PERSPECTIVES OF YOUNG MEN ON INDUCED ABORTION IN KIAMBAA DIVISION, KIAMBU DISTRICT KENYA.

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other university or any other award

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DEDICATION

This work is dedicated to my late parents **Teresia Njeri Ngure** and **Eliud Ngure Nganga** for the discipline, encouragement and education they gave me. To my siblings **Lenny Mbugua, Antony Rebo** and **Catherine Njeri** for their material and moral support. To all the numerous women who have lost their lives in the process of terminating pregnancy for it is they who have motivated me to do this study.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome.
BCC	Behavior Change Communication
CRHCS	Commonwealth Regional Health Community Secretariat
ECSA	East, Central and Southern Africa
FIDA	Federation of Women Lawyers-Kenya
FGDs	Focus Group Discussions.
FP	Family Planning.
FPAK	Family Planning association of Kenya
GoK	Government of Kenya.
HIV	Human Immunodeficiency Virus.
IEC	Information Education and Communication
KAP	Knowledge Attitude and Practice
KDHS	Kenya Demographic Health Survey.
KMA	Kenya Medical Association.
Kshs.	Kenya shillings
MoH	Ministry of Health.
N/A	Not applicable.
NGOs	Non Governmental Organisations
SES	Social Economic Status
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections.
WHO	World Health Organization.
UN	United Nations
USA	United States of America

OPERATIONAL DEFINITIONS

Abortion

This is the termination of pregnancy prior to twenty-four weeks in order to prevent the foetus from developing to viability.

Induced abortion

Induced abortion refers to the termination of pregnancy for medical reasons or otherwise after fertilisation has taken place, by the woman herself or by another person.

Abortifacient

A drug or substance used to cause a pregnant woman to abort.

Attitudes

Mental views, reactions or feelings towards abortion as elicited through a scale of questions read to respondents.

Contraception

This is the practice or methods used to deliberately prevent a woman from becoming pregnant.

Contraceptive use

Number of positive responses to the questions indicating past, present, and future intentions to use contraception.

Contraceptive User

Any man reporting current use of any male contraceptive methods.

Knowledge

The individual's level of contraceptive and abortion knowledge as represented by his answers to simple questions in response to selected aspects of both contraception and abortion.

Partner

Either of the two people who are married to one another or having a sexual relationship with one another.

Perspectives

Views, especially those that stretch far, to give the right impression or picture.

Perceived male involvement in abortion

The way the males view and understand the role they play in abortion.

Unsafe abortion

This is a procedure for terminating an unwanted pregnancy either by persons lacking necessary skills or in an environment lacking the minimal medical standards or both.

Young men

For this study young men were aged 18 years and above but below 25 years.

ABSTRACT

Context: Induced abortions are a major public health problem because they contribute to high maternal morbidity and mortality in Kenya. In many countries including Kenya, abortion is illegal except on medical grounds forcing women who want an abortion to seek non-medical interventions. Young women are more likely to abort than older women. They tend to experiment with impulsive sexual behavior, which may result in unwanted pregnancy. Many of these end up in abortion. A lot of research already done has focused on the female youth and their parents' perspectives while neglecting the young men's perspectives. Views of young men on induced abortion are important as they may influence the practice of abortion in their female partners.

Objective: This study was designed to assess young men's perspectives towards induced abortion and the influencing factors in Kiambaa Division.

Materials and methods: This was a descriptive cross sectional study. This study was conducted in July 2002. Multistage sampling method was used to select the study site and systematic sampling was done to select the households. Data was collected through a household survey. A total of 466 respondents were interviewed using standardized pre-tested questionnaires for quantitative data. An interview guide was used to gather qualitative data from focus group discussions.

Results: All study respondents were consenting young men (aged 18-25) who had an average age of 21.17 years. Majority (81.8%) of them were single. About half (50.4%) of them had secondary level of education. The main religion was protestant (52.2%) followed by the Catholics (44.6%). About half (53.6%) of the respondents indicated that they visited places of worship regularly. Only 15.2% of the respondents had regular income. More than half (58.2%) of the respondents approved the use of contraceptives, and almost a half (49.7%) reported that they had used a form of contraceptive. They

however had inadequate contraceptive knowledge, especially on the likely period for a woman to become pregnant and on the emergency contraceptive pill. The results demonstrated that a large percentage of the young men had good knowledge of what an induced abortion was and of its consequences as well as of the methods and the safest period to induce it. The percentage of young men who had an experience in abortion was 16.3%, which was higher than expected given the fear of legal and social repercussions. The main role played by these respondents was paying for the abortion.

Study findings indicate that most (78.6%) of the respondents disapproved of induced abortion. When the respondents were presented with various circumstances to justify abortion, more than half (56.2%) indicated no approval of abortion. Even on probing, about a third (30.7%) of the respondents did not indicate any circumstance for approval. The circumstance that drew the greatest approval for abortion was when the mother's life was threatened by the pregnancy (17.2% in spontaneous responses and 43.1% in probed responses). Most (86.2%) of the respondents knew that abortion was illegal. On asking these respondents if they preferred abortion to be legalized 82.9% were against it.

In the logistic regression analysis, the respondents' perspectives towards abortion were significantly influenced by their frequency of worship, attitudes on contraceptives and experience in abortion ($P<0.05$).

Conclusion: The study concluded that while the young men were aware of the high prevalence of abortion, they overwhelmingly disapproved abortion. The negative attitude towards induced abortion was mainly due to religious reasons and associated morbidity and mortality.

Recommendations: Some of the recommendations of this study include the need to strategize on gender sensitive Behavior Change and Communication (BCC) targeting young men, on ways of

preventing unwanted pregnancies. This should as priority focus on contraception particularly on the emergency contraceptive pills and on sex education, provided in men friendly health facilities.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

Abortion is the expulsion of the conceptus before 24 weeks of pregnancy. This prevents the foetus from developing and being born with a viable life.[1] Induced abortion refers to the termination of pregnancy for medical reasons or otherwise after fertilisation has taken place, by the woman herself or by another person. There are various reasons why a woman may procure an abortion. This occurs when the pregnancy is unwanted at that particular time. Reasons for this include adolescent pregnancy, when a woman may feel too young to become a mother, contraceptive failure, rape, pressure from spouse, lack of support or financial difficulties. In other instances, the pregnancy may be wanted but may be injurious to the health of the mother if the pregnancy is carried to term or investigations may reveal foetal abnormalities, thus necessitating termination of the pregnancy.

There are wide varieties of techniques and abortifacients used to induce abortion. These include safe modern methods such as vacuum aspiration or dilation and curettage. Others which are unsafe include (a) insertion of probes or catheters, (b) pouring of toxic fluids into the uterus, (c) oral ingestion of concoctions (d) insertion of herbal suppositories into the vagina, (e) jumping falling, exercising violently and (f) using injections. A study in Peru showed that 84% of rural women and 64% of urban women attempted to induce abortion themselves or sought the aid of untrained midwives. Health professionals attended to ninety-five percent of wealthier urban women. [2,3]

Every pregnancy carries potential health risks to women. This is even for those who appear healthy and at low risk. Millions of women have unwanted pregnancies each year. These are pregnancies that are unplanned for or mistimed at conception. Unwanted pregnancies are most likely to be fatal

because they are more likely to end in unsafe abortion. Complications of unsafe abortion cause 50,000 to 100,000 maternal deaths each year.[4]

The concept of Safe Motherhood consists of efforts that ensure good health for women and their babies during pregnancy, at the time of delivery and in the postpartum period. Men play major roles in women's pregnancy and delivery and in the care of babies after birth. They are the ones who mostly decide when a woman's condition is serious enough to seek medical care. Their decisions and actions often make the difference between illness and health. This has a direct bearing on the life and death for women resulting from pregnancy.[4]

Unsafe abortions are common in sub-Saharan Africa. The management of associated complications consume a large amount of resources. These complications include severe bleeding, shock, infection, lacerations of the cervix and vagina, perforations of the uterus and pelvic inflammatory disease. They may be fatal or lead to infertility or disability. These complications are among the five direct causes of maternal mortality, the others being haemorrhage, sepsis, pregnancy induced hypertension and obstructed labour. As defined by WHO, maternal deaths are deaths occurring during pregnancy up-to 42 days after pregnancy, irrespective of the duration or the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management.[4]

Unsafe abortions are a consequence of unwanted pregnancies. They are characterized by the lack or inadequacy of skills of the provider, hazardous techniques and unsanitary facilities. This is one of the greatly neglected problems of health care in developing countries and a serious risk to women during their reproductive lives. Prevention of unwanted pregnancies remains the highest priority and every attempt must be made to eliminate the need for abortion. Unwanted pregnancies can be

prevented by effective use of family planning (FP) methods. Where contraception is not available or inaccessible, many women will seek to terminate unwanted pregnancies even in the face of restrictive laws and lack or inadequate abortion services. Women who resort to unauthorized providers put their health and lives at risk. [4,5]

Young people are more vulnerable to abortion than older people. This is because their social, emotional and psychological development is incomplete. They tend to experiment with irresponsible sexual behavior, which may result in unwanted pregnancies. In general boys engage in more irresponsible sexual behavior than girls do. Many cultures are more tolerant to male youth sexual activity and even encourage it.

In addition these male youth tend to use alcohol and drugs more than girls do, which puts them at a higher risk irresponsible sexual behavior. Encouraging young men to avoid irresponsible sexual behavior can result in better reproductive health for girls as well. [6]

At the turn of the 21st century 1.7 billion people, that is, more than one-fourth of the worlds population of six billion, were aged between 10 and 24. Eighty six percent of the age group 10 to 24 years live in less developed countries such as Kenya. Many of these young people are sexually active which exposes them to sexually transmitted infections (STIs) including human immune deficiency virus/acquired immune deficiency syndrome (HIV/AIDS), unwanted pregnancies and complications from pregnancy and childbirth. Young people often have inadequate or misleading information on sexuality and reproductive health and lack access to reproductive health care.[7]

Men in Africa play an important role in most decisions pertaining to family life, including family size and family planning. A number of cultural factors favour men in matters related to marriage and family life. Men play an important role as heads of households, are viewed as custodians of their lineage and are protectors and providers for their families. The social and economic dependence of wives on their husbands give men a great influence in family decisions .[8]

In addition, the idea of involving men more in reproductive health is rapidly gaining momentum and credibility. This is partly due to a shift in emphasis in the international donor community from family planning being used purely for demographic reasons to broader reproductive health issues for human and health reasons.[9]

Men have been neglected in the past in family planning and reproductive health issues. A growing number of programs and providers are realising these. Men deserve more attention for their own sake, for the women's sake and for the health of their families and communities. From this new perspective, men are potential partners in advocating for good reproductive health rather than being bystanders, barriers or adversaries.[4]

In many countries, traditional male and female gender roles deter couples from discussing sexual matters. They condone risky sexual behaviour and this ultimately contributes to poor reproductive health among men and women. Programs can encourage men to adopt positive gender roles such as being supportive partners.[4]

1.2 Background

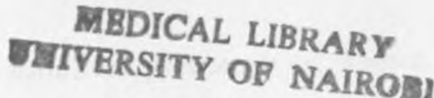
Abortion is one of the oldest methods of preventing an unwanted birth. Among the preliterate people, use of abortion and infanticide exceeded the measures to prevent conception. The earliest written reference to any method of fertility control was a recipe for an oral abortifacient. This concoction, which may have included quicksilver, is found in the ancient Chinese medical text written by the Emperor Shen Nung in the period 2737-2696 BC.[10]

Abortion was common in ancient Greece and Rome. A 1922 review of Greek practices included 12 pages listing abortifacients, instruments, injections and medicated pessaries or tampons used. Hippocrates reportedly advised one woman to jump in the air and striking her heels against her hips to induce abortion. In ancient Rome, abortion was also a frequent practice. The methods used included oral agents (usually strong purgatives), douches, (often-caustic agents) and curettage. Although there are no data to determine the hazards or the efficacy of these methods, clearly they were risky. Purgatives and caustic agents were often administered until either abortion or death resulted. As a result of curettage procedures perforation and sepsis were not uncommon.[11]

Religious criticism of abortion is noted in the Old Testament but became stronger in the Christian era. During the Middle Ages abortion was condemned and, as the procedure was performed in secret, medical information about methods and complications was not readily available. Drugs and herbs were widely used. The limited information available suggests that these abortifacients were usually not effective. If they were effective, they were widely toxic to the woman.[11]

In some African tribes, abortion was practised to terminate premarital or extramarital pregnancies. For example among the Meru in Central Kenya, illegitimate children were not accepted in the

society and uncircumcised women were expected to refrain from sexual activity. If a mother discovered that her uncircumcised daughter was pregnant, she called the *aruti ba mau* (people who terminate pregnancies) who applied pressure to the abdomen until the foetus was expelled.[11]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1.3 Magnitude of the problem

Abortion is one of the greatest public health problems. This is because of its repercussions, which cause maternal morbidity and mortality, and because of its ethical, political, social, religious moral and legal implications. Complications of pregnancy, childbirth and unsafe abortion are the major causes of death among women aged 15-19.[7]

The 1994 UN conference on Population and Development in Cairo confirmed that unsafe abortion is a major public health concern. The Cairo Declaration indicated that appropriate abortion care should be provided in countries where abortion is legal and that quality health services to treat complications should be provided for in all countries.[12]

Worldwide, an estimated half a million women die each year from complications related to pregnancy and childbirth. Every year up to 53 million women seek termination of unwanted pregnancy. Between 150,000 and 200,000 women die in the process and countless more are injured for life. Ninety nine percent of abortion related maternal deaths occur in developing countries.[13]

A third of these deaths, most of which occur in the developing world take place in Africa. This is in the range of 200-600 deaths per 100,000 live births in East, Central and Southern Africa (ECSA). Unsafe abortion accounted for 18 to 28 percent of maternal deaths in hospitals in ECSA region. In South Africa, one out of every four maternal deaths was as a result of abortions. In a Kenyan study,

one out of every ten maternal deaths was due to complications of unsafe abortion. With a current National maternal mortality rate of 590/100,000, approximately 59/100,000 deaths result from complications of unsafe abortion. [14,15]

Abortion related complications account for a significant percentage of women admitted to the gynecological wards in most hospitals in the region.[15,16,17,18,19,20,2122,23,24,25,26] Hospital based studies have shown that abortion accounts for over one-third of maternal mortality and morbidity. [18,19,20,21,22,23,24,25,26] Over 50%of all gynecological admissions in Kenya result from abortion related complications.[19,20,21,22,23,24,25,26]

A study conducted in Nairobi established that unsafe abortion related complications accounted for about 60% of all acute gynecological admissions.[19]

The incidence and magnitude of unsafe abortion and related consequences is high among adolescents in Kenya and out of proportion to their numbers in the total population. A significant proportion of unsafe abortion and related complications occur primarily among people aged 25 years, leading to high mortality and morbidity rates within the same age group. [16,22]

A study of a rural community in Marakwet and Samburu community found that 80% of all cases involved people below 20 years of age. [17] Another study of an urban area revealed that 50% of all women seeking abortion services were between ages of 21-25 years. [24]

Young people often use crude and dangerous methods and objects to induce abortion. This is mainly done by non-medical service providers and leads to complications such as anemia, infection, chronic pelvic pain, infertility and death[16,19,20,21,23,24].

Rural adolescents are as likely to induce abortion as their urban counterparts.[16,19,20,23,24,25,29]. A study of 1058 rural adolescents of four Kenyan districts established that 9% had attempted to have an abortion, 53% of those who attempted fell ill, and 25% had to be hospitalised.[29]

1.4 Legal Aspects of Abortion in Kenya

Abortion law in Kenya, as in most African countries south of the Sahara, is a legacy of the colonial past. According to the Laws of Kenya, Penal code chapter 63 which was last reviewed in 1985, section 158 under the sub-heading: Attempts to procure abortion, states that, "any person who with intent to procure miscarriage of a woman, whether she is not with child, unlawfully administers to her or causes her to take any poison or noxious thing, or uses any force of any kind, or uses any other means whatsoever, is guilty of a felony and is liable to imprisonment for fourteen years.

