojiano. Wasomee washiriki usemi huu kuhakikisha wamekubali kuhojiwa. Hakikisha mhojiwa ame tia sahihi na tarehe kwa fomu.

Tarehe ya leo: __ __ / __ __ / __ __ __ __
dd / mm / year

Jina la mhoji: _____

Eneo la mahojiano: _____

MHOJI, TAFADHALI SOMA USEMI HUU KWA MSHIRIKI PARTICIPANT:

"Jambo, Jina langu nu _____, ninashirikiana na kundi la watafiti wanao chunguza mitazamo na imani ya watu kuhusu utoaji mimba. Ningependa kukuuliza maswali kuhusu hisia zako juu ya utoaji mimba. Sitaandika jian lako pahali popote kwa fomu hii. Yote uyasemayo ni siri na hakuna atakayewezw kukutambua kutokana na habari tutakayoipata kutoka kwako. Kushiriki kwako ni kwa hiari na sio lazima ujibu maswali hautaki kujibu. Kilingana na mahojiano kwingine, tutachukua muda wa dakika 15 kujaza hojaji. Ukimaliza utapatiwa kadi ya simu ____. Je, ninaruhusa yako ya kuendelea?

Idhini ya Mshiriki:
Nimeelewa habari yote. Nilikuwa na nafasi ya kuuliza maswahili kuhusu mahojiano haya.

_____ Nimekubali kushiriki
_____ sitaki kushiriki

_____ _____
Sahahi ya mshiriki Tarehe

Mhoji: kabla ya kuanza hakikisha kuwa kuna fargha kwa eneo la mahojiano

wahoji: tafadhali tumia mwongozo huu kuangazia mitazamo na imani ya washiriki kuhusu utoaji mimba. Kwa habari za kimsingi weka alama kwa sanduku lifaalo. Kwa maswali ya mitazamo na imani,weka alama kwa nambari inayolingana na jibu la mhojiwa.Kwa maelezo ya ***bold and italicized text.***

MHOJI: TAFADHALI SOMA USEMI HUU KWA SAUTI KWA MSHIRIKI KABLA YA KUANZA MAHOJIANO:

"Asante sana kwa nipa nafasi ya kukuhoji. Tutaanza na maswali kukuhusu ya kimsingi halafu nikusomee misemo kuhusu utoaji mimba. Nikimaliza kukusomea utanielezea kama: unakataa kabisa, unakataa, hauna hakika, unakubali au unakubali kabisa. Kama hutaelewa, uniulize ni kusemee tena"

Section 0: Unique Identifier					
Item	**Tarehe ya kuzaliwa**	**Nambari tatu za mwisho za namba yako ya simu** (tafadhali andika 000 kama mjibu hana simu ya mkono)			**Je, una kaka wangapi?**
001					

Section 1: Respondent Background Information		
Item	**Swali**	**Jibu**
101	***Mhoji: Tafadhali jaza tarehe ya leo***	__ __ / __ __ / __ __ __ __ Siku / Mwezi / Mwaka
102	***Mhojiwa: Jaza jinsia ya mhojiwa mume au mke.***	☐Mume ☐Mke
103	How old were you on your last birthday, in years?	Miaka___
104	Taja kiwango cha juu cha masomo umekamilisha ***mhoji: soma majibu yote kwa sauti halafu uweke alama kwa jibu lifaalo zaidi kuhusu kiwango cha elimu***	☐Hujaenda shule ☐Shule ya msingi ☐Shule ya sekondari ☐Shule ya ufundi ☐Chuo kikuu ☐Sijui/kataa kujibu
105	Hali ya ndoa ***mhoji: soma majibu yote kwa sauti halafu uweke alama kwa jibu lifaalo zaidi kuhusu hali ya ndoa***	☐Umeolewa ☐Hujaolewa laikini una mpenzi ☐Pekee (hakuna mpenzi) ☐Utengano/talaka ☐Mjane ☐Sijui/kataa kujibu
106	Tafadhali taja uhusiano wako wa kidini ***Mhoji: soma majibu yote kwa sauti halafu uweke alama kwa jibu lifaalo zaidi kuhusu uhusiano wa kidini***	☐Mkristo ☐Mkatoliki ☐Mwislamu ☐Baniani/mhindu ☐Traditional ☐Nyingine (tafadhali taja)_____ ☐Hakuna uhusiano wowote wa kidini ☐Sijui/kataa kujibu

Section 2: Respondent's attitudes and beliefs about abortion						
Item		**Kataa Kabisa**	**Kataa**	**Hauna hakika**	**Kubali**	**Kubali kabisa**
201	Mwanamke ambaye ametoa mimba afaa akatazwe kuenda kanisani.	1	2	3	4	5
202	Mwanamke ambaye ametoa mimba ametenda dhambi	1	2	3	4	5
203	Mwanamke akitoa mimba mara ya kwanza atafanya liwe jambo la mazoea	1	2	3	4	5
204	Mwanamke ambaye ametoa mimba sio wakuaminika.	1	2	3	4	5
205	Naweza nikamtania mwanamke ambaye ametoa mimba kuwa ataaibika	1	2	3	4	5
206	Mwanamke ambaye ametoa mimba huaibisha familia yake.	1	2	3	4	5
207	Mwanamke ambaye ametoa mimba aweza kusababisha magonjwa	1	2	3	4	5
208	Naweza kumaibisha mwanamke yoyote yule kwa jamii nikigundua ametoa mimba.	1	2	3	4	5
209	Mwanamke ambaye ametoa mimba afaa atengwe kwa jamii kwa muda usiopungukia mwezi mmoja baada ya kutoa mimba	1	2	3	4	5
210	Afya ya mwanamke huadhirika baada ya kutoa mimba	1	2	3	4	5
211	Mwanamume hafai kuoa mwanamke ambaye ametoa mimba kwa sababu aweza kukosa kupata watoto	1	2	3	4	5
212	Naweza kukatiza urafiki wangu na mwanamke nikifahamu ametoa mimba	1	2	3	4	5
213	Mwanamke ambaye ametoa mimba aweza kuwashauri wanawake wengine kutoa mimba.	1	2	3	4	5
214	If a man has sex with a woman who has had an abortion, he will become infected with a disease.	1	2	3	4	5
215	Mwanamke ambaye ametoa mimba ni mama(mzazi) mbaya	1	2	3	4	5
216	Mwanamke ambaye ametoa mimba huaibisha jamii yake.	1	2	3	4	5
217	Naweza kutoa kidole cha lawama kwa mwanamke ambaye ametoa mimba ndiyo wengine wafahamu	1	2	3	4	5
218	Mwanamke ambaye ametoa mimba afaa atazamwe sawa na watu wengine	1	2	3	4	5