The Abortion Act of 1967 modifies the law relating to abortion, in important respects. Section 1 of that Act provides:

1. Medical termination of pregnancy states that "subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when the pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith:

    a) That the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

    b) That there is substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped."[31]

CHAPTER TWO

2.1 Literature Review

There is little information about the role men play in decisions to terminate pregnancy. However there is little indication that some men pay for their partner's abortion. Men have an important role to play as collaborates, medical practitioners, political and religious leaders to improve the conditions surrounding women's reproductive health. They should thus be involved in discussions to resolve problems of contraception and unsafe abortion .[12]

A study on adolescent males' attitudes towards abortions in 1988 in the United States, found that nearly 90% agreed that abortion is acceptable if pregnancy endangers the woman's health, 86% agreed that it was acceptable if the pregnancy resulted from rape. Young men were supportive of abortion in the event that the child might be born deformed or mentally defective. Sixty percent agreed that abortion was acceptable in this respect. Thirty five percent approved of abortion if the male partner would not support the child. 43% approved if the woman felt that she could not afford to take care of the child. About a third agreed that abortion was acceptable for any reason.[32]

Data from Latin America and elsewhere indicate that the role of men in abortion has been studied only slightly but has proved important. A review of Latin American literature suggests that a man's feelings and agreement plays an important role in the woman's decision. This review recommends that a comprehensive examination of the role of men in abortion decisions should therefore be undertaken. [33]

Interviews with 60 males, mostly adolescent, in 1991, in Washington who accompanied female partners to an abortion clinic indicated a need for greater participation by men in the abortion

process. Study subjects were observed to derive considerable relief from both the provision of knowledge about abortion and an opportunity to reveal fear and guilty feelings .It was evident from this study that these men were already sensitive. There is a need to study the males who do not accompany their partners. [34]

Respondents presented with different circumstances to justify abortion in Edmonton, Canada were asked to indicate the condition in which they felt women ought to or ought not to be allowed to obtain legal abortion. Findings reveal that attitudes towards abortion varied greatly depending upon the criteria for abortion. Pregnancy endangering the mother's health generated the most favorable attitude towards abortions between 1977 and 1987. They also depict a slight trend towards greater opposition to legalized abortion on the grounds of possible birth defects. Approval of legal abortion on grounds of rape increased marginally during the 10-year period .[35]

Two studies designed to help understand the rights and responsibilities of men in abortion situations showed that men should be part of the abortion decision-making process. The weight each partner carries in the decision making process would depend on the intimacy of the relationship. In both studies, college students in introductory psychology classes and sophomore classes were surveyed. In both Study 1 and Study 2, the majority of students (70.1% and 80.8% respectively) believed that the final decision on abortion was a woman's decision. Most (95.9%) of the students in the first study and 100% of the students in the second study believed that men did not have a right to force a woman to have an abortion. In more intimate relationships, particularly involving engagements, the students believed the man had the right to stop an abortion. However, in such intimate relationships, few thought the man should have more responsibility than the woman for termination of pregnancy.[36]

In a study done among Undergraduate male Nigerian students in the United States, 64.1% of the students were opposed, 18.8% were in favor and 17.1% were uncertain on issues regarding abortions. Their attitudes towards abortion were found to be statistically related to the number and sex of children they had and to their marital status. Those against abortion had fewer children or no male children. Unmarried respondents were more often in favor of abortion. The authors concluded that initially acquired values and opinions are often preserved despite exposure to the western culture .[37]

In a 1975 study on attitudes towards abortion among 601 men residing in Toronto and married to women of reproductive age, non-Catholic men and Catholic men of weak religious beliefs had significantly more permissive attitude towards abortion than Catholic men who had strong religious beliefs did. Each respondent received a scale score based on his acceptance of abortion under 7 different conditions.[14] The conditions were threat to maternal life, pregnancy due to rape, predicted birth of a mentally or physically handicapped child, threat to maternal mental health, unmarried mother, marriage break-down and inability to support the child. A high score indicated a permissive attitude towards abortion. High score were associated with high income and educational levels, non-Catholic affiliation, weak religious beliefs and being Canadian by birth. When religious factors were controlled for, the effect of other factors was markedly reduced .[38]

A survey conducted on abortion attitudes as determinants of perceptions regarding male involvement in abortion showed that half of the respondents held pro-life attitudes. The data further suggested that 14.3% of the students held relatively radical pro-choice attitudes, whereas 17.4% of the students expressed relatively radical pro-life attitudes. Furthermore, college students in

the study rated abortion as the most acceptable alternative in cases of rape and physical or mental deformity of the fetus. Abortion attitudes and opinions regarding the extent to which abortion should be conceptualized as strictly a female issue was found to operate as effective predictors of perceptions regarding the appropriate level of male involvement in abortion decisions. Furthermore, the tendency to view abortion, as a female issue was inversely proportional to the level of male involvement deemed appropriate in abortion decisions.[39]

In a study on abortion and unmet need for contraception in Tanzania, in 1998, only 31% of adolescent girls reported that their male partner was instrumental in locating an abortionist. Close relatives, friends, neighbors and work colleagues were more likely to be sources of information. On the other hand, 47.6% of the male partners were willing to pay the abortionist's fee and 16.1% of male partners advised or helped the girl to seek hospital treatment when related complications occur [40].

A study by Mpagile in Tanzania on the role of male partners in teenage induced abortion, among girls who first confided in the male partner, showed that 62% were urged to abort, 16% were encouraged to carry the pregnancy to term and 17% were not given any advice. Almost a third (31%) of male partners were instrumental in helping the women locate an abortionist. On the other hand 48% of the men responsible agreed to pay the abortionist's fee. Only 16% of the men responsible were involved in facilitating hospital treatment for the woman's abortion related complications. Men informed of the abortion after the procedure were more likely to be indifferent. [41]

Little information exists on the role of men in decisions with regard to performing abortions except for two studies that researched on the psychological reaction of men in pregnancy conflicts. Half of

the men responsible for the pregnancy accompanied their partners to the family planning center in Hanover Germany to seek abortion services. Another 15% of the partners were present during the medical procedure. The men confirmed that interests of the woman carried more weight in mutual decision making.[42]

Little is known about how men perceive their reproductive function and sexual lives. There is little relevant research on program experience upon which researchers can draw. Little is also known about what drives men to be concerned about unwanted pregnancies. A combination of male attitudes and provider bias has resulted in men being a neglected and poorly prepared constituent for family planning and reproductive health care.[43]

2.2 A Gender Framework For Understanding Abortion Among The Young Men

Gender imbalances influence risky sexual behaviour among the youth. A mix of cultural norms, social expectations, and men's sex drive encourages men's risky sexual behaviour.[4] Studies around the world have found that young men are let off, when the society, including parents does not hold them accountable for their sexual activity. Compared with girls more boys report being sexually active. Young men sexual behaviour and attitudes reflect the double standard that exists in most societies, tacitly approving and even encouraging premarital sexual activity for young men, while disapproving of and often punishing such behaviour in girls and women. Young men learn from the society's definition of masculinity from which he associates sexual activity with masculinity.[44]

At the individual level factors such as being single, drug abuse and unemployment predispose young men to premarital sex, sex with multiple sexual partners and unprotected sex.

Serious risks and consequences accompany increased premarital sex, particularly when combined with inadequate information and youth unfriendly reproductive health services. Increased sexual activity places the youth at greater risk of unintended pregnancies and STIs including HIV/AIDS.

Perspectives of young men on abortion are likely influence the decision young women make in case of unintended pregnancy, whether or not to terminate the pregnancy. Faced with unintended pregnancy many young women turn to abortion whether or not it is legal or safe. Unsafe abortions, which are sometimes self-induced, can result in severe illness, infertility and death.[7]

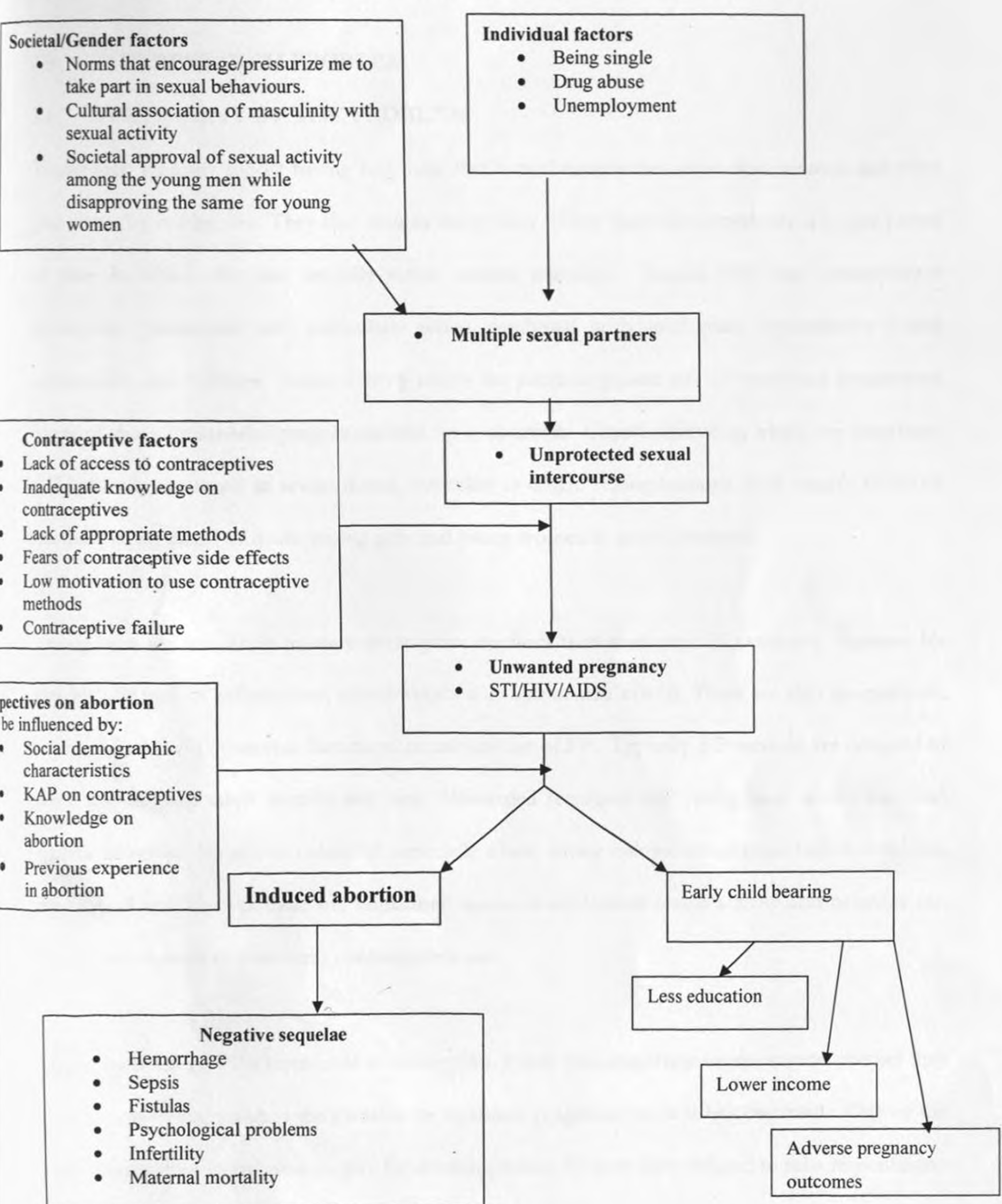
Early child bearing whether pregnancy wanted or unwanted can be dangerous for both mother and infant. For many young women just beginning their adult lives the risks of child bearing do not end

with delivery. Compared with a woman who delays child bearing until her 20's the woman who has the first child before the age of 20 is more likely to, obtain less education, have lower income and live in poverty. [44]

In 1988, about 10,000 girls were forced to leave school every year because they were pregnant many schools routinely expel girls who become pregnant. Even where policies have changed, childcare responsibilities prevent most young mothers from returning to school.[27]

Men will be more likely to participate responsibly in reproductive health if they begin to do so at a young age, even before they marry. Programs need to address gender perspective in reproductive health issues, including STDs, contraception, unintended pregnancies and unsafe abortion. These programs should also encourage young men to adopt positive gender roles such as being supportive partners.

Figure 1. **A gender framework for understanding abortion among the youth**



CHAPTER THREE

3.0 THE RESEARCH PROBLEM

3.1 STATEMENT OF THE PROBLEM

Young men typically report having had their first sexual experience earlier than women and often gain status by having sex. They also tend to marry later. They therefore experience a longer period of time in which they are sexually active outside marriage. Serious risks and consequences accompany premarital sex, particularly when combined with inadequate reproductive health information and services. Sexual activity places the youth at greater risk of unwanted pregnancies. Many of these unintended pregnancies end up in abortion. Unsafe abortions, which are sometimes self-induced, can result in severe illness, infertility or death. Complications from unsafe abortions are the leading cause of death among girls and young women in some countries.

Young men are less likely to use contraceptive methods than men over 25 years are. Reasons for this include lack of information, misinformation or fear of side effects. There are also geographical, social, cultural and economic barriers to access and use of FP. Typically, FP services are designed to serve the married adult women and men. Unmarried teenagers and young male adults may find service providers hostile or unhelpful, especially where strong cultural or religious beliefs condemn pre-marital sex. The sporadic and unplanned nature of adolescent sexual activity and behavior can also be an obstacle to consistent contraceptive use.

Young men have a 50% sexual role in conception. It was thus important to investigate whether they have an equivalent stake in the decision to terminate pregnancy once it has occurred. One of the main reasons that young women give for aborting is that the men have refused to take responsibility

for the pregnancy. This may be partly due to lack of the male understanding of abortion and the role they play as partners and lack of understanding of the full consequences of engagement in sexual activity, which includes unwanted pregnancies. Most of these abortions can be averted if there is the necessary male support. After pregnancy men should take responsibility. They should otherwise help women prevent pregnancy by supporting them in the use of contraception.[14]

Limited information regarding the male perspective towards abortions is a major barrier to developing effective programs to reach young men that would encourage responsible sexual behavior. Such programs can also support other positive behaviors and attitudes such as re-examining their perceptions of gender roles and responsibilities, supporting female partners in their reproductive health needs and decisions in relevant issues with regard to sexuality.

3.2 RESEARCH QUESTIONS

- What are the young men's perspectives on abortion?
- Do the following factors influence the young men's perspectives towards abortion significantly?
    - Social demographic characteristics
    - Knowledge, attitudes and practice of contraception
    - Sexual activity.
    - Knowledge of abortion
    - Previous experience in abortion through a female partner's procedure
- What are the young men's suggestions to reduce the problem of induced abortion?

3.3 JUSTIFICATION OF THE STUDY

The complications of illegal abortion are a burden not only to individual women but also to medical institutions and society as a whole. Treating abortion complications consumes substantial amount of scarce resources, which include blood supplies, the time of trained medical personnel and hospital beds. This is unaffordable in many developing countries. This is more so when meeting the basic needs of maternal and child health is in itself a task.[45,46]

Men have an important role to play not only as partners, but also as medical practitioners, political and religious heads and community leaders to improve the conditions surrounding women's reproductive health. It is thus necessary to involve men in discussions to resolve the problems of unsafe abortions.[4] The male's perspectives regarding abortion needs to be studied to provide them with the support necessary, to make them better and more responsible partners. This will reduce unwanted pregnancies, which often result in unsafe abortions.

The study site was selected conveniently due to its proximity to the investigators institution hence was able to fit within investigator's budget.

The study is in line with current trends in which a growing number of FP and other reproductive health care programs and providers are realizing that men deserve more attention as partners and advocates for good reproductive health.

The information gathered from this study will help policy makers in designing policies and programs that will incorporate young men into reproductive health issues and help them become full partners in reproductive health.

3.4 STUDY HYPOTHESES

1. The social demographic characteristics (marital status, educational level, religion, frequency of worship and occupation) do not influence the perspectives of young men towards abortion.
2. Knowledge, attitudes and practice of contraception by the young men have no relationship with their perspectives towards abortion.
3. Being sexually active does not influence the perspectives of young men towards abortion.
4. Knowledge of young men on abortion has no relationship with their perspectives towards abortion.
5. Previous experience in a female partner's abortion does not influence the young men's perspectives towards abortion.

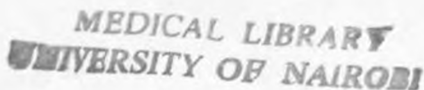
3.5 STUDY OBJECTIVES

3.5.1 Main Objective

To assess the perspectives of the male youth towards abortion and the influencing factors in Kiambaa, Njiku, Muchatha and Karuri Sub-locations, Kiambaa Division, Kiambu District.

3.5.2 Specific Objectives

1. To establish whether young men's knowledge, attitudes and practice of contraception have a relationship with their perspectives towards abortion.
2. To assess whether the knowledge of the young men on abortion influences their perspectives on induced abortion.
3. To assess whether young men's previous experience in a female partner's abortion influences their perspectives towards abortion.
4. To establish whether young men approve abortion and specifically under which circumstances they approve abortion.
5. To document suggestions from the young men that may help to reduce the problem of induced abortion among the youth.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CHAPTER FOUR

METHODOLOGY

4.1 Study Design

This is a descriptive cross sectional study using a combination of qualitative and quantitative techniques to gather information from the study population.

4.2 Variables

4.2.1 Independent variables

- Education level
- Marital status
- Religious affiliation
- Frequency of worship
- Economic status/employment
- Knowledge of contraception
- Attitude towards contraception
- Use of contraception
- Experience in abortion through their female partners
- Knowledge of abortion

4.2.1 Dependent variables

These were variables related to the male perspectives on abortion such as:

- Opinion on abortion (approval versus disapproval)
- Recommendation of abortion to a female partner
- General advice in unwanted pregnancy

- Opinion on legalization of abortion

4.3 Study site

The study site was Kiambaa Division, in Kiambu District.

4.3.1 Location

Kiambu District is located in Central Province and has a total area of 1458.3 square Kilometres. It is divided into five administrative divisions namely Kiambaa, Limuru, Githunguri, Kikuyu and Lari. There are 22 locations and 90 sub-locations in the district. Kiambaa Division has 4 locations and 14 sub-locations, which has 10,235 households. [47]

4.3.2 Population

The District has a population of 744,010 people.[31] Data from the District Statistics office indicate a higher proportion of females to males in the population. In 1999 there were 369,101 males and 374,909 females. Specifically Karuri has 4,943 males and 4943 females, Muchatha 4,728 males and 4,874 females, Njiku has 4,575 males and 4,694 females, and Kiambaa has 3,814 males and 4,059 females. Karuri has 2,675 households, Muchatha has 2,556, Njiku has 2,403 and Kiambaa has 1,900.[47]

4.3.3 Economic activities

The economic activities undertaken in the District include farming, livestock production, trade and commerce, tourism, forestry and industrial activities. Males dominate all sectors except unpaid family labour. Females constitute about 49.6% of the total labour force in the district. A comparatively high female population (35.2%) is actively engaged in the subsistence-farming sector as unpaid family labour.[30]

4.3.4 Health Facilities

According to the Kiambu District Development Plan, the District has fairly well distributed health facilities. It has 6 hospitals, 19 health centres, 37 dispensaries and 55 clinics. The health facilities are either government or non-government institutions. Kiambaa division specifically has 2 hospitals, 4 health centres, 8 dispensaries and 13 clinics. The degree of utilisation of these health facilities varies according to the size of the population of the catchment's area, ease of communication and services offered. [47]

The District has some sector policy objectives. One of them is to intensify activities aimed at control, prevention and eradication of diseases. The other is to promote and develop cost-effective research aimed at promotion and protection of people's health. Based on these objectives the district was identified as an appropriate site to conduct the survey.[47]

4.4 Study population

The study population comprised of adult men who satisfied the eligibility criteria outlined below.

4.4.1 Inclusion criteria

The study included the following:

- Consenting young men aged between 18 –25 years.
- Participants in the FGDs were also young men aged between 18-25 years men, but, had not participated in the quantitative data collection exercise.

4.4.2 Exclusion criteria

- All men who declined to participate in the study.
- All men whose mental status was questionable due to illness or intoxication.

- All men aged less than 18 years or over 25 years.

45 Sampling

The sampling unit was individual households sampled from the total households of Kiambaa Division. They were sampled from 4 Sub-locations namely, Karuri, Muchatha, Kiambaa and Njiku.

4.5.1 Sampling Procedure

The study population comprised of men aged between 18 and 25 years. They were recruited from the general male population in Karuri, Muchatha, Kiambaa and Njiku Sub-locations. These Sub-locations were selected by simple random sampling. Kiambaa Division was conveniently selected. Multistage sampling was applied to select study population as follows:

1. Kiambaa Division has 4 locations; one Location (Kiambaa) was randomly selected.
2. Kiambaa location has 5 sub-locations, 4 sub locations were randomly selected.
3. For each of the selected Sub-locations an initial 100 households were systematically selected to achieve the minimum sample size. Since on average every sub-location had at least 2000 households n= 2000/100 thus selecting every 20th household. In case any of the sampled households did not have an eligible male respondent the next household was selected. All eligible males within sampled household were interviewed. To ensure that the sub-locations were adequately covered the sampling began at the center of each village and involved spinning a bottle-top and where the bottle top pointed the first house was selected and from there every 20th household once the research assistants reached to the end of the sub-location they would then go back to the center and start on a different direction. However even after getting at least a 100 household each, the quantitative data collection continued for the 2 weeks

allocated for quantitative data collection achieving a sample of 466 respondents

4.5.2 Sample size calculation

Sample size was determined using the following formula.[49]

$$n = \frac{z^2 pq}{d^2}$$

Where,

n= desired sample size (when population is greater than 10,000)

z= standard normal deviate which is equal to 1.96 corresponding to the 95% confidence limit.

p= prevalence of approval of induced abortion was hypothesized to be 50%

p= 0.5

q=1.0- p = 0.5

d= The confidence limit of the prevalence (p) at 95% confidence interval

= 1 – Confidence interval

= 1 – 0.95

= 0.05

Degree of accuracy desired for the study was hence set at $\pm$ 0.05

Thus

$$\mathbf{n = \frac{(1.96)2 \times 0.5 \times 0.5}{0.05 \times 0.05} = 384}$$

The minimum sample size for this study was 384

A minimum of 384 young men were targeted to be interviewed. Abortion is illegal in Kenya hence the topic is very sensitive and it was expected that about a quarter of the respondents would not respond to the questionnaire. A deliberate effort was therefore made to exceed the minimum sample size with about a quarter more of the respondents resulting in a total of 466 respondents, to take care of the non-response and to limit any bias.

4.6 Data collection

4.6.1 Initial Preparation

The survey instruments were pre-tested at Rironi sub-location, which has a similar population to the study population. Twenty respondents were interviewed. This was done after the study population was identified. The population in which the instruments were pre-tested was drawn from outside the study area.

4.6.2 Data Collection Technique and Procedure

After pre-testing the study instruments, data collection was done for a total of six weeks, which started from 15th June 2002 to 30th July 2002.

4.6.2.1 Quantitative Data

The quantitative data was collected by use of a structured questionnaire. Data from open-ended questions was coded at the end of the study. The interviews were conducted in English

and sometimes in Kikuyu when necessary. For this purpose a translated version of the questionnaire was available.

4.6.2.2 Qualitative data

Focus Group Discussions (FGDs) were used to elicit qualitative data following prepared guidelines. Guiding the discussion, the principal investigator elicited views on abortion from the group members. The methods used for selecting participants for FGDs was by way of purposive/convenient sampling.[50]

The participants were selected with the help of local youth leaders. Participants per FGD were between 8-10. In total four focus group discussions were conducted, two FGDs among the single young men and two FGDs among the married. The FGDs were conducted in Kikuyu, the local language of the study area. These FGDs were useful in eliciting views that are not obvious from the structured questionnaires and helped in clarifying issues that emerged from the quantitative data collection exercise.

4.6.3 Personnel

The data was collected with the help of research assistants. The principal investigator trained and closely supervised the research assistants. The research assistants were males. Two were university graduates in sociology. The other two were graduates of the middle level colleges of pharmacy. They were aged between 18-25 and could speak Kikuyu, the local dialect of the study area. The research assistants attended two days training on data collection. Two scouts from the area were recruited with the help of Karuri Health Centre staff helped in guiding movement in the sub-locations. For the FGDs a trained social scientist was present during all the sessions.

4.6.4 Organization

Subjects for the study were approached in their households. The prospective respondents were told about the purpose of the study and requested for their consent to participate. If they declined the interviewers moved to the next home. If they agreed to participate verbal consent was obtained. A separate room/area was used for the interviews for confidentiality. Since most data collection was done during the day, some of the respondents were not found in their households. However attempts were made to have return visits at night and very early in the morning. A total of four FGDs were conducted. Two were at Karuri health center and two at Muchatha Anglican Church. On average 10 men participated in each FGD. These were held three weeks after quantitative data collection.

4.7 Data Management

4.7.1 Quantitative Data

The investigator together with a trained assistant did data cleaning and data entry concurrently. The questionnaire was semi-structured. All open-ended questions were coded before data entry. A computer based data file was developed using SPSS for data entry and analysis. The results are presented in descriptive form using frequency tables, contingency tables, bar charts and histograms. Different analytical methods were used as follows:

(a) Univariate analysis was used to analyze each variable.

(b) A bi-variate analysis was used to compare dichotomous variables.

(c) Multivariate analyses was used to determine predictors of perspectives.

(d) Chi-square test for significance was used. Level of significance was fixed at 0.05 (p =0.05)

4.7.2 Qualitative data

Qualitative data was first transcribed then translated into English. Back translation was also done to ensure consistency and to eliminate any translation bias. It was analyzed thematically according to the study objectives and a summary written. Data from the summary provided the necessary explanation for the quantitative data.

4.8 Minimizing Bias and Errors

- All eligible research subjects selected from each sampled household.
- The research assistants were trained on the study objectives and methodology
- A standard questionnaire was used on all respondents
- The principal investigator supervised the research assistants.

4.9 Ethical considerations

The issue under investigation was a sensitive one. This sparked suspicion especially with the current debate on legalization of abortion. The respondents were made to feel comfortable and the study spelt out clearly to them so as not to raise suspicion.

Considering the right to privacy for each individual, and the sensitive nature of the topic under investigation, confidentiality was guaranteed. The respondents were asked for their informed verbal consent to participate. Only those who gave their consent were interviewed. Further, specific measures were taken to ensure confidentiality during the interviews. This was done by identifying a room or an area that offered privacy.

In addition written consent from the Ethical Committee at the Ministry of Research and Training was sought. Permission was also sought from the District Commissioner and the sub-chiefs of the study sub locations.

4.10 Study Limitations

- Due to the fact that abortion is illegal, most respondents were not free to discuss the issue.
- Since some of the questions were also personal and sensitive there were chances of dishonest responses.
- Only a small proportion of the respondents were willing to state their monthly income. Thus further analysis based on the respondents' income was not done.

CHAPTER FIVE

STUDY FINDINGS

This chapter presents results of both the quantitative and qualitative findings. The quantitative results were from a total of 466 respondents while the qualitative were from four FGDs. This chapter is divided into the following sub-sections;

5.1 Background information.

5.2 Knowledge, Attitude and Practice of contraception.

5.3 Knowledge on abortion.

5.4 Role of young men in induced abortion.

5.5 Male perspectives on induced abortion.

5.6 Young men's recommendations to reduce induced abortion.

5.1 Background Information

The respondents were from four Sub-locations in Kiambaa Division, namely Muchatha (26.9%), Karuri (26.5%), Kiambaa (21.7%) and Njiku (24.9%). The two first sub-locations were more populated and therefore had more respondents as shown by the percentages. The respondents were aged between 18-25 years with a mean age of 21.17 years. The majority of the respondents were aged 20 years. Social demographic characteristics of the respondents are shown in Table 1.

Majority (81.8%) of the respondents were single. Most (72.1%) of the respondents had secondary and post secondary education. Only less than two percent reported no schooling

About half (51.9%) of the respondents were in Protestant religions. Protestant groups comprised of a number of churches such as the Anglicans, Presbyterians, and Seventh Day Adventists among

others. Traditional (1.5%) comprised of the Mungiki and the Thai groups, which advocate for Kikuyu tradition.

Frequency of worship was also reported. The majority of the respondents were regular in worship (53.2%), which meant that they visited their places of worship on every worship day. Some visited their places of worship rarely and only went there once a month or less or during occasions such as weddings and funerals.

More than half (57.1%) of the respondents were not employed. Only those in salaried employment earned a regular income. The self employed ones were involved in running of small kiosks-mostly by the road side-and in small-scale farming. The students were mostly in their final years of high school or in colleges. Casual workers were engaged in employment, which paid irregular daily income and were mostly Matatu touts.

Participants for the four FGDs were also young men with an age range of between 18 and 25 years. Each group had between 8 and 12 participants, mainly from Protestant and Catholic religious backgrounds. Their education status ranged from primary Standard 5 to college, with majority of the participants having finished high school education. Most of them were single and unemployed. During the focus group discussions it was also established that the self employed ones had some difficulties in estimating their income since it was mostly subsistence and depended on seasons. Those who reported to have jobs were mainly in the informal sector and small-scale business.

Table 1 **Social Demographic characteristics of the Respondents**

Characteristic	Frequency	Percentage
(i) Age		**n=465**
15-19	90	19.4
20-24	308	66.2
25-29	67	14.4
(ii) Marital Status		**n=464**
Single	381	82.1
Married	48	10.3
Divorced	2	0.4
Separated	4	0.9
Cohabiting	29	6.3
(iii) Educational Level		**n=466**
No schooling	7	1.5
Primary	123	26.4
Secondary	235	50.4
College	101	1.7
(iv) Religion		**n=464**
Catholic	208	44.8
Protestant	242	52.2
Muslim	5	1.1
Traditional	7	1.5
None	2	0.4
(v) Frequency of Worship		**n=463**
Regularly	248	53.6
Rarely	160	34.6
Never	55	11.9
(vi) Occupation Status		**n=462**
Unemployed	185	40.0
Salaried employed	70	15.2
Self employed	102	22.1
Student	79	17.1
Casual	26	5.6

5.2 Knowledge, Attitude and Practice of Family Planning/Contraception

This section assessed whether the young men were knowledgeable, willing and taking an active role in preventing unwanted pregnancies, which mostly result in abortions.

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5.2.1 Family Planning Knowledge

On asking the respondents when a woman was most fertile within her menstrual cycle, only 21.4% of them were able to identify correctly this period. Very few of them admitted that they did not know (8.4%). Most of them therefore had incorrect knowledge (Table 2).

Table 2. **Respondents' knowledge of the fertile period in the female menstrual cycle**

Response	Frequency	Percentage (n=463)
In Mid-cycle	99	21.4
Just before periods	193	41.7
During periods	81	17.5
Immediately after periods	51	11.0
Do not know	39	8.4

The most reported FP method available to men was the male condom (87.4%) followed by periodic abstinence (35.7%), Vasectomy (9.7%), withdrawal (7.1%) and natural (4.8%). Those who did not mention any method were 1.9%.

When the respondents were asked whether they had ever heard of the emergency contraceptive pill, only 38.4% indicated that they had heard of it while majority of them (61.6%) had not heard of it.

Correct knowledge of the emergency contraceptive pill was reported by slightly over a third (36.2%) of those who had heard about the emergency contraceptive pill. This translated to only 13.7% of the total number of respondents (Figure 2).

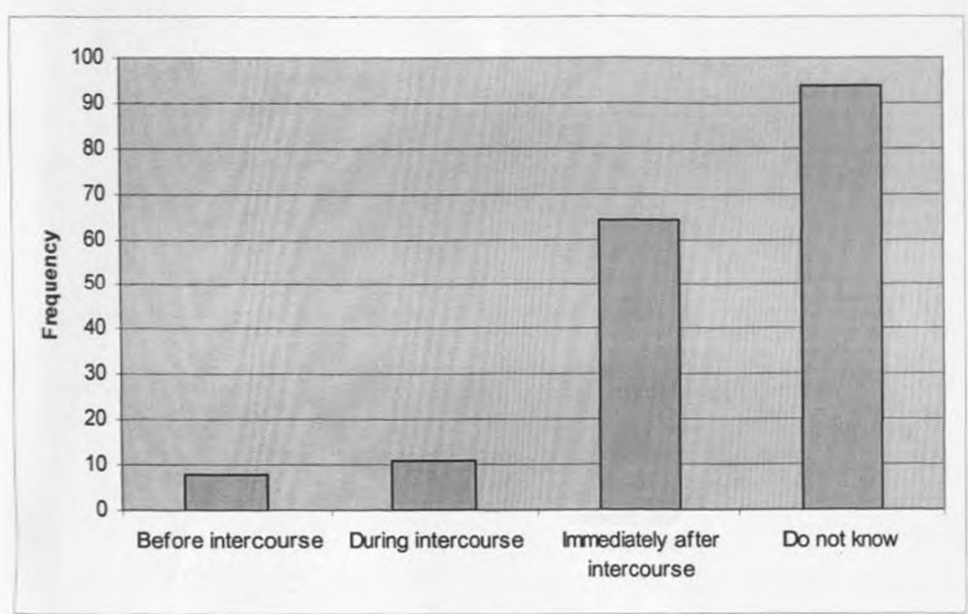

Figure 2. Respondents' knowledge about emergency contraceptive pill (n=179)

When respondents were asked whether they had adequate knowledge to prevent unwanted pregnancy, more than half of them (57.1%) reported that they had the knowledge while slightly more than a third (36.7%) reported that their knowledge was inadequate to prevent pregnancy.

For the purpose of cross-tabulation respondents' responses on contraceptive knowledge were scored. This scoring was based on an 8-point scale. Those scoring less than 4 points were classified as having inadequate knowledge while those who scored 4 points and above were classified as

having good knowledge. Only 13.1% of the respondents had good knowledge while most had inadequate knowledge 86.9%. This is illustrated in Figure 3.

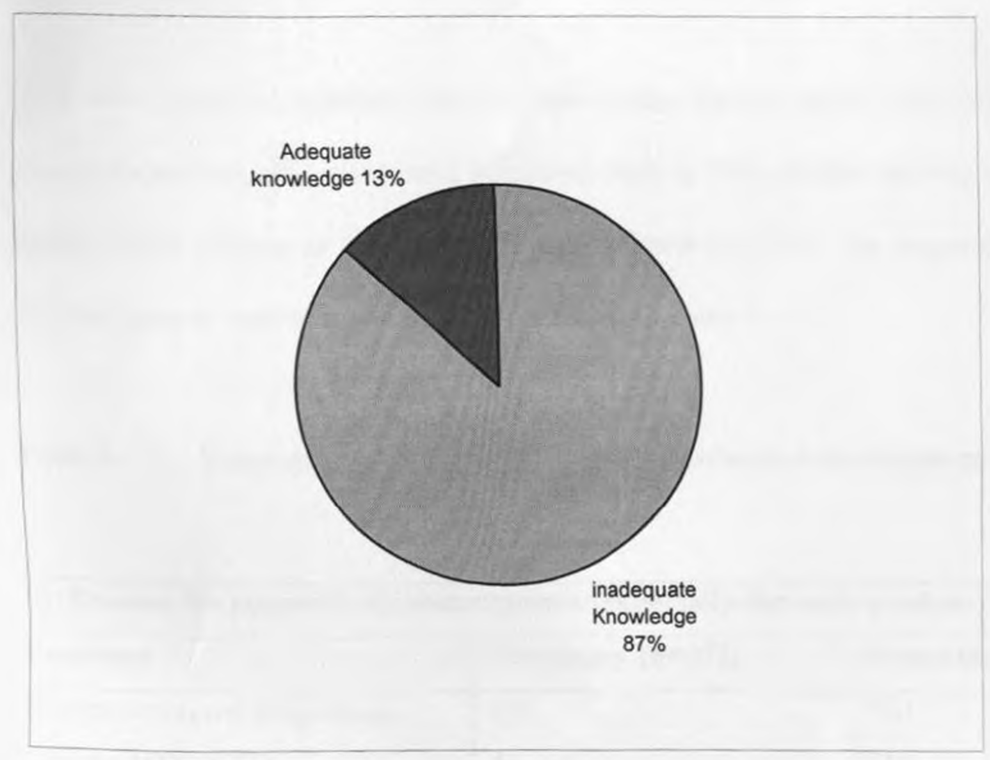

Figure 3. Respondents' scores on contraceptive knowledge

5.2.2 Attitude towards FP methods.

Approval of FP methods was reported by 58.2 % of the respondents, 38.8% of the respondents disapproved and 3% of the respondents were either neutral or did not have any comment.