Appendix 9: In-depth Interview Guide (clients in English)

IN-DEPTH INTERVIEW GUIDE FOR WOMEN (PATIENTS)

This document provides data collectors a semi-structured in-depth interview (IDI) guide with which to interview women seeking abortion care or post-abortion care (PAC) to ascertain how they may experience institutionalized abortion-related stigma in a health care setting. You will ideally be interviewing women who have just completed their abortion care and/or post abortion care. Probes are indicated by *italicized text.*

Before beginning the interview, consent forms (included at the end of this guide) must be administered and signed. Please be cognizant of and adhere to the ethical research standards within which you have been trained.

Introduction (read aloud to respondent or paraphrased by interviewer)	I want to thank you for taking the time to meet with me today. My name is ___ and I would like to talk to you about your experiences receiving abortion-related health care services here at "FACILITY X". All information that you provide is confidential and anonymous however we will need you to sign a consent form indicating that you agree to this interview. I would like to assure you that I do nt hold any bias opinion towards persons who terminate a pregancny butt we are seeking to understand the experience a woman going through this process goes through The primary goal of this interview is to gather information on abortion provision at "FACILITY X" that can be used in future interventions to increase the quality of information and services that women receive and address the barriers patients may face in receiving abortion care. The interview should take about an hour. I will be taping the session so that I do not miss any of your comments. I will also be taking notes during the session. All responses will be kept confidential. This means that your interview responses will only be shared with the research team and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you do not have to talk about anything you do not want to and you may end the interview at any time. Are there any questions about what I have just explained?

	Are you willing to participate in this interview? Sign consent form
Ascertain Nature of Care Induced or PAC?	What brought you to the hospital? • Did any one interfere with Pregancny What type of care did you come to Facility X to receive? • Ask here whether the woman came to X to receive induced abortion care or post abortion care (PAC). • Follow the appropriate protocol below
Questions	**For a woman receiving <u>induced abortion care</u>:**
• Keep the questions open-ended without leading • Use probes when necessary: *Would you give me an example?* *Can you elaborate on that idea?* *Would you explain that further?* *I'm not sure I understand what you are saying.* *Is there anything else you'd like to share about that?*	1. Let's start out by having you tell me a little bit about yourself. • Personal life: family, married, other children, etc. • How do you feel about abortions? • Is it okay for a woman to end pregnancy? o When is it okay for a woman to end a pregancy 2. Thank you for sharing that information with me. Please tell me about how you came to seek care here at "FACILITY X" • Who did you first talk to about seeking pregnancy termination information and care? Who did you talk to prior to coming to this facility? • How did you find out about the abortion services available here? • Did you have to seek out the information or is it readily available in your community? • If you had to seek out the information, can you describe how you did this? • Did you feel comfortable seeking this information out? Why or why not? • Were there any individuals at "FACILITY X" that were particularly helpful in providing you with information about the abortion services available here? If so, can you explain how? 3. What is "FACILITY X's" general reputation in your

	community? 4. What were your first impressions of "FACILITY X" when you walked in? • How organized did you find "FACILITY X"? • How open and inviting did you find "FACILITY X"? 5. Again, thank you for sharing this information with me. Let's now talk about your decision to terminate your recent pregnancy. What are the primary reasons for your decision to seek an abortion? • What type of support did you have in making this decision? (Family, friends, professional, etc.) 6. Please tell me a little bit about how you are feeling at this time. • How are you feeling physically? Emotionally? • *Probe on her feelings in general, and begin to steer her towards talking about her experiences at "FACILITY X".* 7. Can you walk me through your experience here - please describe for me what happened from your arrival until your departure/now? • What happened when you first arrived? How long did you have to wait before someone attended to you? • Who did you first make contact with? How did you feel about that interaction? How comfortable did you feel telling that person that you were here for an abortion? • What type of information did you get receive prior to the procedure (*or getting the pills in the case of MA)*? Who provided you with the information? How did you feel about the information that they provided you? • How do you feel about how you were treated by the staff during the services that you received today? What was your interaction with the provider like? • ***FOR MVA clients only:*** How do you feel about how you were treated by the staff after the procedure? What kind of interaction did you have with the provider after the procedure (in recovery)? • What are your next steps in terms of follow-up care? Will you return for a follow-up appointment? Why or why not?

	8. Did someone accompany you to the facility today? If so, who accompanied you? Were they allowed to be with you during counseling, the procedure and/or recovery? How do you feel about having that person accompany you (or having that person not be allowed to accompany you)? 9. Did you have a need for family planning counseling today? If so, did you receive it? Please tell about what the counseling was like? How do you feel about the information that you received? How do you feel about the family planning methods that you were offered? 10. Overall, how did you feel about the care you received here at "FACILITY X"? 11. Can you describe instances within the care process that were difficult for you, or which you think need improvement? • *Probe on physical layout and care-oriented aspects of "FACILITY X"* • *Probe on interactions with staff and providers* 12. Are there any pamphlets, posters, or written guidelines on-site that helped you understand what type of care was available to you at "FACILITY X"? • If so, can you explain to me what these are, how you use them, and whether you feel they are helpful? 13. Did you feel that in getting abortion care from "FACILITY X", you were treated differently than women who are here for other types of services? For example, did you feel like the nurses or administrative staff treated you differently? How so? 14. Are you satisfied with your choice to get abortion care here at "FACILITY X"? Explain why or why not. 15. If you could change anything about your care or about "FACILITY X" as it relates to the provision of abortion care, what might that be? 16. Thank you so much for sharing so much personal information with me about your experiences here at Facility

	X. Finally, if you feel comfortable, let's talk briefly about the issue of abortion. • In general, how do you feel about a woman's decision to terminate a pregnancy? • What has influenced this opinion? • Do you think there are certain situations or circumstances where abortions should be allowed? Situations or circumstances where abortions should not be allowed? • What do you think has influenced you in feeling this way about abortion? 17. How have your thoughts or feelings about abortion been affected by or changed by your experiences here at Facility X?
Wrap-up	Is there anything else that you would like to add or discuss here that you think would be relevant to the issue? Do you have any questions or concerns? If you would like to follow-up with anything, please do not hesitate to contact me at _____. Thank you very much for your time.
Questions	**For a woman receiving PAC:**
• Keep the questions open-ended without leading • Use probes when necessary: *Would you give me an example?* *Can you elaborate on that idea?* *Would you explain that further?*	1. Let's start out by having you tell me a little bit about yourself. • Personal life: family, married, other children, etc. • How do you feel about abortions? • Is it okay for a woman to end pregnancy? o When is it okay for a woman to end a pregancy 2. Thank you for sharing that information with me. Please tell me about how you came to seek post-abortion care here at "FACILITY X" • How did you find out about the PAC services available here? • Did you have to seek out the information or is it readily available in your community? • If you had to seek out the information, can you describe how you did this?

I'm not sure I understand what you are saying. *Is there anything else you'd like to share about that?*	• Did you feel comfortable seeking this information out? Why or why not? • Were there any individuals at "FACILITY X" that were particularly helpful in providing you with information about the PAC services available here? If so, can you explain how? 3. What is "FACILITY X's" general reputation in your community? 4. What were your first impressions of "FACILITY X" when you walked in? • How organized did you find "FACILITY X"? • How open and inviting did you find "FACILITY X"? 5. Again, thank you for sharing this information with me. Let's now talk some more about how you ended up needing post abortion care. • What occurred that made you feel like you needed to seek care at this facility? How did your miscarriage begin? • Do you feel comfortable disclosing whether you did anything or took anything to induce your miscarriage? • If yes, can you please explain what you did or took to start the miscarriage process? *Probe on who helped the woman, what kind of pills she may have taken, where she got information, etc.* • *Note to interviewer: If a woman says no to this probe, assure her that this is not a problem, and move to the next question.* 6. Please tell me a little bit about how you are feeling at this time. • How are you feeling physically? Emotionally? • *Probe on her feelings in general, and begin to steer her towards talking about her experiences at "FACILITY X".* 7. Can you walk me through your experience here - please describe for me what happened from your arrival until your departure/now? • What happened when you first arrived? How long did you have to wait before someone attended to you?

	• Who did you first make contact with? How did you feel about that interaction? How comfortable did you feel telling that person that you were here for PAC services? • Did anyone ask you whether or not you had done anything to induce the miscarriage? If so, what did you tell them? How did they react? • What type of information did you get receive prior to the procedure (or being given pills)? Who provided you with this information? How did you feel about the information that they provided you? • How do you feel about how you were treated by the staff during the services that you received here today? What was your interaction with the provider like? • How do you feel about how you were treated by the staff after the procedure (or after receiving pills)? What kind of interaction did you have with the provider after the procedure (in recovery)? • What are your next steps in terms of follow-up care? Will you return for a follow-up appointment? Why or why not? 8. Did someone accompany you to the facility today? If so, who accompanied you? Were they allowed to be with you during counseling, the procedure and/or recovery? How do you feel about having that person accompany you (or having that person not be allowed to accompany you)? 9. Did you have a need for family planning counseling today? If so, did you receive it? Please tell about what the counseling was like? How do you feel about the information that you received? How do you feel about the family planning methods that you were offered? 10. Overall, how did you feel about the PAC services you received here at "FACILITY X"? • Did you receive the kind of care that you expected to receive? Please explain. *Probe on how the woman expected to be treated vs. how she was treated.* 11. Can you describe instances within the care process that were difficult for you, or which you think need improvement? • *Probe on physical layout and care-oriented aspects of "FACILITY X"*

	• *Probe on interactions with staff and providers* 12. Did you feel that in getting PAC services from "FACILITY X", you were treated differently than women who are here for other types of services? For example, did you feel like the nurses or administrative staff treated you differently? How so? 13. Are there any pamphlets, posters, or written guidelines on-site that helped you understand what type of PAC services were available to you here? • If so, can you explain to me what these are, how you use them, and whether you feel they are helpful? 14. Are you satisfied with your choice to seek post-abortion care here at "FACILITY X"? Please explain why or why not. 15. If you could change anything about your care or about "FACILITY X" as it relates to the provision of post-abortion care, what might that be? 16. Thank you so much for sharing so much personal information with me about your experiences here at Facility X. If you feel comfortable, let's talk briefly about the issue of abortion. • In general, how do you feel about a woman's decision to terminate a pregnancy? • What has influenced this opinion? • Do you think there are certain situations or circumstances where abortions should be allowed? Situations or circumstances where abortions should not be allowed? • What do you think has influenced you in feeling this way about abortion? 17. How have your thoughts or feelings about abortion been affected by or changed by your experiences here at Facility X?
Wrap-up	Is there anything else that you would like to add or discuss here that you think would be relevant to the issue? Do you have any questions or concerns? If you would like to

	follow-up with anything, please do not hesitate to contact me at _____. Thank you very much for your time.