Those who approved condom use by male youth argued mostly that it prevented unwanted pregnancies and sexually transmitted infections such as HIV /AIDS (41.9%) while those who were against it cited religion as the major prohibiting factor (12.2 %). The respondents' explanation for attitudes towards contraceptive usage is presented in Table 3.

Table 3. Respondents' reasons for attitudes towards contraceptives

(i) Reasons for approval of contraceptives (especially the male condom)		
Response	**Frequency (n=271)**	**Percentage**
Prevent unwanted pregnancies	144	53.1
Prevent AIDS/STDs	47	17.3
Condoms prevent both unwanted pregnancies and STDs (Dual)	51	18.8
Others	14	5.2
No comment	15	5.5
(ii) Reasons for disapproval of contraceptives (n=174)		
Against Religion	64	36.8
Fear of side effects	40	23.0
Should Abstain before marriage	28	16.1
Promote promiscuity	10	5.7
Not 100% effective	6	3.5
Others	91	19.5
No comments	12	6.9

About half of the respondents (49.1%) reported that both men and women should use contraceptives. Only 9.6% of the respondents reported that only men should use contraceptives (Table 4).

Table 4. Respondents' opinion on who should use contraceptives

Response	Frequency	Percentage (n=456)
Both men and women	224	49.1
Only women	103	22.6
Only men	44	9.6
Either men or women	25	5.5
Married couples	14	3.1
None	43	9.4
No comment	3	0.7

5.2.3 Family Planning Practice

About three-fifths of the respondents (60.4%) of the sexually active respondents reported having ever used contraceptives while 39.1% reported non-use of contraceptive.

The most common method of FP used by the respondents was the condom (91.5%). The other methods were periodic abstinence (3.6%) and withdrawal (3.6%). Vasectomy and other natural methods were both reported by less than 1% (Figure 4).

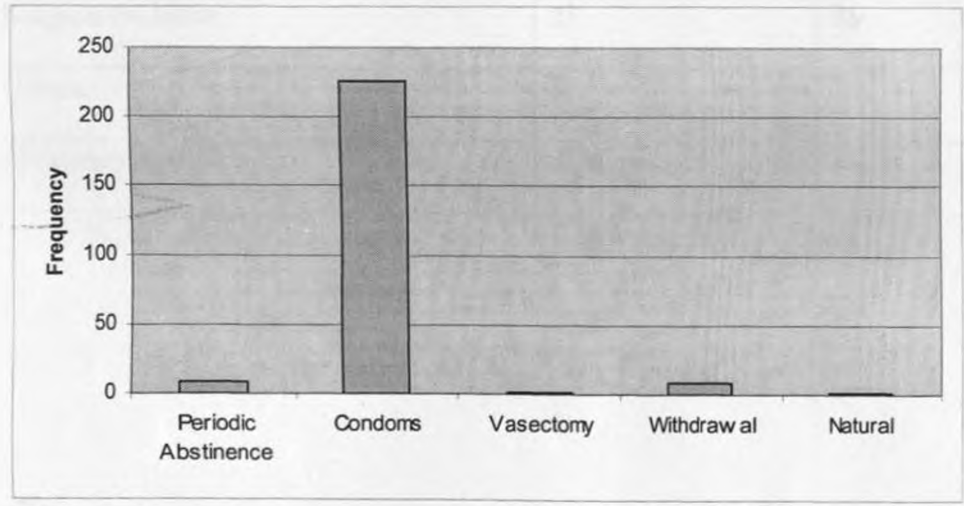

Figure 4. Methods of contraception use by Respondents (n=231)

When respondents were asked who suggested the use of the above contraceptive methods, most (61.7%) of them indicated that it was they. A few (13%) of them reported it was the female partner while 20% said it was agreement between them and the female partners. Friends' suggestions accounted for only 5.2%. Overall 37.3% of the respondents reported that they were not sexually

active, while 27.5% indicated disapproval and 18.5% indicated that they had never thought about it (Table 5).

Table 5. Respondents' reasons for not using contraceptives

Reason	Frequency	Percent (n=233)
Do not know where to obtain them	3	1.3
Never thought about it	43	18.5
Disapprove usage	64	27.5
Not sexually active	87	37.3
Religion Prohibits	23	9.9
Others	5	2.1
No comment	8	3.4

5.3 KNOWLEDGE ON ABORTION

Knowledge of various aspects of abortion was also assessed in order to establish whether this influenced the young men's perspectives towards abortion.

Almost all (97.8%) of the respondents indicated that they had heard about abortion while only 2.2% had not heard about it. When asked what they understood by the term abortion, about half (53%) of the respondents indicated that abortion meant removal of the baby. This is shown in Table 7.

Table 6. Respondents' understanding of abortion

Response	Frequency	Percentage
Killing the unborn	263	56.4
Terminating the pregnancy	183	39.3
Miscarriage	8	1.7
Do not know	12	2.6
Total	466	100

When respondents were asked about the magnitude of abortion in the community more than three-quarters were (77.5%) of them indicated that it was very common or common.

During the FGDs various standpoints were taken as to the magnitude of abortion in the area. Some participants reported that abortion was very common. Despite abortion being done secretly, one could still *"find a baby thrown in a garbage pit every six months"*. Some participants thought that abortion was not very common because girls fear death and abortion-related complications. Others said that

it was difficult to know the actual magnitude of abortion as *"men do not hear of abortions, it is done secretly by the girls"*. Overall, there was a consensus that abortion was a common problem in the study area.

When the respondents were asked where abortion services were obtained, private health facilities were reported by the most (73.8%) followed by homes (38.7%) and back street premises 30.9% .

(Figure 5.).

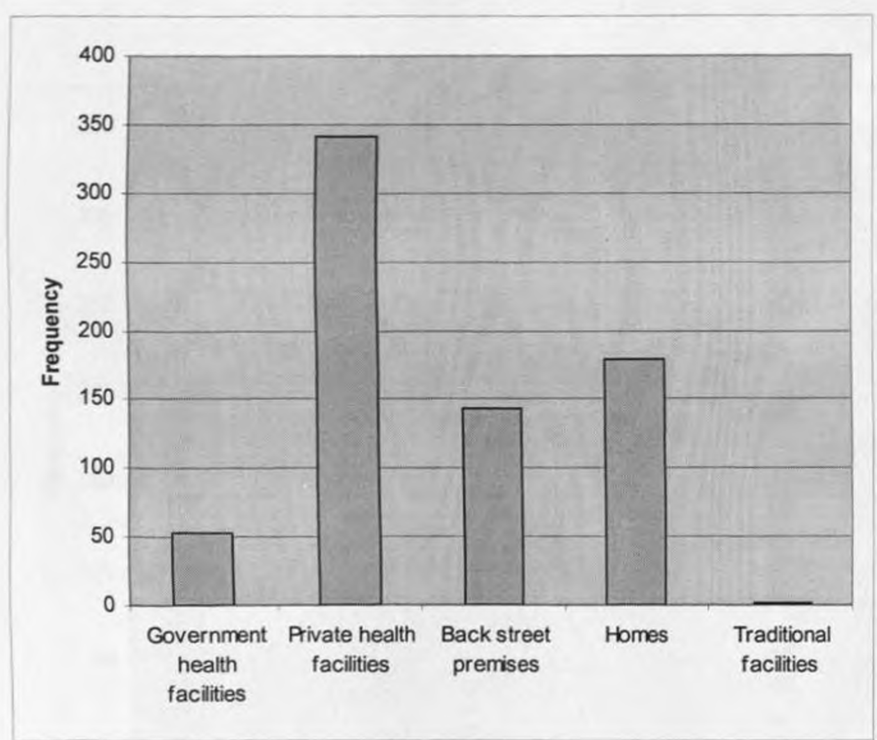

Figure 5. Respondents' knowledge of facilities where abortions were performed.

Participants in the FGDs mentioned similar locations where abortions were conducted, these included private hospitals, public facilities, homes and back street facilities. Participants further noted that abortion was more commonly practised in homes and the foetus thrown into toilets/bush.

A number of the respondents (64.3%) reported that doctors are the people who help in abortion process. This was followed by the nurses (42.3%). This is illustrated in figure 6.

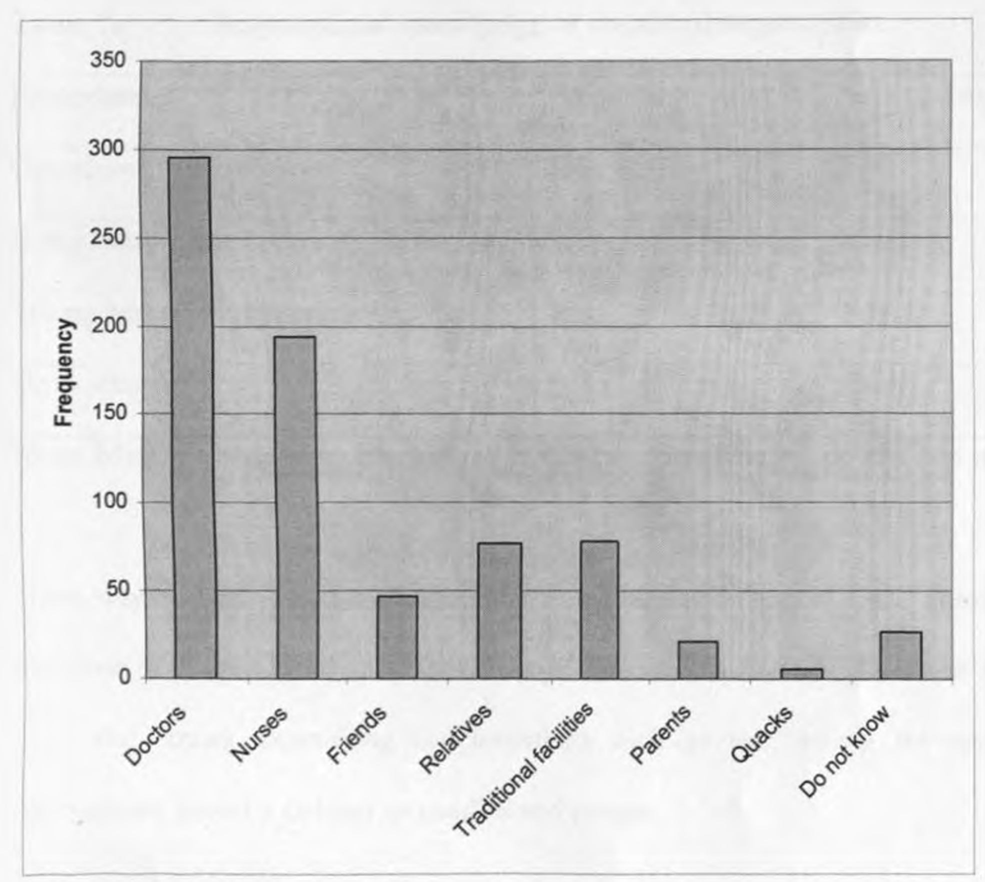

Figure 6. Respondents' knowledge of people who perform abortions

Participants in FGDs gave the various categories of those that provided or assisted in abortion services. These were private doctors, TBAs, self, through medication with overdose, fellow students, quacks, parents, herbalists and nurses in public facilities or other facilities, old women and other people who have abortion experience such as female sex workers and bar maids.

When respondents were asked to mention the various ways used to procure abortion, almost three-quarters (71.9%) reported that drugs were usually taken in overdose while 17.2% did not know. (Table 7).

Table 7. Respondents' knowledge of the abortion procedure.

Procedure	Frequency	Percent (n=454)
Drugs(usually in overdoses)	335	75.9
Using instruments to destroy foetus	201	44.3
Taking herbs and concoctions	75	16.1
Do not know	80	17.6

Note. Multiple responses were allowed thus the percentages do not add up to 100

Many ways of carrying out abortions were mentioned in the FGDs. These included taking an overdose of drugs such as anti-malaria drugs. Instruments that can poke such as crotchets, scissors, pens and straws, consuming concentrations such as salt, strong tea and detergents, herbal concoctions, use of a catheter or needles and pumps.

When the respondents were asked on the adverse effects of abortion, permanent loss of fertility by women was reported by the highest number (70.3%) of respondents. This was followed by death of

the women at 61.2%. The respondents' knowledge of the adverse outcomes of abortion is shown in table 8.

Table 8. Respondents' knowledge of the adverse outcomes of abortion procedure

Response	Frequency (n=454)	Percentage
Permanent loss of fertility	319	70.3
Death	278	61.2
Infections	132	29.1
Psychological effects	73	16.1
Disability	31	6.8
Bleeding	19	4.2
Damage to the womb	18	4.0
Loss of weight	3	0.7
Do not know	16	3.5

Note. Multiple responses were allowed thus the percentage do not add up to 100

In the FGDs it was reported that complications of abortion were death of the woman, medical complications such as bleeding, infections, urinary incontinence, repeated miscarriages and infertility.

When the safest stage to abort was asked to the respondents, early pregnancy (up to the third month of pregnancy) was reported by 55.8%. Almost a fifth (17.7 %) of the respondents indicated that there was no safe stage to abort (Table 9).

Table 9. Respondents' opinion of safest stage to abort.

Stage	Frequency	Percentage (n=454)
Early pregnancy (<3months)	252	55.8
Mid-pregnancy (>3month<6months)	32	7.1
Late pregnancy (>6 months)	8	1.8
None	80	17.7
Do not know	82	18.1

The study sought to assess the knowledge of respondents concerning the law on abortion. When the respondents were asked the legal status of abortion in Kenya 86.2% of the respondents indicated that abortion was illegal, 6.9% indicated that it was legal while 6.9% were not aware of the law.

A majority of the participants of the FGDs said they were aware that the Kenyan law prohibits abortion. Very few did not know this provision while others reported that abortion was legal. Only two or three participants mentioned that the law provided for abortion on circumstances such as medical complications that could endanger the life of the woman.

The scores on abortion knowledge were calculated to enable cross tabulations. It was based on a 16-point system with a maximum of 16 points. Those who scored 8 points and above were classified as having good knowledge while those who scored less than 8 points were classified as having inadequate knowledge (see appendix 5). More than three quarters (77%) of the respondents had good knowledge while more than a fifth (23%) did not. This is shown in Figure 7.

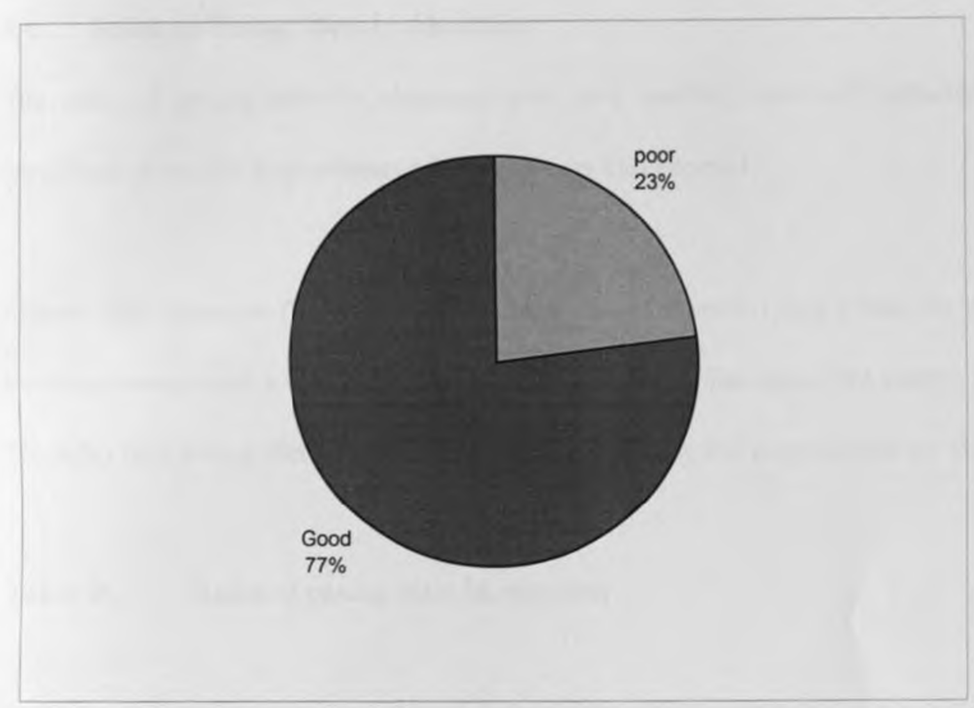

Figure 7. Respondents' scores on abortion knowledge

5.4 Roles of Young Men in Abortion

The roles of young men in abortion were also studied, from all respondents in general and specifically from the respondents whose partners had aborted.

Almost three-quarters (74.7%) of all the respondents reported that it was the young men who paid for the abortion and a quarter (25.4%) reported that it is the men who coerce the females to abort. The roles that young men play in abortion as reported by the respondents are shown in Table 10.

Table 10. Roles of young men in abortion

Response	Frequency (n=454)	Percentage
Paying for the abortion	339	74.7
Coercing the female to abort	116	25.6
Accompanying female to abortion clinic	13	2.9
Locating abortion clinic	5	1.1
None	29	6.4
Other	18	4.0
Do not know	32	7.1

Note. Multiple responses were allowed thus the percentages do not add up to 100.

Participants in the FGDs concurred that the main role that men play in abortion was provision of financial support to the girl. Other roles included providing moral support or 'a shoulder to lean on' after abortion, accompanying the girl when going for abortion, advising on the available services and locations for abortion, consulting the practitioner on behalf of the girl, and, when it was done at

home, spying around to keep people away from the home where abortion is taking place, and usually disposing the dead foetus. It was further reported that not all men took such roles. There were those who actually run away from the girl who has procured an abortion causing psychological trauma due to lack of post-abortion support.