Appendix 10: Translated In-depth Interview Guide (Swahili)

MWONGOZO WA UANGALIZI WA MOJA KWA MOJA WA VITUO VYA KUTOA HUDUMA ZA AFYA

Mwongozo wa uangalizi wa moja kwa moja unatoa utaratibu na mpangilio kwa wakusanyi data wa kufuata wakati wa utafiti. Wakusanyi data wataangalia hatua zote za utoaji huduma kwa kituo kutoka kuingia, kungojea, kupokelewa, huduma ya utoaji mimba, chumba cha kupata nafuu na mawaidha nasaha ya baada ya utoaji mimba. Mwongozo huu unaorodhesha yote yakuangaliwa na unatoa nafasi ya kujaza wakati wa uangalizi. Mwongozo huu utasanifisha uangalizi na kuhakikisha taratibu zote muhimu zimeangaliwa.

Uangalizi wa moja kwa moja ni muhimu kwa utafiti wa aina hii. Unawezesha upokezi wa habari moja kwa moja, uangalizi wa shughuli na taratibu. Uangalizi huu utaongezea kwa taratibu zingine za kukusanya data kwa kutoa habari za taasisi na vituo kwa mandhari yake ya asili. Mwongozo huu unaangazia kama huduma za afya kwa vituo hivi vinafuata mipangilio na itifaki zilizo kubaliwa.

Maswali Muhimu Yanayoelekeza Uangalizi wa Moja kwa Moja

1. Je, shughuli na miingiliano ya kila siku ya wafanya kazi huendeleza unyanyapaa wa kutoa mimba kwa wanawake wanao tafuta huduma za utoaji mimba? Kama ndiyo, unajitokeza aje?

2. Je, shughuli na miingiliano ya kila siku ya wafanya kazi huendeleza unyanyapaa wa kutoa mimba kwa wanaotoa huduma za utoaji mimba? Kama ndiyo, unajitokeza aje?

Miongozo ya uangalizi

Hata ingawa maswali haya mawili hapo juu, yanahusu uangalizi, utafiti huu unahusu uangalizi wa vitendo, uingiliano yafanyikao moja kwa moja kwa vituo vy afya. Kwa hivyo, wakusanyi data wanahimizwa kuangalia yote yanayohusu utafiti hii na wala wasikomee kwa orodha imetolewa. Uangalizi pia wa yale yasiofanyika ni muhimu pia; kuangalia taratibu, sera na itifaki sizofuatiliwa. Itifaki ambayo imedokezwa hapa chini ni pamoja na mwongozo wa uangalizi, mwongozo wa kuchukua/kuandika nakala. Nafasi imetolewa ya kuandikia makundi pana ya uangalizi..

Watoa huduma za afya kwa kituo watakuwa wamejulishwa sababu zako za kutembea kwa kituo. Kuna uwezakano mkubwa kutakuwa na mawasiliano rasmi kati yako na kituo kuwajulisha sababu za kutembelea kituo. Kwa sababu hiyo, unaweza kutarajia mabadiliko ya mtazamo kwako. Ni lazima utembelee kituo mara nyingi kuhakikisha namna ya utoaji huduma. Dhana kuu hapa ni kuwa matembezi yakiwa mengi watakuzoea na hivyo kurejea hali yao ya kawaida ya kutoa huduma. Unasihiwa usiingilie au kutia vikwamisho kwa hali ya kawaida ya kutoa huduma kwa sababu waweza ukafuatilia na kuongezea uangalizi wako kwa mahojiano.

Jina na eneo la Kituo cha afya
Tarahe ya uangalizi
Muda wa uangalizi (kwa dakika)

Sehemu I. Uangalizi wa Jumla wa Vituo (pamoja na chumba cha kungojea na pahali pa kupokelewa)
Mawazo na maoni ya kwanza baada ya kuingia kwa kituo
Mtazamo wa Mazingira • Sura ya mazingira • Chumba – nafasi, faraja, kufaa • Kutengwa kwa vyumba vya kungojewa na kupokelewa • Je, chumba cha MVA kimewekwa saini? rooms labeled as such? Wanawake hujuaje mahali pa kupata huduma za utoaji mimba na huduma zingine za PAC ? Elezea wa kina mahali pa kupokelewa: • Mipangilio ya viti • mapambo/mabango/nakala na gazeti za kusoma za wateja • Huduma za kuburudisha– vinywaji, nk. • Elezea jinsi ya watu kupokewa • Elezea wanawake hufanya aje wakifika kwa kituo • Je, kuna taratibu rasmi za kupokea wanawake? Kama ndiyo,elezea. • Elezea wanawake hupokelewa aje na wanaenda wapi baadaye Elezea wa kina mahali pa kungojea: • Wanawake wanangojea wapi? Elezea jinsi wanawake hungojea-kama kuna mahali pa kungojea na kama kuna mtu anayewaangalia, nk. • Mipangilio ya viti – je, kuna mpangilio wa wanawake wakati wanangojea? • mapambo/mabango/nakala na gazeti za kusoma za wateja • Huduma za kuburudisha– vinywaji, nk. Elezea mpangilio wa kituo (ikiwezekana toa chora ramani)

Kiwango cha Mpangilio wa jumla kuhusu taratibu za upokezi na kungojea:

- Je, yaeleweka wazi pahali pa kwenda mtu akiingia kwa kituo?
- Je, vyumba vya kupokea na kungojea vina karibisha? Elezea kama ndiyo au la, na utoe sababu.
- Je, vyumba vimepangwa vizuri-usafi,mpangilio nk?

Umati (elezea jinsi ya kuingia kwa umati)

- Elezea idadi ya watu kwa vyumba vya kupokelewa na kungojewa
- Je,kituo kina watoa huduma wa kutosha?
- Je,kuna nafasi ya kutosha ya wateja?
- Je, watu wanaelekezwa kwa vyumba mbali mbali?

Kiwango cha kelele

- Elezea kiwango cha kelele kwa vyumba vya kungojea na kupokelewa.
- Je, kuna faragha ya wateja wakati wanaelezea sababu za kutembelea kituo?
- Waweza kusikia yanayoendelea kwingineko ukiwa kwa vyumba vya kupokelewa na kungojewa?

Taritibu za mawasiliano ya kwanza na wateja.

Elezea jinsi ya taratibu za mawasiliano; nani wateja wanaongea nao kwa kituo.

Taja utaratibu wa matukio ikiwa ni pamoja na:

- Mtazamo kwa wateja
- Kiwango cha ujuzi na maarifa
- Kiwango cha kushiriki na ujali wa maslahi
- Uhisiano wenye upo kati ya wakubwa na wadogo, hali ya uamuzi na masual ya kisasa
- Kwa kijumla, hali ya kutoa habari kwa wateja
- Hali ya usaidizi, ushirikiano na uelewaji wa hadhi ya wateja.
- Uwazi wa mawasiliano na urahisi wa kuuliza maswali.
- Urahisi wa kubadilisha huduma

Sifa za wafanya kazi na watoa huduma

Unaona wa toa huduma wangapi kwa kituo? Taja jinsia,umri, mavazi, na kuonekana kwao..

Ukiona mawasiliano kati ya watoa huduma na wateja, elezea.

Taja utaratibu wa matukio ikiwa ni pamoja na:

- Mtazamo kwa wateja
- Kiwango cha ujuzi na maarifa
- Kiwango cha kushiriki na ujali wa maslahi
- Uhisiano wenye upo kati ya wakubwa na wadogo, hali ya uamuzi na masual ya kisasa
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- Uwazi wa mawasiliano na urahisi wa kuuliza maswali.
- Urahisi wa kubadilisha huduma

Kumbuka pia kuangalia mawasiliano ya mwili bila maneno kama vile:

- Ishara za uso, mkao na ishara ya mkono au kichwa
- Hali ya kujitokeza na moyo wa kutoa huduma

Sehemu II – uangalizi wa utaratibu mwanamke anapitia kutoka kupokelewa hadi kupata nafuu. *(onyo: ungalizi huu utafanyika baada ya mwanamkw kutoa idhini na wato huduma kupatiana ruhusa)*

Elezea yote unayo kuhusu utaratibu wote wa utoaji mimba kutoka kuingia kwa mwanamke kituoni.

Taratibu za kabla kutoa mimba

- Elezea nama mwanamke ako:
    - Basic demographics (observer: please fill out a demographics sheet for each woman that you observe directly)
    - Ameandamana nani?
    - Elezea hali yake kiakili- wasiwasi, uoga au ukosefu nk.

- Mwanamke huenda wapi akiingia kwa kituo?
    - Inaeleweka wazi ataenda wapi? Kuna mtu wa kumpokea kunamwelekeo wazi wa kuanza utaratibu?
    - Elezea hali ya mazingira (hali ya mapangilio, idadi ya wateja, kiwango cha kelele nk.)
    - Je, mwanamke anakaribishwa?

- Elezea utaratibu wa kupokelewa:
    - Jinsi ya mwanamke ya kuwasiliana na wafanyakazi wa kituo. Elezea ni nani.

- Elezea itifaki na taratibu zote mwanamke anapitia akifika kwa kituo kama baadhi ya shughuli za kupokelewa ikiwa ni pamoja na lakini si pekee:
    - Elezea jinsi mwanamke anaulizia huduma aitakayo, na ni kwa nani?
    - Fomu za kujazwa
    - Kupatiana idhini (nani anatoa idhini)
    - Kukutana na watoa huduma
    - Habari kuhusu kutoa huduma, sera, itifaki na taratibu zinazo patiwa mwanamke. Ni nani? (mifano: kwa mazungumzo, vipeperushi)
    - Elezea namna ya kutamatisha utaratibu wa kupokelewa.

- Elezea utaratibu wa kungojea
    - Mwanamke anangojea wapi kupokelewa kukimalizika?
    - Mwanamke alikuja aje mahali hapa?
    - Elezea namna ya mahali hapa –
        - Sura ya mazingira
        - Idadi ya wanawake wanaongojea
        - Mpangilio wa viti
        - Kuna nakala za kusoma?
        - Nani awezakuandamana na wanawake? Kuna nani wnegine?
        - Elezea hali ya mwanamke kiakili- wasiwasi, uoga au ukosefu nk.
    - Je kuna miondoko ya wafanya kazi, kuingia na kutoka? Elezea hali ya wafanyakazi hao na kazi zao.
    - Kwa maoni yako,mwanamke anasubiri kwa muda gani?
    - Mwishowe wanawake wanashughulikiwa aje?
        - Na nani?
        - Elezea kwa kina mwingiliano wa mwanamke. (taja hadhi yake, na hali na maudhui ya mawasiliano)

Wakati wa utaratibu wa kutoa mimba *(mwangalizi: kama umeweza kuandamana na mwanamke, elezea namna ya mawasiliano kati ya mtoa huduma na mwanamke, aina ya huduma na mandhari)*

- Dokeza vile ulipata idhini/ruhusa ya kuangalia utaratibu :
    - Nani alikupatia ruhusa?
    - Je, mwanamke alitoa ushauri? Kama ndiyo, vipi na kwa nani?

- Eleza vile mwanamke alielekezwa kwa chumba cha utaratibu:
    - Nani alimpeleka?
    - Aliandamana na nani?
    - Kama hakuna mtu yeyote aliruhusiwa kwenda na yeye, walienda wapi? Nani huwajulisha hivyo?

- Elezea jinsi ya mwingiliano kato ya mwanamke na anaye mpeleka kwa chumba cba utaratibu:
    - Je, kuna mazungumzo kuhusu utaratibu? Mwanamke anauliza maswali kuhusu utaratibu?