The study also sought to understand the role played by the young men in decision-making and in the abortion procedure. When asked who makes the decision to abort, half (50%) of the respondents indicated that it was the women. More than a third (36.3%) of the respondents reported that it was both men and women, 5.7% indicated that it was the men,4.2% indicated that it was the parents and 1.3% indicated that it was friends, 2.4% did not know. Thus although men are not largely involved in decision making to abort however when the decision is made by their female partners, the young men's role is largely financial.

The study further sought to establish the number of respondents who had personal experience in abortion through their female partners and what role they had played. Most (82.7%) of the 454 respondents indicated that their female partners had not aborted, a few of the respondents (16.4%) indicated that their partners had, and 0.9% did not know. For the respondents whose female partners had procured abortion, the main role they played in the partners' abortion were varied with half (54.1%) of them reporting that they paid for the partners' abortion. A quarter (25.7%) did not play any role. The roles played in partners' abortion are shown in Figure 8.

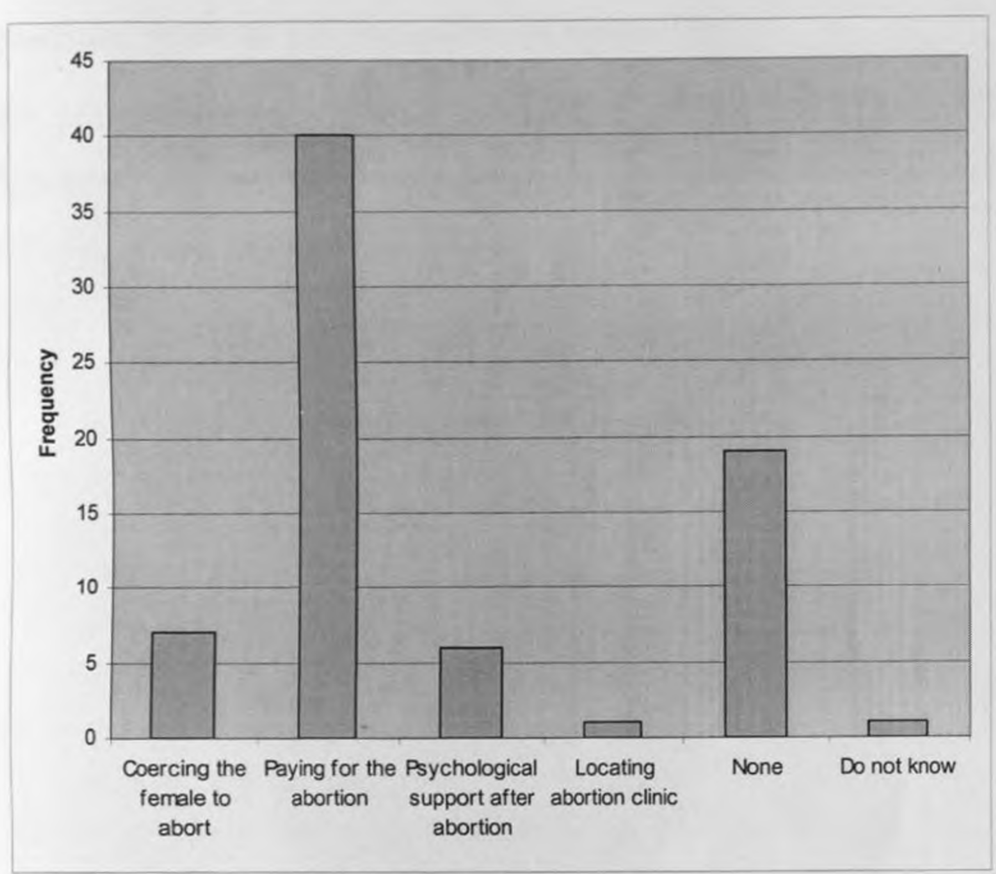

Figure 8. Respondents' role in their partner's abortion procedure (n =74)

PERSPECTIVES OF YOUNG MEN ON ABORTION

The survey sought to establish the perspectives of the young men on abortion. When the respondents were asked for their opinions on abortion, 14.2% approved of it, 78.6% did not and 6.8% were neutral. This is shown in Figure 9.

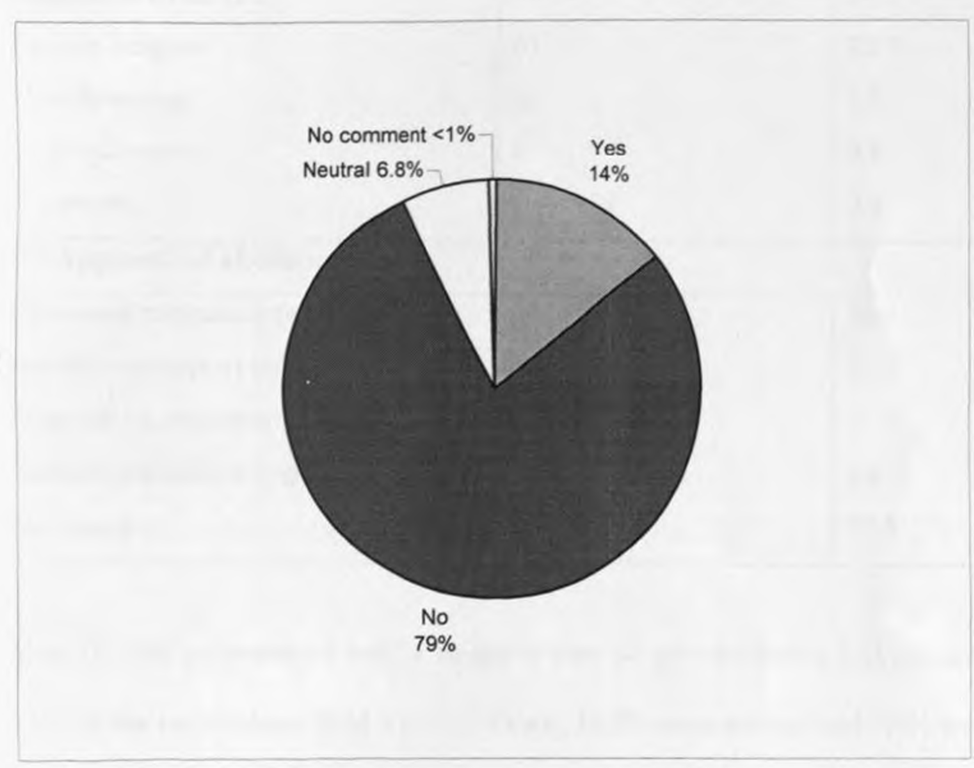

Figure 9. Respondents' approval status for abortion

When the respondents were asked to explain the reasons for approval or disapproval, killing the unborn was given as the main (29.4%) reason. This is shown in Table 11.

Table 11. Respondents' reasons for opinion on abortion

(i) Disapproval of abortion		
Reason	**Frequency**	**Percentage (n=357)**
Killing the unborn	132	37.0
Dangerous to mother	99	27.7
Against Religion	81	22.7
Morally wrong	21	5.9
Its illegal status	9	2.5
No reason	7	2.0
(ii) Approval of abortion		**(n=58)**
Unwanted pregnancy (solution)	33	56.9
Inability to support baby	6	10.3
Depends on situation	9	15.5
Reduces population growth	4	6.9
No reason	6	10.3

Most (75.3%) respondents held a negative view of a woman who had procured an abortion. Only 6.6% of the respondents held a positive view, 16.8% were neutral and 0.9% were not sure or did not give their views. The main reason given for the respondents' negative view was that they equated the woman to a murderer (Table 12).

Table 12. Respondents' reasons for negative views of the women who abort.

Reason	Frequency	Percentage n=342
Killed/murdered	166	48.5
Morally loose/Sinner	114	33.3
Physical/psychological health problems	48	14.1
Not specified	14	4.1

FGD participants were asked what their attitudes were towards women who had procured abortions. A myriad of attitudes were put forward. These were mainly negative ones. The woman was regarded as a harlot, unholy, murderer, one who does not appreciate the gift of life, irresponsible, immature, illiterate, untrustworthy and promiscuous.

Only a few of the FGD participants viewed such women positively. This was if abortion was not intended as in the case of miscarriage, if the parents pressured the girls to abort, or if the partners advised them to abort. This would make them to be viewed positively.

When opinions of the young men were sought on the reasons why they thought women procure abortion, unintended pregnancy was the main reason (54.8%). Reasons for abortion are presented in Table 13.

Table 13. **Respondents' perspectives on causes of induced abortion**

Reasons given for inducing abortions.	Frequency	Percentage of responses
Unintended pregnancy	249	54.8
Parental pressure	220	48.5
If a girl is in school	202	44.5
Inability to support child	165	36.3
Unmarried mother (stigma attached)	147	32.4
Rape	89	19.6
If there is no male support/rejection	85	18.7
Threat to maternal life	56	12.3
Peer pressure	48	10.6
If a woman has enough children	25	5.5
Threat to maternal mental health.	22	4.8
Chance that the child will be born deformed	21	4.6
Contraceptive failure	15	3.3
Male partner pressure	8	1.8
Others	14	3.1
Do not know	5	1.1

***Note. Multiple responses were allowed thus the percentages do not add to 100.**

Asked why some girls opt to abort, FGD participants mentioned that one of the leading factors was poverty *"there is no money for the baby's upkeep".* Those who were looking for jobs or wanted to retain their jobs would also not want to keep the pregnancy. Others said that some girls found it shameful to get pregnant before marriage. Some participants said that some girls aborted because *"they are just being naughty."* Others are advised by parents to abort so as to continue with education. Other reasons included fear of rejection by peers (in schools) or clients (for the female sex workers), desire to remain or look young, fear of parents who may chase them away, retention in school, fear to be

abandoned by boyfriend, costly medical fees, fear of embarrassing parents if in church leadership, and fear of losing the job (mainly for house girls, hairdressers and bar maids).

Married women were said to abort if they either had extra-marital pregnancies or had complications of pregnancy. Cases of married women who have aborted were also cited – *"if she gets pregnant with another man who is not her husband".*

When respondents were asked under what circumstances they would support abortion, threat to maternal life drew relatively the most support for both spontaneous and probed responses (17.6 % and 44.3% respectively). Unwanted pregnancy and abortions due to divorce (1%) drew the least support for spontaneous responses. Unwanted pregnancy and when the girl is too young to be a mother did not draw any support on probed responses. This is tabulated in Table 14.

Table 14. **Respondents' circumstances for approval of abortion.**

Circumstance mentioned	Spontaneously Frequency	Probed Frequency	Cumulative Frequency
Threat to maternal life	80(17.6)	201(44.3)	281(61.9)
If a woman was raped	68(15.0)	141(31.1)	209(44.3)
Threat to maternal health	21(4.6)	175(38.5)	196(43.2)
If a girl is in school	58(12.8)	68(15.0)	126(27.8)
Parental pressure	30(6.6)	95(20.9)	125((27.5)
Inability to support child	46(10.1)	76(16.7)	122(26.9)
Possible of deformity of baby	25(5.5)	94(20.7)	119(26.2)
Lack of male support	23(5.1)	73(16.1)	96(21.2)
If a woman has enough children	19(4.2)	77(17.0)	96(21.2)
If a woman has enough children	19(4.2)	77(17.0)	96(21.2)
Unmarried mother	13(2.9)	50(11.0)	63(13.9)
Contraceptive failure	11(2.4)	65(14.3)	76(16.7)
If a girl is too young	7(1.5)	0(0)	7(1.5)
Unintended pregnancy	6(1.3)	0(0)	6(1.3)
Divorce	4(.9)	1(0)	5(1.1)

Note:

- Multiple responses were allowed thus the percentages do no add up to a 100
- Percentages in brackets
- The above circumstances are not mutually exclusive.

When the respondents were asked whether they would approve of abortion under any circumstance, 57.7% indicated no circumstance for approval. On further probing, still 31.4% did not indicate any circumstance for approval for abortion. Probing yielded more approval of abortion in general. For instance those giving more than 3 reasons increased from 8.6% to 36.7% as shown in the table 15.

Table 15. Summary of the respondents' circumstances for abortion approval.

Circumstance	Spontaneous		Probed	
	Respondents	**Percentage**	**Respondents**	**Percentage**
No circumstance	262	56.2	143	30.7
Exceptional 1-2 circumstances	164	35.2	152	32.6
Any >2 circumstances	40	8.6	171	36.7

These results imply that approval or disapproval of abortion should be looked at circumstantially rather than absolute.

When the respondents were asked whether they would recommend abortion to their female partners in case of unwanted pregnancy, 85.9% were against it, 9.9% would recommend while 4.2% were not sure. These included the respondents with previous experience in abortion. More than a quarter (29.7%) of the respondents explained that they wouldn't kill their own child. Slightly above a quarter (27.9%) of respondents reported that the mother might be at risk of losing her life (Table 16).

Table 16. Advice to female partner against abortion.

Reason	Frequency	Percentage (n=390)
Killing own child	117	29.7
Risks maternal death	111	27.9
Against Religion	61	15.6
Will take responsibility	29	7.4
Risks maternal health (infections)	16	4.1
Morally wrong	25	6.4
Disapproves abortion	13	3.3
Others	12	3.1
Not specified	9	2.3

Respondents were asked what advice they would give in unwanted pregnancies. Majority (77.5%) indicated that the women should give birth. More than a tenth(13.4%) of the respondents reported that a woman should procure an abortion, 6.7% reported that a woman should seek counselling and only 2.5% did not know what to advice. This question further sought to find out what the respondents would advise the women. This is illustrated in Figure 10.

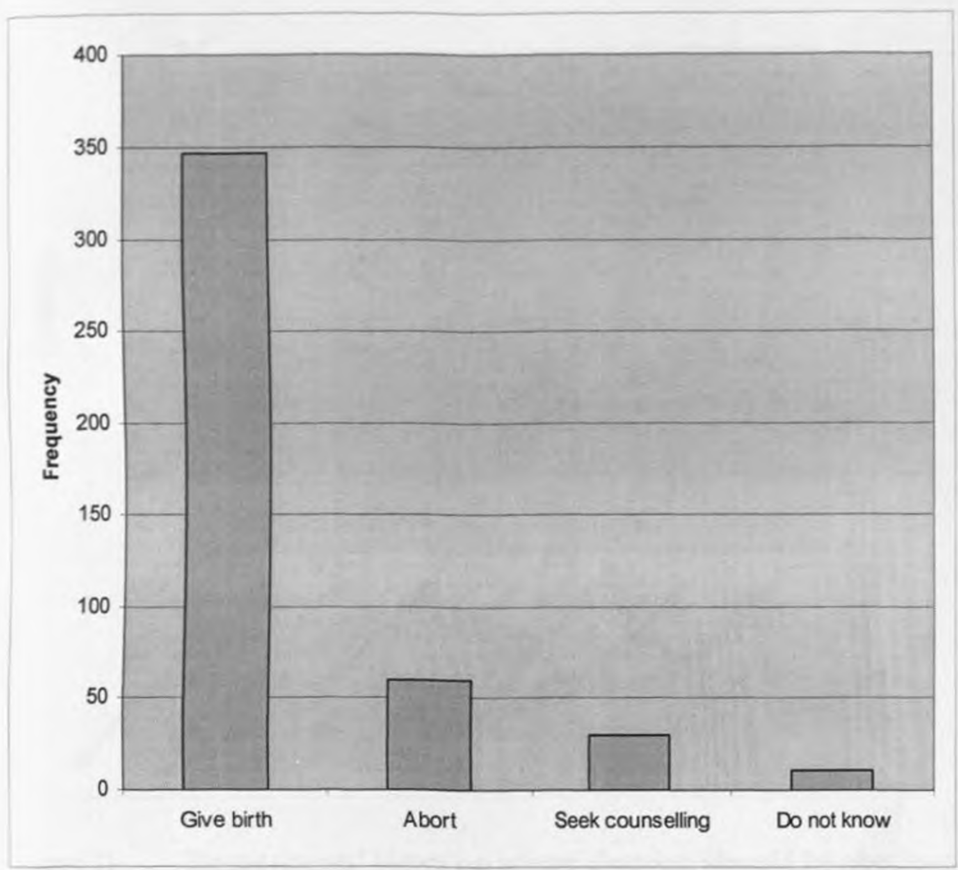

Figure 10. Respondents' advice on unwanted pregnancies

When respondents were asked their views on where the abortion services should be obtained, slightly more than two-thirds (69.8%) of the respondents indicated that they should be obtained in government health facilities. Half (49.6%) of the respondents indicated private facilities (Figure 11).