- Elezea hadhi ya mwanamke kuhusu anavyoonekan-mwenye uoga,wasiwasi, kuchanganyikiwa, au ujasiri. Nk

- Eleza namna ya mandhari ya chumba cha utaratibu:
    - Mpangilio wa chumba.
    - Eneo la chumba hicho kulinganisha na vyumba vingine ndani ya kituo hicho.
    - Elezea hali ya chumba cha faragha-wengine humu nje waweza kufahamu yanayotendeka ndani?
    - Nani ako kwa chumba cha utaratibu?
    - Mtoa huduma anaingi lini kwa chumba?

- Elezea mwingiliano na mawasiliano kati ya mteja na mtoa huduma:
    - Taja hali ya mtoa huduma kwa kando ya kitanda-muda anaouchukua na mteja..
    - Kuna nafasi ya mwanamke ya kuuliza maswali wakati wa utaratibu?Kama ndiyo,eleza namna ya mawasiliano na nani anahusika.

Huduma ya baadaye na kupata nafuu

- Eleza mahali mteja anaenda baada ya utaratibu kukamilika:
    - Anaenda aje kwa chumba hicho (anatembea, au anatumia kiti cha magaradumu)
    - Anaandamana na nani?
    - Nani anaruhusa ya kuingia kwa chumba hicho (jamaa,nk.)?

- Elezea mandhari ya chumba cha kupata nafuu:
    - Mahali pake ndani ya kituo?
    - Mahali pake kulinganisha na chumba cha utaratibu.
    - Je, kuna nakala za kusoma kuhusu huduma hizo?

- Elezea hali na hadhi ya mteja akiwa kwa chumba cha kupata nafuu:
    - Eleza namna na maana kupata nafuu kwa mteja.
    - Nani anamtembelea mwanamke? Taja utaratibu na mtazamo wao.
    - Dokeza namna ya mawasiliano na mteja:
        - Na nani?
        - Maudhui?

- Taja wateja wanakaa kwa muda gani kwa chumba cha kupata nafuu?
    - Nani anampatia ruhusa ya kwenda nyumbani ?
    - Taja hali ya mawasiliano wakati wa ruhusa ya kwenda nyumbani.
    - Mteja anahitaji huduma za baadaye? Kama ndiyo taja ni huduma ya aina gani na ni wakati upi?

Appendix 11: Focused Group Guide

<u>Focus groups with women and men (conducted separately for Young unmarried women, Married women, Unmarried men, married men)</u>

Introduction

1. **What are the main health issues that affect women and young women in your community?**

Probes: Do they have anything to do with sexual health?Pregnancy?

2. **Are pregnancies that women do not want common in your community?**

Probe Who is most affected, women, married, young women?

3. What are some reasons why young women in your community have pregnancies that they do not want?

Probes: Do they not have access to family planning?
Are they afraid to use family planning?
Are their boyfriends/sexual partners opposed to their use of family planning?
Other reasons?
How might this be different for young unmarried women compared to married women?

4. Where can a woman go in your community to get help if she has a pregnancy she does not want?

Probes: To a health facility?
To a midwife or community health worker?
To a pharmacist/medicine seller?
Who does she talk to about her situation?
Who usually gives young women advice in situations like this?
How might this be different for young unmarried women compared to married women?

5. Are there any reasons why a woman might not go to any of the places in the community to get help if she has a pregnancy she does not want?

Probes: Will she be treated badly?
Does she not have enough money to get there?
Other reasons?

<u>Manifestations of Stigma</u>

Show a drawing of a woman (perhaps 20-25 years old). Tell the group that her name is (add name), she is 22 years old in (add place name). Ask the group

6. What do you think of when you see the drawing of (name)?

Last year (name) had an abortion.

Forms of stigma among general community members

7. Think about the community where you live:

- What does the word "abortion" mean to people in your community?
- What words do people use in your community to talk about abortion (*probe: do they say the word "abortion" or are there other words or phrases, like "bringing down the period" that people use to talk about terminating a pregnancy*)
- What would people in your community think about (name)?
- What might they say about her?
  - Why would they say these things?
  - Who would they say them to? The woman herself? Only friends and family?
- Would people in your community accept her action and support her? Would people in your community isolate her in any way or make her feel bad about the abortion? What would they do? (*note: the facilitator should try to get at specific actions that community members might take to support or isolate, discriminate or abuse her*)
  - Why would they take these actions?

Community views on Self stigma

8. How do you think women feel about themselves after an abortion?

a) What do they think about themselves after having an abortion?
b) Why do they think or feel this way?

Community views on providers of abortion care

9. What do people say about the person (doctor, nurse, midwife, other) who helped the woman have the abortion?

- Are these health care providers viewed or thought of by community members in the same way as health care providers who don't provide abortion services?
- Why or why not?

Sources of information regarding abortion

10. When you think about what you hear on the radio or TV or what you read in the newspapers, what do you hear or read about abortion?

- What is said about abortion?
- What is said about women who have abortions (*probe: why do they have abortions, who are the women, how are they described?).*
- What is said about the people who help women have abortions (*probe: why do they perform abortions, who are they, how are they described?)*

Community perceptions on women's situation regarding abortion

11. **Would the reaction to (name)'s having an abortion be any different if her pregnancy was the result of being raped? If the pregnancy was going to present a risk to (name)'s life?**
    - What would be different? (what people say about her, who they say them to, what actions would be taken)
    - Why would the reactions be different?
12. **Are women who have an abortion in your community treated differently than women who have never had an abortion? In what ways? Why?**

    If participants do not discuss the topic of women being imprisoned for having abortions, the facilitator should probe with the question: should women go to jail?

    b) Do you think that there is anything that can be done in your community so that women who have an abortion are treated in the same way as other women? What can be done?

Ethical Approval Letters

KEMRI ERC Approval Letter

KENYA MEDICAL RESEARCH INSTITUTE

P.O. Box 54840-00200, NAIROBI, Kenya
Tel (254) (020) 2722541, 2713349, 0722-205901, 0733-400003; Fax: (254) (020) 2720030
E-mail: director@kemri.org info@kemri.org Website:www.kemri.org

KEMRI/RES/7/3/1 **September 05, 2014**

TO: **ERICK KIPROTICH YEGON,**
PRINCIPAL INVESTIGATOR

THROUGH: **DR. CHARLES MBAKAYA,**
THE DIRECTOR, CPHR,
NAIROBI

Forwarded 12/09/2014

Dear Sir,

RE: **SSC PROTOCOL NO. 2768 (*RESUBMISSION 2*): ABORTION RELATED STIGMA: INVESTIGATING CORRELATES OF STIGMA AND UNSAFE ABORTIONS IN REGIONS WITH HIGH AND LOW INCIDENCE OF UNSAFE ABORTIONS IN KENYA**

Reference is made to your letter dated 21st August, 2014. The ERC Secretariat acknowledges receipt of the revised study protocol on August 28, 2014.

This is to inform you that the Ethics Review Committee (ERC) reviewed the documents submitted and is satisfied that the issues raised at the 228th meeting of the KEMRI ERC on 24th June, 2014 have been adequately addressed.

The study is granted approval for implementation effective this **5th September, 2014**. Please note that authorization to conduct this study will automatically expire on **September 4, 2015.** If you plan to continue with data collection or analysis beyond this date, please submit an application for continuing approval to the ERC Secretariat by **July 21, 2015**.

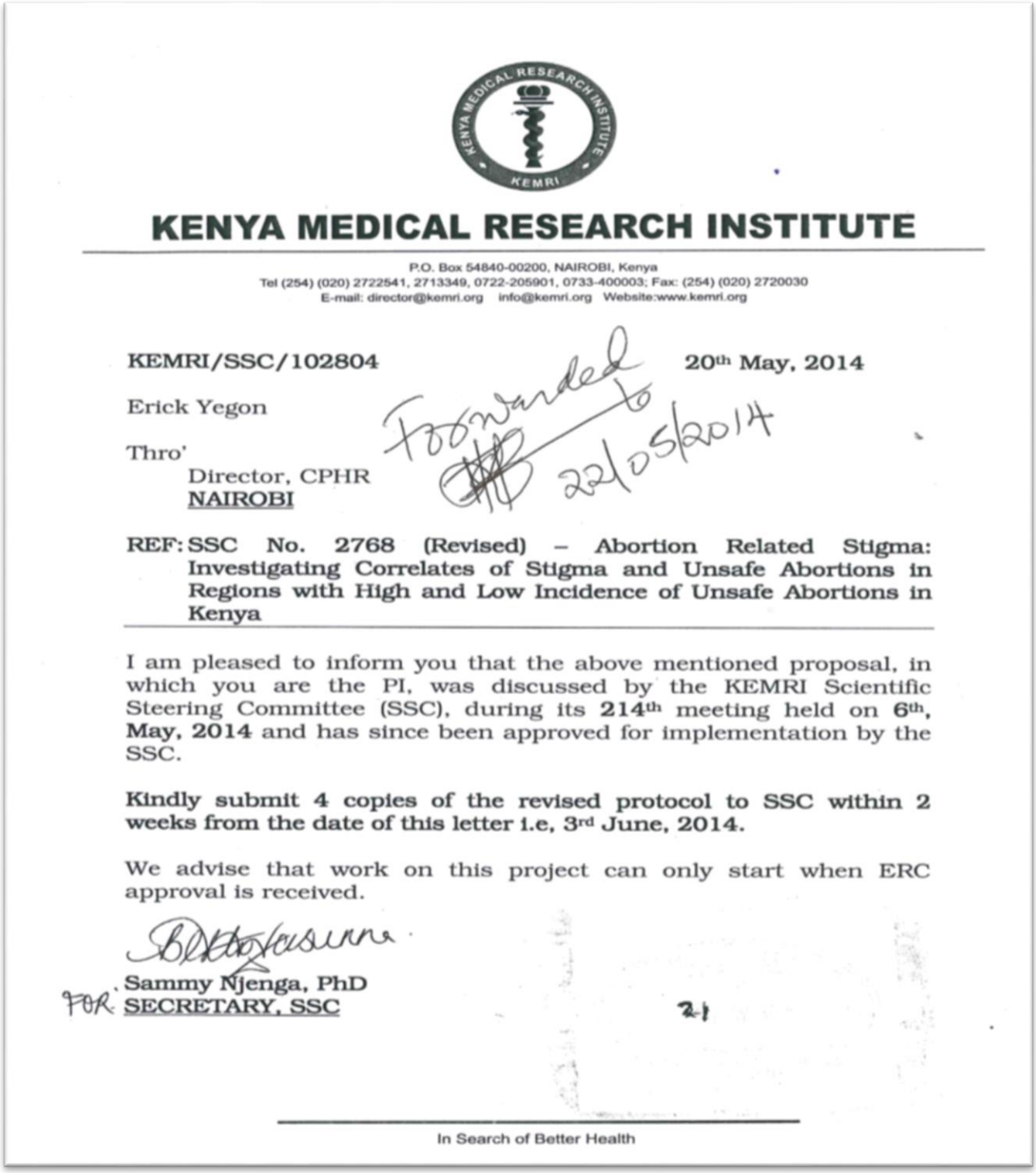
Any unanticipated problems resulting from the implementation of this protocol should be brought to the attention of the ERC. You are also required to submit any proposed changes to this protocol to the SSC and ERC prior to initiation and advise the ERC when the study is completed or discontinued.

You may embark on the study.