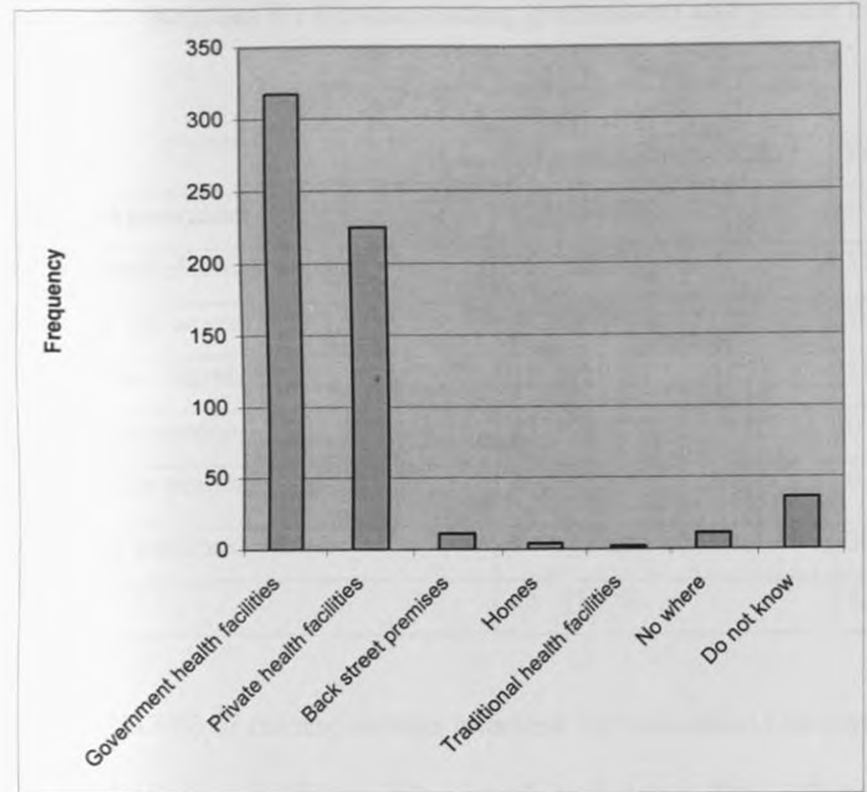

Figure 11. Respondents' views on where abortion should be obtained

The main reasons for the respondents' recommendation of government and private health facilities were availability of qualified personnel and professional abortion services (Table 17).

Table 17. Reasons for recommending government and private health facilities for abortion

Reason	Government (n=321)	Private (n=223)
Qualified personnel	125 (38.9%)	105 (47.1%)
Professional abortion services	76 (23.7%)	31 (13.9%)
Safety of the woman	47 (14.6%)	19 (8.5%)
Availability `Standard equipment	18 (5.6%)	16 (7.2%)
Affordable services	21 (6.5%)	0 (0%)
Responsible practices	19 (5.9%)	0 (0%)
Routinely practised there	0 (0%)	30 (13.5%)
Others	15 (4.7%)	12 (5.4%)

A third (33.3%) of the respondents indicated that men should be paying for abortions, while 24.7% indicated that men should not have any role in abortion. This is illustrated in Table 18.

Table 18. Respondents' opinion on the main role men should play in induced abortion

Response	Frequency	Percent (n=454)
Paying for the abortion	151	33.3
No role	112	24.7
Preventing abortion	76	16.7
Psychological support after the abortion	63	13.9
Others	48	10.6

When asked whether a woman should consult male partner before procuring abortions most of them (94.3%) agreed that they should, while 4.2% disagreed and 1.3% did not know. When the

respondents were asked whether without a man's consent, the woman should still abort, 15.6% agreed while 79.1% disagreed and 5.3% did not know. This indicates that the respondents would like to have their opinions considered in decisions to terminate a pregnancy.

Legalisation of abortion is a current debate and the male youth perspective on the same was sought. About three-quarters (75.1%) of the respondents reported that abortion should not be legalised while 15% of them said that abortion should be legalised, the rest were neutral. Reasons for these are shown in Table 19.

Table 19. Respondents' views against legalisation of abortion.

Reason given	Frequency	Percentage (n=358)
Killing the foetus	111	31.0
Endangers maternal life	36	10.1
Against religion	43	12.1
People will take undue advantage	46	12.8
Will lead to a rise in promiscuity	36	10.1
Many deaths of mother and foetus.	36	10.1
Others	34	9.5
Not specified	16	4.5

The FGD participants took varied opinions on the law on abortion. Majority of them said that it should remain illegal because if it is legalised, cases of abortion will increase to uncontrollable levels. They thought that fear of law discourages abortions. They also cited reasons such as the law would discourage sexual relations that are unsafe, the unborn baby was innocent, it would decrease chances of death of mother, it would help decrease cases of infertility and would get rid of single mothers

and hence reduce poverty resulting from burden of children. One participant said *"abortion should remain illegal as it is killing and a sin. It should also remain illegal to prevent it from being abused by girls under the guise of having a medical problem".* Some also feared that if abortion is legalised, the human race would be wiped away.

About half (52.8%) of those who were for legalisation of abortion indicated that it would lead to abortion being made safer (26.4%) and would take care of unwanted pregnancies (26.4%).

FGD participants who said that abortion should be legalized cited reasons such as the law would assist in getting rid of children who are without parents and assist parents who cannot take care of children and thus reduce burden on the nation. Others said "abortion should be legalized because our parents cannot support many children these days. It is a burden to the girl's parents and this will enable the girl to continue with education".

The third category of participants said that the law should provide for abortion under specific circumstances only such as "when a girl is very young and gets complications, you should let the girl do abortion to make her productive in the economy." Others said that abortion should be legalised under circumstances such as rape or when the girl conceives while in school.

On the whole, there was a general feeling that people would continue aborting whether there was law or not. They however resolved that women who abort should be arrested and prosecuted.

5.6 Young Men's Suggestions to Reduce Induced Abortions

Young men's recommendations were also sought because they are important and should be incorporated as much as possible, when designing programs to reduce the problem of abortion among the youth.

When the respondents were asked what they should do to reduce the problem of induced abortions, half of them (50.1%) reported that the young men should abstain from sex before marriage, 42.9% said that FP methods should be used, 4.9% gave other recommendations and 2.1% did not know.

When asked what the government should do to reduce the problem of abortion, 36.3% reported that sex education should be taught in schools, 32.5 % reported that a ban on abortion should be reinforced and 25% said that contraceptives should be made available to youth. Others advocated for creation of jobs for male youths, counselling the youth on abortion, banning of prostitution, legalisation of abortion and availing safe abortion to the youth.

A number of recommendations for reducing abortions were presented during the FGDs. These included:

- *Use of contraceptives*
- *Sex education in schools and homes*
- *Having safe sex when one cannot abstain (e.g. when the woman is on safe days, withdrawal, condoms, use of sex toys)*
- *To reduce the cases of abortion, moral standards should be kept high by going to church and getting saved, which will lead to abstinence*
- *Schools should retain girls in schools even after pregnancy*
- *Parental guidance and counseling*
- *Adoption centers for children to be set up*
- *They also indicated that men should accept the pregnancy, take responsibility and stick to one partner, and if the partners pregnant they should be ready to marry them*
- *On a more comical note, a participant said "men should be involved more in drinking so as to distract them from thinking about women and sex and if that is not possible they should go for vasectomy"*

The top four preferred sources of information recommended by the respondents to reach them were the radio (21.4%), health facilities (17.5%), magazines and pamphlets (16%) and the television (15.9%.). Other sources named were the newspapers, posters, relatives, friends, schools, church leaders, barazas, seminars/workshops and films.

On male participation in reproductive health issues the young men recommended the use of social and recreational facilities to educate them, conducting seminars on sexual matters, exposing men to magazines/information free of charge, putting up legislation compelling men to play a role in reproductive lives of their partners, sensitizing men through seminars in hospitals and churches, taking up FP as men and not leaving the whole issue to women and Family Planning Association of Kenya (FPAK) should be conducting mass campaigns to educate men. Others recommended that

men should come up front in breaking cultural barriers and norms that prohibit or limit them from participating in reproductive issues of their partners and support them fully. This could be done through counseling at the family level by encouraging men to participate in antenatal clinics and post-natal visits as well. They added that men should look for an income generating activities so that they could afford to support the women.

5.7 BIVARIATE ANALYSES

In order to determine the factors that had a significant relationship with young men's perspectives towards induced abortion. Cross – tabulations were done with ach of the following independent variables. Chi-square test for significance was used. Level of significance was fixed 0.05. ($p=0.05$).

5.7.1 Social Demographic Characteristics

Marital status was collapsed into dichotomous (single and married). On cross tabulation it was found to influence the advice the respondents would give incase of unwanted pregnancies with the single being more likely to advice the respondents to abort ($p<0.014$).

Surprisingly the more educated the respondents were the less likely they were to approve abortion ($P<0.001$). They were also less likely to recommend abortion to their partners ($p<0.001$) or to advice abortion incase of unwanted pregnancies ($p<0.000$). Education level however did not influence their opinion on legalization of abortion significantly (Table 20a).

Table 20. (a) Cross tabulations between social demographic characteristics and selected perspectives of abortion

Perspectives On abortion	Marital Status			Educational level			
	Single	Married	Statistics	Primary	Secondary	College	Statistics
Opinion on abortion			χ^2 = 1.23				χ^2= 13.2
Approve	59(15.2)	8(10.4)	DF= 1	31(23.8)	26(11.1)	10(9.9)	DF = 2
Disapprove	328(84.8)	69(89.6)	P< 0.268	99(76.2)	209(88.9)	91(90.1)	P<0.001
Recommendation of abortion			χ^2 = 2.3				χ^2= 15
Yes	42(10.9)	4(5.2)	DF =1	24(18.5)	16(6.8)	6(5.9)	DF= 2
No	345(89.1)	73(94.8)	P< 0.129	106(81.5)	219(93.2)	95(94.1)	p < 0.001
Advice in unwanted pregnancy							
Give birth	289(75.7)	63(82.9)	χ^2= 8.6	80(62.0)	187(81.3)	86(85.1)	χ^2 = 48
Abort	61(16.0)	3(3.9)	DF = 2	41(31.8)	18(7.8)	5(5.0)	DF = 4
Do not know	32(8.3)	10(13.2)	p < 0.014	8(6.2)	25(10.9)	10(9.9)	p < 0.000
Opinion on Legalization			χ^2 = 0.6				χ^2 = 2.03
Approve	62(17.4)	10(13.7)	DF= 1	23(19.5)	31(14.1)	18(18.9)	DF = 2
Disapprove	295(82.6)	63(86.3)	p < 0.444	95(80.5)	188(85.9)	77(81.1)	p <0.363

Whereas there was no difference in perspectives between the Catholics and Protestants, frequency of worship had a strong influence on perspectives of the respondents towards abortion. The respondents who attended their places of worship every worship day (regular) were more likely to disapprove abortion than those who only attended their places of worship occasionally or never ($p<0.000$). These regular worshippers were also less likely to recommend abortion to their female partners and advice others to abort ($p<0.000$). Regular worshippers were also more likely to oppose legalization of abortion ($p< 0.000$). This is shown in Table 20 (b).

Table 20. (b) Cross tabulations between social demographic characteristics and selected perspectives of abortion */ Continued*

Perspectives On abortion	Religion			Frequency of worship			
	Catholic	Protestant	Statistics	Regular	Occasional	Never	Statistics
Opinion on abortion							
			$\chi^2 = 1.1$				$\chi^2 = 44$
Approve	34(16.3)	33(12.9)	DF = 1	22(8.9)	21(13.1)	24(43.6)	DF = 2
Disapprove	174(83.7)	223(87.1)	$p < 0.292$	226(91.1)	139(86.9)	31(56.4)	$p < 0.000$
Recommendation of abortion							
			$\chi^2 = 0.014$				$\chi^2 = 70.9$
Yes	21(10.1)	25(9.8)	DF = 1	14(5.6)	9(5.6)	23(41.8)	DF =2
No	187 (89.9)	231(90.2)	$p < 0.906$	234(94.4)	151(94.4)	32(58.2)	$p < 0.000$
Advice in unwanted pregnancy							
Give birth							
Abort	161(78.5)	190(75.1)	$\chi^2 = 0.821$	203(82.9)	121(76.6)	27(49.1)	$\chi^2 = 53$
Do not know	27(13.2)	37(14.6)	DF= 2	20(8.2)	19(12.0)	25(45.5)	DF = 4
	17(8.5)	26(10.3)	$P < 0.663$	22(9.0)	18(11.4)	3(5.5)	$p < 0.000$
Opinion on Legalization							
			$\chi^2 = 0.2$				$\chi^2 = 37$
Approve	30(15.6)	41(17.2)	DF = 1	20(8.9)	28(18.4)	23(43.4)	DF = 2
Disapprove	162(84.4)	198(82.8)	$p < 0.670$	204(91.5)	124(81.6)	30(56.6)	$p < 0.000$

Occupation did not influence perspectives towards abortion significantly. There was no significant difference in perspectives towards induced abortion between the employed, unemployed and students (P> 0.05). This is shown in Table 20 (c).

Table 20 (c) Cross tabulations between social demographic characteristics and selected perspectives of abortion */ Continued*

Perspective	Occupation			
	Unemployed	Employed	Student	Statistics
Opinion on abortion				
Approve	25(13.5)	33(16.7)	9(11.4)	$\chi^2 = 1.5$
Disapprove	160(86.5)	165(83.3)	70(88.6)	DF = 2 $p < 0.470$
Recommendation of abortion				
Yes	17(9.2)	23(11.6)	6(7.6)	$\chi^2 = 1.2$
No	168(90.8)	175(88.4)	73(92.4)	DF = 2 $p < 0.543$
Advice in unwanted pregnancy				
Give birth	139(76.4)	148(75.9)	63(79.7)	$\chi^2 = 8.8$
Abort	28(15.4)	31(15.9)	4(5.1)	DF = 4
Do not know	15(8.2)	16(8.2)	12(15.2)	$P < 066$
Opinion on legalization				
Approve	29(17.1)	37(19.9)	5(6.9)	$\chi^2 = 6.3$
Disapprove	141(82.9)	149(80.1)	67(93.1)	DF = 2 $p < 0.42$

5.7.2 Knowledge, attitude and practice of contraceptives (FP)

FP attitude influenced perspectives on induced abortion significantly. The respondents who approved contraceptives were also more likely to approve abortion ($p<0.000$) they were also more likely to recommend abortion to their female partners ($p<0.000$) and to advice others to procure abortion incases of unwanted pregnancy ($p <0.001$). These respondents were also more likely to support legalization of abortion ($p<0.000$).

FP use by the respondents influenced their perspectives towards abortion significantly. The respondents who had reported contraceptive use were more likely to approve of abortion ($p<0.000$); they were also more likely to recommend abortion to their female partners ($p<0.000$). These respondents who had reported contraceptive use were also like to advice others to procure abortion incases of unwanted pregnancy ($p< 0.002$) and to support legalization of abortion ($p<0.000$). This is shown in Table 21 (a).

Table 21. (a) Cross tabulations between KAP on contraceptives and selected perspectives of abortion

Perspectives On abortion	FP attitude			FP use		
	Approve	Disapprove	Statistics	Yes	No	Statistics
Opinion on abortion						
Approve	55(20.3)	12(6.2)	χ^2= 18.4 DF=1	48(20.8)	19(8.1)	χ^2=15.1 DF = 1
Disapprove	216(79.7)	183(93.8)	P<0.000	183(79.2)	215(91.9)	p < 0.000
Recommendation of abortion						
Yes	40(14.8)	6(3.1)	χ^2= 17.4 DF= 1	36(15.6)	10(4.3)	χ^2= 16.7 DF = 1
No	231(85.2)	189(96.9)	P< 0.000	195(46.5)	224(95.7)	p < 0.000
Advice in unwanted pregnancy						
Give birth	191(71.3)	162(84.4)	χ^2= 14.7	167(72.6)	186(80.9)	χ^2= 12.7
Abort	51(19.0)	13(6.8)	DF=2	45(19.6)	19(8.3)	DF=2
Do not know	26(9.7)	17(8.9)	P<0.001	18(7.8)	25(10.9)	P< 0.002
Opinion on Legalization						
Approve	55(22.2)	17(9.2)	χ^2= 12.7 DF= 1	53(24.2)	19(9.0)	χ^2= 18 DF = 1
Disapprove	193(77.8)	167(90.8)	P< 0.000	166(75.8)	193(91.0)	P <0.000

When knowledge on contraception was cross-tabulated with perspectives towards abortion, it was found to influence whether the young men recommended abortion to their partners and the advice they gave others in case of unwanted pregnancy.

Those respondents with inadequate contraceptive knowledge were more likely to recommend abortion to their female partners ($p < 0.047$). They were also more likely to advice others to go for an abortion in case of unwanted pregnancy ($p< 0.001$). However there was no difference on opinion on legalization of abortion between those who had inadequate knowledge on contraceptives and those who had adequate ($p <1$). This is shown in Table 21 (b).

Table 21. (b) Cross tabulations between KAP on FP and selected perspectives of abortion / *continued*

Perspective	Knowledge on contraception		
	Inadequate	Adequate	Statistics
Opinion on abortion			$\chi^2 = 1.4$
Approve	59 (15.2)	8(10.1)	DF =1
Disapprove	328 (84.8)	71 (89.9)	$p < 0.237$
Recommendation of abortion			$\chi^2 = 2.1$
Yes	43(11.1)	3(3.8)	DF = 1
No	344(88.9)	76(96.2)	$p < 0.047$
Advice in unwanted pregnancy			
Give birth	293(76.5)	60(77.9)	$\chi^2 = 14.4$
Abort	61(15.9)	3(3.9)	DF = 2
Do not know	29 (7.6)	14(18.2)	$p < 0.001$
Opinion on legalization			$\chi^2 = 0$
Approve	59(16.7)	13(16.7)	DF = 1
Disapprove	295(83.3)	65(83.3)	$p < 1$

5.7.3 Sexual activity

The respondents were divided into two, those who were sexually active and those who were not. The respondents who were sexually active were more likely to approve abortion ($p < 0.011$); they were also more likely to approve legalization of abortion ($p < 0.035$) than those who were not (Table 22).