Yours faithfully,

PROF. ELIZABETH BUKUSI,
ACTING SECRETARY,
KEMRI/ETHICS REVIEW COMMITTEE

KEMRI SSC Approval Letter



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KEMRI/SSC/102804 20th May, 2014

Erick Yegon

Thro'
Director, CPHR
NAIROBI

Forwarded to 22/05/2014

REF: SSC No. 2768 (Revised) – Abortion Related Stigma: Investigating Correlates of Stigma and Unsafe Abortions in Regions with High and Low Incidence of Unsafe Abortions in Kenya

I am pleased to inform you that the above mentioned proposal, in which you are the PI, was discussed by the KEMRI Scientific Steering Committee (SSC), during its 214th meeting held on 6th, May, 2014 and has since been approved for implementation by the SSC.

Kindly submit 4 copies of the revised protocol to SSC within 2 weeks from the date of this letter i.e, 3rd June, 2014.

We advise that work on this project can only start when ERC approval is received.

Sammy Njenga, PhD
FOR: SECRETARY, SSC

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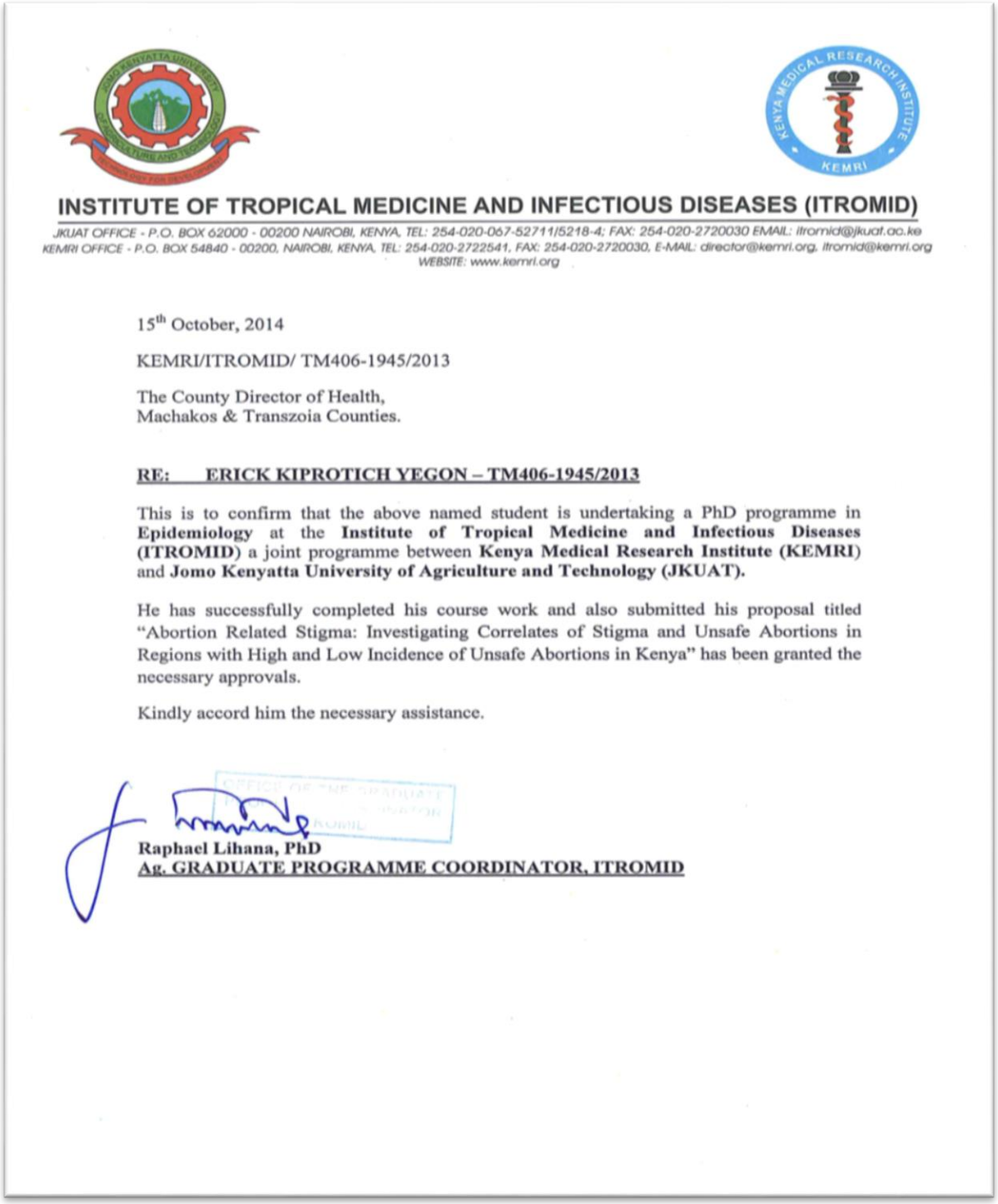
In Search of Better Health

ITROMID Introduction letter to County Directors of Health in Study Regions



INSTITUTE OF TROPICAL MEDICINE AND INFECTIOUS DISEASES (ITROMID)

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15th October, 2014

KEMRI/ITROMID/ TM406-1945/2013

The County Director of Health,
Machakos & Transzoia Counties.

RE: ERICK KIPROTICH YEGON – TM406-1945/2013

This is to confirm that the above named student is undertaking a PhD programme in **Epidemiology** at the **Institute of Tropical Medicine and Infectious Diseases (ITROMID)** a joint programme between **Kenya Medical Research Institute (KEMRI)** and **Jomo Kenyatta University of Agriculture and Technology (JKUAT).**

He has successfully completed his course work and also submitted his proposal titled "Abortion Related Stigma: Investigating Correlates of Stigma and Unsafe Abortions in Regions with High and Low Incidence of Unsafe Abortions in Kenya" has been granted the necessary approvals.

Kindly accord him the necessary assistance.

Raphael Lihana, PhD
Ag. GRADUATE PROGRAMME COORDINATOR, ITROMID