Table 22. Cross tabulation between sexual activity and selected perspectives towards abortion

Perspective	Sexual active		
	Yes	No	Statistics
Opinion on abortion			
Approve	62(16.4)	5(5.7)	$\chi^2 = 6.5$
Disapprove	317(83.6)	82(94.3)	DF = 1 $p < 0.011$
Recommendation of abortion			
Yes	41(10.8)	5(5.7)	$\chi^2 = 2.1$
No	338(89.2)	82(94.3)	DF = 1 $p < 0.153$
Advice in unwanted pregnancy			
Give birth	283(75.5)	70(82.4)	$\chi^2 = 2.9$
Abort	53(14.1)	11(12.9)	DF = 1
Do not know	39(10.4)	4(4.7)	$p < 0.234$
Opinion on legalization			
Approve	65(18.5)	7(8.8)	$\chi^2 = 4.4$
Disapprove	287(81.5)	73(91.3)	DF = 1 $p < 0.035$

5.7.4 Knowledge on induced abortion

Although most of the respondents had good knowledge on abortion it did not influence their perspectives towards induced abortion significantly ($p > 0.05$). This is shown in Table 23.

Table 23. Cross tabulation between knowledge on abortion and selected perspectives towards abortion.

Perspective	Knowledge on Abortion		
	Poor	Good	Statistics
Opinion on abortion Approve Disapprove	 10(14.1) 61 (85.9)	 57(14.4) 338 (85.6)	$\chi^2 = 0$ DF =1 p <0.939
Recommendation of abortion Yes No	 6(8.5) 65(91.5)	 40(10.1) 355(89.9)	$\chi^2 = 0.19$ DF = 1 p < 0.663
Advice in unwanted pregnancy Give birth Abort Do not know	 49(70.0) 13(18.6) 8 (11.4)	 304(77.9) 51(13.1) 35(9.0)	$\chi^2 = 0.2$ DF = 2 p < 0.340
Opinion on legalization Approve Disapprove	 11(16.7) 55(83.3)	 61(16.7) 305(83.3)	$\chi^2 = 0$ DF = 1 P< 1.000

5.7.5 Experience in abortion

There was a significant relationship between the respondents experience in abortion and their perspectives towards abortion. The respondents, whose female partners had procured abortion in their current or past relationship were more likely to approve abortion, recommend abortion to their partners, advice others to procure abortion in case of unwanted pregnancy and support legalization of abortion ($p<0.000$). This is shown in table 24.

Table 24. Cross tabulations between experience in abortion and selected perspectives of Abortion

Perspective	Experience in abortion		
	Yes	No	Statistics
Opinion on abortion			$\chi^2 = 57.7$
Approve	32 (42.1)	34(8.8)	DF =1
Disapprove	44 (57.9)	353 (91.2)	P< 0.000
Recommendation of abortion			$\chi^2 = 53.6$
Yes	25(32.9)	21(5.4)	DF = 1
No	51(67.1)	366(94.6)	P< 0.000
Advice in unwanted pregnancy			
Give birth	45(60.0)	306(80.1)	$\chi^2 = 28.9$
Abort	25(33.3)	38(9.9)	DF = 2
Do not know	5 (6.7)	38(9.9)	P< 0.000
Opinion on legalization			$\chi^2 = 38.4$
Approve	30(41.1)	41(11.5)	DF = 1
Disapprove	43(58.9)	315(88.5)	P< 0.000

5.8 MULTIVARIATE ANALYSIS (LOGISTIC REGRESSION)

In order to determine whether several factors had any joint impact on opinion on abortion (dependent variable), logistic regression methodology was used to assess critical predictors to approval of abortion as the dependent variable. All the hypothesized predictors including those with significant relationships were entered.

This model requires a logistic approach due to the binary form of the dependent variable (Table 25).

Table 25. Logistic Regression Model. Respondents' opinion on abortion and related Variables

Variable	p -value	Odds ratio	95% C.I Lower - Upper
Marital Status	0.674	0.8	0.3 - 2.0
Educational level	0.104	0.4	0.2 - 1.2
Religion	0.171	0.7	0.4 – 1.2
Frequency of worship	0.015*	2.9	1.2 – 6.9
Occupation	0.327	1.6	0.6 - 4.5
Attitudes on FP	0.01*	0.4	0.2 - 0.8
Ever use of FP	0.941	0.9	0.5 - 2.1
Inexperience in abortion	0.000***	0.2	0.1 - 0.4
Sexually active	0.145	2.4	0.7 – 7.6
Knowledge on abortion	0.485	1.4	0.6 – 3.2
Knowledge on contraceptives	0.834	1.1	0.4 – 2.8

Except for respondents' frequency of worship, attitude towards FP and experience in abortion, all the other variables that had a significant relationship during bivariate analysis were not significant during logistic regression analysis.

Experience in abortion emerged the strongest predictor of abortion perspectives with those whose partners had not experienced abortion being five times less likely to approve abortion than those whose partners had not (O.R 0.2, p <0.000). As in the bivariate analysis, the type of religion did not show significant relationship with the dependent variables, while the frequency of worship was an important predictor of abortion perspectives (O.R 2.9, p< 0.015). Respondents' attitudes on contraceptive use were also significant predictors of abortion perspectives (O.R 0.4, p< 0.01), while the actual use of a contraceptive use did not remain significant during multivariate analysis.

A similar relationship was also found with the other dependent variables namely, recommendation of abortion to a female partner, advice given to others in case of unwanted pregnancy and opinion on legalization of abortion.

CHAPTER 6

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS.

6.1 DISCUSSION

6.1.1 Introduction

The results from this study indicate that the only social demographic characteristic of the respondents that influenced their perspectives towards abortion significantly was their frequency of worship. However the religion of the respondents did not significantly affect the perspectives. A similar study from the United States found that high frequency of attendance of religious services was an important factor associated with conservative opinions towards abortion. The same study also found that being Catholic was associated with conservative opinions towards abortion. However in this study the type of religion did not influence the young men's perspectives towards abortion. One possible explanation for this is that a higher proportion of the population in the sample was Catholic than in the United States sample and regular church attendance is more common in Kenya. Traditional conservative institutions such as the Roman Catholic Church may have less influence on young people's opinion than older people's.[51]

6.1.2 Contraceptive knowledge, attitude and practice of male youth

Only a few of the respondents knew the fertile period in the female cycle or the probable time to become pregnant. It is important especially for young men and women who intend to practice natural family planning to have a good functional knowledge of the female cycle. This is contrasted by a KAP survey on contraception among male and female undergraduate students in a university in Kenya, which found that about half (51.8%) knew the most probable time to become pregnant.[51] However this contrast is expected considering that university students are expected to have higher

knowledge on reproductive biology than the general male population. Current gender imbalances may also hinder the young men from knowing the female cycle.

Thus young men need to be encouraged to know their female partner's reproductive cycle, which can help them cope, better with their partners emotional and reproductive health needs. This involves changing social norms on how young men perceive themselves and their female partners and the expectations that society in general and educators in particular have with regard to gender relations.

More than half (58.2%) of the respondents approved the use of family planning. The main reason given being to prevent unwanted pregnancy and some of the respondents indicating the dual nature of the condoms, which prevent unwanted pregnancies and AIDS/STDS. This is in line with the current trend, which is trying to market male and the female condoms for preventing pregnancies and STDs including AIDS. This agrees with the study on the undergraduate students which found that males advocated use of contraceptives by the female youth.[51] About half (48.1%) indicated that both men and women should use family planning, about a fifth (22.1%) indicated women only and almost a tenth (9.4%) indicated that men only should use contraceptive. This contrasts with a study done on adolescent males on attitudes towards abortion, contraception and sexuality, which reported that nearly half of the respondents placed contraceptive responsibility with the girl. The study had further added that there were indications that the attitude was changing. The fact that the study was done in 1978 might explain the change since the society is dynamic.[40]

Half of the respondents (49.7%) reported ever use of FP methods. A similar study on University of Nairobi undergraduate students (1992), which found that 49.7% of the males were current

contraceptors.[35] Most (61.7%) of the respondents indicated that they had instructed themselves to use. Some (18.7%) of those who had not used reported that they were not sexually active. Thus only about a half of the young men had reported taking an active role versus a passive role in preventing pregnancy although a small percentage reported not being sexually active.

Respondents' attitudes towards contraceptives influenced their use significantly ($p<0.000$), with those who approved contraceptive use being more likely to report use than those who did not.

Hence in order to increase use of contraceptives, appropriate attitudinal change towards contraceptives should be addressed. This should also emphasize contraceptive use as a shared responsibility rather than a female only responsibility.

Only 38.4% of the respondents were aware of the emergency contraceptive pill, and only 13.7% of those knew of the right time that it could be used. This agrees with a study done by Muia et al (1999) on conflicting attitudes towards the use of emergency contraception by young people in Kenya, which noted, "knowledge about emergency contraception was extremely limited with much misinformation." Arguments for the use of emergency contraception meets an important contraceptive need for the youth since they have a high risk of unprotected and unplanned sex. In addition the youth lack access to regular contraceptive methods as well as emergency contraception.[54]

Slightly above half of the respondents (58.3%) indicated that they had adequate contraceptive knowledge to prevent unwanted pregnancy. This is an important finding in that two-fifths (41.7%)

admitted that they did not have adequate knowledge to prevent unwanted pregnancy hence may put their partners at risk of induced abortions.

The respondents who approved of contraceptives, or who reported actual use of a male contraceptive method were more likely to hold liberal perspectives towards induced abortion. This finding could be explained by the fact that these respondents held liberal views towards many issues in general.

6.1.3 Knowledge on abortion

The study results indicate that almost all (97.8%) of the respondents indicated that they were aware of abortion. This finding compares well with a study done on women's views towards induced abortion at Babadogo in Nairobi where the same proportion of the women had heard of abortion.[55]

About three-quarters of the respondents indicated that abortion was common in this rural community. This was supported in FGDs where participants added that while abortion was done in secret one could still "*find a baby thrown in a garbage pit every six months.*"

Few indicated that they could not know the actual magnitude of abortion since "*men do not hear of abortions, since they are conducted secretly by the girls.*" This is an important consideration to those seeking to know the actual prevalence of abortion since what they may be getting is just a tip of the iceberg.

Respondents indicated that the most common facility where abortions are conducted were private health facilities followed by homes, back street premises and public facilities. This is an expected

finding since abortions are illegal therefore the health care workers would be hesitant to use the public health facilities for abortions.

Findings from this study indicate that doctors and nurses are the main professionals who conduct abortions irrespective of the facility where the abortion is conducted. This is an important finding for those designing programs to reduce the problems of unsafe abortions should target these professions for example through further training on safer abortion procuring procedures. These findings agree with a survey done on the knowledge, attitudes and practice of induced abortion among nurses in Kisii District, Kenya, where eleven percent of the nurses admitted to having been involved in abortion. Furthermore this was probably an underestimate as few nurses would admit to ever having induced abortion for fear of social and legal repercussions.[55] It is thus important to involve these health professionals in any discussions to resolve the problem of induced abortions.

When respondents were asked on the various methods used to induce abortion, drugs usually taken in over dose elicited the highest response (73%). In addition about two fifths (43.8%) of the respondents also indicated various instruments are also used such as coat hangers. In the FGDs the main drugs mentioned were the anti-malarials, instruments mentioned were crotchets, scissors, pens and straws while the concoctions included detergents and strong teas. This implies that the respondents are mainly aware of the clandestine methods of procuring abortions.

More than a half (54.1%) of the respondents were aware of the safest period to procure an abortion by reporting that abortions should be done early (less than 3 months gestation) in pregnancy.

This was a surprising finding since a study on nurses showed that only 26-28% were aware of this provision.[55] The safest gestation for inducing abortion has been shown by the Centers for Disease

Control to be at 8 weeks. The associated morbidity rates progressively increase there afterwards. It is critical that young men recommending abortion to their female partners do so early in pregnancy in order to reduce morbidity and mortality from abortions.

Abortion is illegal in Kenya except where the life of the mother is in danger.[31] Most (86.2%) of the respondents were aware that abortion is illegal in Kenya. In the FGDs two or three participants were also aware that the law allows abortion when the mother's life is in danger - these were university students. This is an important finding in that young adults' knowledge and opinion about abortion law are likely to influence their advice on abortion. Some young people, particularly the urban youth, have access to good sources of information-such as Internet and other media and schools- that make them better informed than older people.[51]

Thus the results from this study have demonstrated that a large percentage of young men had knowledge of what an induced abortion was and its consequences, as well as of the methods used to induce the fetal loss. These finding are comparable to a study done on knowledge of college students on induced abortion in Portugal.[57]

Knowledge on abortion however did not influence the young men's perspectives towards abortion significantly ($p>0.05$). This knowledge should be translated into shared responsibilities to prevent unwanted pregnancies, which result in induced abortion and to encourage men to support the women during and after an unwanted pregnancy.

6.1.3 The role of young men in abortion.

Findings from this study indicate that 16.4% of the respondents' female partners had procured an abortion at some time. This is a high number considering the expected high level of under reporting partly due to the illegal nature of abortion in Kenya and also the stigma attached to the issue.

Slightly over half (54.1%) of these respondents indicated that they had paid for their partners abortion while a quarter of them (25.7%) indicated that they had not played any role. This non-involvement by a quarter of these male partners is one pointer to the gender in-equality in reproductive health. This non-involvement of the male partners was further supported by the FGD findings "*there are those male partners who actually run away from the girl.*" This agrees with a study done in Dar es Salaam on the role of male partners in teenage–induced abortion in which nearly 50% were prepared to pay for the partner's abortion procedure.[41] There is thus a need to integrate the men more into reproductive health issues to extend beyond paying for the services.

There was a strong significant association (O.R 0.2, p<0.000) between experience in abortion through partners' abortion and respondents perspectives towards abortion. The young men whose partners had procured abortion were more like to approve abortion. One possible explanation is that when young men are faced with a personalized situation of unintended pregnancy their perspectives are likely to change and approve of abortion.

6.1.4 Young Men's Perspectives on abortion

The young men in this study overwhelmingly disapproved of abortion. Most of the respondents, who were against argued that it was killing the unborn, were dangerous to the mother while others argued it was against their religion. This reflects a double standard by the young men. This is

because most of the single young men are sexually active but do not take an equal responsibility in preventing an unwanted pregnancy. They are also not ready to support the girl once unwanted pregnancy occurs.

When respondents were asked from their perspective why women procure abortion, the main reasons put forth were unintended pregnancy, parental pressure, inability to support the child and unmarried status with the stigma attached to it. This agrees with two studies done in Kenya that a woman seeking care for abortion related complications is likely to be single, with few or no children, less than 20 years old, in school or unemployed.[15,16] In the FGDs poverty was mentioned as the main reason for abortion *"there is no money for the baby's upkeep"*. The participants further named the girls who abort as economically unstable groups such as schoolgirls, house girls, hairdressers and barmaids. These are important reasons to be considered when designing programs to address the problem of unwanted pregnancies among the youth.

As a justification for abortion, threat to maternal life drew the most support in both spontaneous and probed responses. The circumstance of a girl being too young to be a mother and unwanted pregnancy did not draw approval on the probed responses. A similar study done to establish adolescent males' abortion attitudes in the US established that 90% agreed that abortion was acceptable if the pregnancy endangered the woman's health, 86% agreed it was acceptable if the pregnancy resulted from rape. Young men were less supportive of abortion in the event the child might be born deformed or mentally defective. These findings contrasts with a study done in the United States among college students in which abortion was reported most acceptable alternative incases of rape and physical or mental deformity of the fetus. [57] It is obvious that reasons for abortion are important to male populations and the young men are less tolerant to abortions that are

approached casually or for convenience. Though unwanted pregnancy did not draw any approval from the respondents in this study, it is interesting to note that more than half (53.4%) respondents viewed it as the main reason why girls procure abortions. This can be interpreted to mean that the young men disagree with the main reason girls give for abortion, which may further explain why a quarter of the men whose female partners had aborted had not played any role. This demonstrates conflict and lack of acceptance of responsibility. Thus approval or disapproval of abortion by the young men should be viewed as circumstantial rather than absolute.

Only a few of the respondents indicated that they would recommend abortion to a girlfriend/wife in case of unwanted pregnancy. The two main reasons why the male youth are against abortion for their own partners are that they 'could not kill their own child' and that the woman risked losing her life in the process (25.2% and 23.9% respectively). Though over half of the respondents indicated that unwanted pregnancies lead to abortion, when asked what advice they would give in case of unwanted pregnancy only 13.4% indicated that a woman should abort while 77.5% indicated that the woman should give birth. This further emphasizes the young men's strong pro-life perspective. These findings contrast the findings of a study done on the role of male partners in teenage induced abortion in Dar es Salaam in which 62.3% of the teenage girls were advised by their male partners to abort while only 15.9% were urged to carry the pregnancy to term.[41] This difference may be explained by the fact that when faced with the real case of unwanted pregnancy more young men may advocate for abortion rather than when responding to a hypothetical situation.

When respondents were asked for their views on where abortion services should be obtained most indicated public health facilities and private health facilities the main reason being availability of qualified personnel and quality services which would reduce mortality and morbidity from abortions.

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It is thus noteworthy that young men, irrespective of their perspective towards abortion, would still advocate for safe abortion services as opposed to back street abortion services provided by quacks.

Almost all of the respondents agreed that the women should consult men before they procure an abortion and when further asked whether even without their consent women should still go ahead and procure an abortion, 79.1% disagreed. This is a comparable result to a study done on adolescent males' abortion attitudes which found that 61% of the males felt that it was not right for a women to opt for an abortion if the partner objected, which was indicative of a gender conflict of interest.[16] This indicates that the young men strongly felt that their opinions should be considered before termination of a pregnancy. Thus abortion is not strictly a female issue. This was not surprising since in many developing countries men are the primary decision-makers in many reproductive health matters including on sexual activity, fertility control and contraceptive use.

Most of the respondents (82.9%) indicated that abortion was not legal in Kenya or were not aware of its legal status. Three-quarters (75.1%) of these respondents thought that abortion should not be legalized while only 15% of the respondents were for its legalization. This is comparable with the findings of a study on the views of women in which 87.3% were against its legalization and only 11.6% were for it.[55] This could be due to the poor understanding of the concept of legalization and safe abortion.

This was not a surprising finding since most Kenyans in general hold are still very conservative on issues regarding legalization of abortion. In the recent constitutional review process it was agreed almost unanimously that abortion should remain illegal, leaving the legalization debate to the pro-

abortion activists such as Federation of Women Lawyers-Kenya (FIDA) and Kenya Medical Association (KMA) carrying on with the debate.

6.1.5 Young men's suggestions on reducing the problem of induced abortions

When asked what the young men should do to reduce the problem of induced abortion, 60.1% of the single men indicated they should abstain from sex before marriage and 42.1% recommended that the male youth should use contraceptives to avoid unwanted pregnancies. The FGDs supported these findings, participants further adding that there is need for the young men to take responsibility when their partners become pregnant and marry them. Half of the respondents would want to abstain until marriage thus the young men should be equipped with life skills to help them abstain.

The respondents mainly recommended that the government should teach sex education in schools, reinforce the ban on induced abortions and avail contraceptives freely to the young men. Whereas some of the contraceptives such as the male condom are freely available they may not accessible to the youth since they are not located in 'youth friendly facilities'. This may make the youth to be unaware of their availability or be unable to access them when they need them. In addition the FGD participants felt that schools should retain girls in schools after they get pregnant. This is an important recommendation in that it may not only reduce abortions in school girls in order to continue schooling but it will also ensure that the girls who opt to keep the pregnancies resume normal schooling after delivery. However this recommendation may be there in principle, but not in practice due to the resultant stigma, which these girls may experience when they resume their schooling. In addition as demonstrated by the respondents not everyone is aware of this provision. Increasing adoption centers for babies resulting from unwanted pregnancies was also mentioned.

Surprisingly the young men did not offer any suggestions to address traditional gender roles, which lead to inequalities in power relations, which often make women vulnerable to men's risky sexual behaviors and irresponsible decisions. The only gender sensitive suggestion offered was that young men should take responsibility after pregnancy and marries the girl.

6.2 CONCLUSIONS

The main objective of this study was to assess the perspectives of young men towards induced abortion. From the study findings, it became apparent that young men overwhelmingly disapproved of abortion and preferred that their female partners give birth than induce abortions. Threat to maternal health/life and pregnancy as a result of rape were circumstances with which pro-abortion attitudes were more likely. Thus this study was able to fill an important gap on the male gender perspective on induced abortion.

The young men's religiosity strongly affects their perspectives towards induced abortion. This reflects official ecumenical views on abortion and therefore the strong attitudinal influences of the church on regular churchgoers.

Findings from this study established that young men had limited knowledge on contraceptives, especially on the emergency contraceptive pill. A number of the youth disapproved contraceptive use, which explains why some (39.1%) did not use any form of contraceptive despite being sexually active. This demonstrates that most young men may not support their female partners effectively in contraception. Hence there is an unmet need for IEC on all matters relating to contraceptives. However on contraceptives, it was only the respondent's attitudes that influenced their perspectives towards abortion significantly on logistic regression ($p<0.01$, O.R 0.4).

The study respondents were knowledgeable on various aspects of abortion although many viewed abortion as a cause of mortality and morbidity. However this knowledge did not influence their perspectives on abortion significantly.

This study also established that the young men whose female partners had procured abortions were more likely to approve abortion than those whose partners had not. This previous experience with abortion influenced their perspectives towards abortion significantly (O.R 0.2, $p<0.000$). This means that when the young men are faced with a real situation of unwanted pregnancy their perspectives towards abortion may most likely change to approval.

It also means that public attitude and private behaviour may not be the same, this is very common especially with regard to HIV/AIDS. These contradictions between stated attitudes and practiced behaviour could be best understood via gender analysis.

Suggestions from the young men to reduce the problem of induced abortion demonstrate that the young men have diverse needs. There are those whose needs are restricted to sex education, counselling, life skills building and negotiation skills to delay sexual debut while others require a wide range of FP services. It also demonstrates that young men have no practical answers to the problem as they are enclosed in their own contradictions.

6.3 RECOMMENDATIONS

1. The Ministry of Health is currently at the draft stage of a National Youth Reproductive Health and Development Policy. The policy proposals that are in line with this study recommendations are:

   - To improve accessibility of contraceptives especially the social accessibility with youth friendly health facilities offering FP services where the youth are found.

   - Advocacy for behaviour change communication (BCC) among the youth. Programs here will include life skills training to help them assess situations and possible outcomes, as well as efforts to help them identify risky sexual behaviour and its consequences.

   - The promotion of knowledge and adoption of appropriate attitudes towards abortion and related issues. Strategic (information education and communication) IEC on all aspects of abortion should be given to the young men, since most of them view abortion as a cause of mortality and morbidity to the woman and only know of the unsafe methods of doing it. This may have an effect on their perspectives towards abortion. This information may also influence their role in induced abortion and reproductive health in general to the benefit of the girls as well.

2. In addition to implementing the policy proposals the Ministry of Health should provide appropriate IEC on contraceptives and especially on the emergency contraceptive (EC) pill. The EC is relevant to the youth due to the sporadic and unplanned nature of their sexual

activity, which makes the cyclic contraceptive methods sometimes inappropriate to their circumstances.

3. The Ministry of Health together with other stakeholders such as NGOs should establish programs focusing on appropriate attitudinal change towards contraceptives by the young men, which will most likely translate to increased use of contraceptives. These programs should emphasize on shared responsibilities on contraception between young men and their partners. Increase in contraceptive prevalence rates has been shown to reduce abortion prevalence rates.

4. Focus on gender relations from an early stage of socialization and formal education is crucial. Positive change in male sexual behaviour depends on changes in gender relations and in male attitudes towards women. For this reason it is important that programs encourage young men to adopt positive gender roles such as being supportive partners and over the long term, encourage more equality between the sexes.

5. Programs targeting the young men should use a variety of approaches to provide sexual and reproductive health information such as combining this information with popular entertainment and sports.

7.0 REFERENCES

1. Stanley G. Clayton, T.L.T Lewis, G. Pinker, (1980). Ten Teachers, A Text Book of Gynecology 14th edition

2. Segal SJ., LaGuardia K.D.(1990). Termination of pregnancy-a global view. Baillieres Clinical Obstetrics and Gynaecology; 4(2): 235-47

3. Ferrando D. (1994). Peru: reproductive health, abortion and family planning, Revista Peruana De Poblacion.; (4): 123-36

4. New Perspectives on Men's Participation; (1998). Population Reports Volume XXVI, Number 2

5. World Health Organization, (1998). Division of Reproductive Health
Unsafe abortion. Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data.3rd ed.109p

6. NETWORK (2000) Family Health International volume 20 Number 3, p21

7. The world youth (2000). Population Reference Bureau, Measure Communication

8. Roudi F., Asford L. (1996). Men and Family Planning in Africa.

9. Population Council Report (2000) integrating men into the Reproductive Health Equation: Acceptability and Feasibility in Kenya

10. Himes.N.E. (1980). Medical History of Contraception. Newyork, Shocken Books,1970.521p

11. Complications of Abortion in Developing countries Population Reports Series F Number 7 p107

12 Sundstorm K. (1996). Abortion across social and cultural borders. Demography India. 25(1): 93-103

13. Van Look P.F., Von Hertzen H. (1993). Demographic aspects of induced abortion. Mini-Symposium: Therapeutic abortion. Current Obstetrics and Gynaecology.; 3:2-10

14. Kinoti et al. (1995). Addressing Complications of Unsafe Abortion in Sub-Saharan Africa

15. Rogo, K., Bohmer, L., Ombaka, C. (1999). Community level dynamics of unsafe abortion in Western Kenya and opportunities for prevention: Pacific Institute for Women's Health and Centre for Study in Adolescence

16. CRHCS. (1996) Addressing complications of abortion in sub-Saharan Africa. Program and Policy Actions. Arusha, Tanzania

17. WHO. (1995) Complications of abortions: Technical and managerial guidelines for prevention and treatment: Geneva

18. Lema V.M. and Kabeberi-Macharia, J. (1992). A review of abortion in Kenya. Centre for the study of Adolescence, Nairobi

19. Lema, V., Kamau, R.K. and Rogo, K. (1989). Epidemiology of abortion in Kenya: Centre for the study of Adolescence, Nairobi

20. Lema V. and Njau, P.W. (1990). Abortion in Kenya, Traditional approach to unwanted pregnancy. Centre for the study of Adolescence, Nairobi

21. Makokha, A.E. (1980). Maternal mortality, Kenyatta National Hospital 1972-1977 in East Africa Medical Journal, Vol. 57:451

22. Aggarwal, V.P. and Mati, J.K.G. (1980). Review of abortion at the KNH. East Africa medical journal, No. 57:138

23. Rogo, K.O. (1990) Induced abortion in Kenya. A paper prepared for IPPF. Centre for the study of Adolescence, Nairobi

24. Baker, J. and Khasiani, S. (1990). Induced abortion in Kenya: Case histories. Unpublished report

25. Aggarwal, V.P. and Mati, J.K.G. (1992). Epidemiology of induced abortion in Nairobi, Kenya. Journal of Obstetrics and Gynecology of East and Central Africa. Vol. 1:54

26. Rogo, K.O. (1996). Induced abortion in sub-Saharan Africa. Africa Journal of fertility, Sexuality and Reproductive Health. 1(1) 14-16

27. Ferguson, A.G. (1988). Schoolgirl pregnancy in Kenya. Unpublished report. MoH, Division of Family Health, GTZ support Unit, Nairobi

28. Kigondu, A.G (1986). Foreword in Rogo, K.O. (Ed) (1986) Adolescent fertility in Kenya. Centre for the study of Adolescence, Nairobi

29. Illinigumugabo, A., Rogo, K., and Njau, P.W. (1995). Sociocultural and medical consequences of adolescent pregnancies. A survey report of four rural communities in Kenya. Centre for African Family Studies, Nairobi

30. Ssenyonga, J.W. (1988). Abortion in Kenya. Case studies of the Marakwet and Samburus. Unpublished paper, Institute of African Studies, University of Nairobi

31. The laws of Kenya Cap 63:158-160

32. Marsigilio W; Shehan CL. (1993). Adolescent males' abortion attitudes: Data from a national survey. Family Planning Perspectives; 25(4): 162-9

33. Tolbert K. (1994). Abortion: what role do men, husbands and partners, play? WHO. Special program of Research, Development and Research Training on Human Reproduction.Universidad Externado de Colombia,: 47

34. Rothstein A. (1991). Male experience of elective abortion: Psychoanalytic perspectives. In: Psychiatric aspects of abortion, edited by Nada L.Stotland. Washington, D.C., American Psychiatric Press.145-58. Issues in Psychiatry.

35 Adebayo A. (1988). Male attitudes toward abortion: An analysis of urban survey data. Edmonton Alberta, Canada, University of Alberta, Dept. of sociology, Population Research Laboratory; 12p Edmonton Area series Report No.61

36. Rosenwasser S.M., Wright L.S., Barber R. (1987). The rights and responsibilities of men in abortion situations. Journal of Sex Research; 23(1): 97-105

37. Adebayo A., Nassif F. (1985). Opinions regarding abortion among male Nigerian undergraduate Students in the United States. Social Biology; 32(1-2): 132-5

38. Osborn RW., Silkey B. (1980). Husbands' attitude towards abortion and Canadian abortion law. Journal of Biosocial Science.; 12(1):21-30

39. Coleman P.K., Nelson ES. (1999). Abortion determinants of perceptions regarding male involvement in abortion decisions. Journal of American College Health; 4(4): 164-71

40. Mpagile GS; Leshabari MT; Kaaya S: Kihwele D. (1998). Abortion and unmet need for contraception in Tanzania – the role of male partners in teenage induced abortion in Dar es Salaam. African Journal of Reproductive Health; 2(2): 108-21

41. Mpangile GS; Leshabari MT; Kaaya SF; Kihwele DJ., (1994). The role of male partners in teenage induced abortion in Dar Es Salaam. (Unpublished). Presented at the conference on unsafe Abortion and post Abortion Family planning in Africa, Mauritius, March 24-28,34p

42. Dragestein B. (1994). Abortion. What does the accompanying male partner feel? Pro Familia Magazine.; (3):16-7

43. Timmerman D.(1996). May Men's role in reproductive health: Family planning is a family affair-Entre Nous; (32): 8-9

44. Meeting the Needs of Young Adults(1995) Population Reports Volume XXIII Number 3. Series J, Number 41

45. Chikamata DM. (1996). Male needs and responsibilities in family planning and reproductive health: Planned Parenthood Challenges.;(2):8-10

46. Wanjala S., Murugu NM., Mati JG. (1985). Mortality due to abortion at Kenyatta National Hospital 1974-1983. In: Abortion: Medical progress and social implications, edited by Ruth

Porter and Maeve O'Connor. London, England, Piton: 41-53 Ciba Foundation Symposium 115

47. Government of Kenya, Office of the Vice President and Ministry of Planning and National Development. (1997/2001). Kiambu District Development Plan

48. Population and Housing Census. (1999). Central Bureau of Statistics Ministry of Finance and Planning; p15

49. Woolson R. (1987), Statistical Methods for the analysis of Biomedical data. John Wiley and Sons. PP 65-70

50. Dawson.S., Manderson Land Tallo V.L (1993). A manual for the use of focus groups. W.H.O., Social and economic Research (SER)- UNDP/WORLDBANK/W.H.O Special programme for Research and Training in Tropical Diseases (TDR) International Nutrition Foundation for developing countries (INFDC) BOSTON M. A USA

51. International Family Planning Perspectives; (2002). 28(4) 205-213

52. Rukaria R.M., Sekadde-Kigondu C., Oyieke J.B.O. (1992). A Knowledge, Attitude and Practice Survey on Contraception Among Male and Female Undergraduate Students in a University in Kenya. Journal of Obstetric and Gynecology of Eastern and Central Africa. 10(2) 65-69

53. Vadies E., Hale D. (1978). Adolescent males attitudes towards abortion, contraception, and sexuality. Advances in Planned Parenthood.13 (2): 35-41

54. Muia E. (1999) Conflicting Attitudes towards the Use of Emergency Contraception by Young People in Kenya. Journal of Obstetric and Gynecology of Eastern and Central Africa: 15(1) 45-48

55. Mitula P. Women's views on adolescent induced abortion at Babadogo Nairobi. A thesis submitted in partial fulfillment for the degree of masters of in Public Health of the university of Nairobi, Department of Community Health

56. Kidula N.A., Kamau R.K., Ojwang S.B.,Mwathe E.G. (1992). A survey of the knowledge, Attitude and Practice of Induced abortion among Nurses in Kisii District, Kenya Journal of Obstetric and Gynecology of Eastern and Central Africa.10 (10) 10-12

57. De Brito R.S., De Almeida M.S, EndersB.C. (2000). Knowledge of male college students on induced abortion. Rev Bras Enferm Apr-Jun; 53(2): 173-82

58. Coleman.P.K., Nelson E.S. (1999). Abortion Attitudes as Determinants of Perceptions regarding Male involvement in Abortion Decisions: Journal of American College Health.17 (4). 164-171

APPENDIX 1 - RESEARCH PARTICIPATION CONSENT FORM

"My name is ……………………………….….. I am standing for the principal investigator from the University of Nairobi in carrying out a study on views of males on induced abortion. You have been selected by sampling as one of the respondents. All information that you give is important and shall be treated in strict confidence. You are not obliged to respond to all the questions and you may withdraw at anytime during the interview should you feel the need to do so. If you do participate, the information you give will help us to recommend policies that will be able to address the problem of unwanted pregnancies and abortions. Thank you for your co-operation"

Do you agree to participate?

Yes ______________

No ______________

Signature ______________

APPENDIX 2 - QUESTIONNAIRE

Name of village : ______________

Questionnaire number : ______________

Name of the interviewer : ______________

Date of the interview : ______________

Checked by : ______________

Date of entry : ______________

1. SOCIAL DEMOGRAPHIC DATA

1.0 Age (in completed years): ______________

2.0 Marital status:

1. Single ☐
2. Married ☐
3. Divorced ☐
4. Separated ☐
5. Widowed ☐
6. Cohabiting with girlfriend ☐

3.0 Highest grade of education attained:

1. None ☐
2. Primary ☐

3. Secondary ☐

4. College ☐

4.0 Religion:

1. Catholic ☐

2. Protestant ☐

3. Muslim ☐

4. Others ☐ ________________ (specify)

4.1 How often do you go for worship?

1. Regularly ☐ (every worship day)

2. Rarely ☐ (occasionally)

3. Never ☐

5.0 Occupation:

1. Unemployed ☐

2. Salaried employed ☐

3. Self-employed ☐

4. Student ☐

5. Others ☐ ________________ (specify)

5.1 If employed how much do you earn per month? Kshs. ________________

2. CONTRACEPTION

1.0 In your opinion, when is a woman likely to become pregnant during her menstrual ("monthly") cycle?

1. In mid-cycle ☐
2. Just before the periods ☐
3. During the periods ☐
4. Immediately after the periods ☐
5. Do not know ☐
6. Others (specify) ☐ ________________

2.0 What methods are available for men to prevent women from becoming pregnant? Multiple answers. (MA) can be provided.

1. Periodic abstinence ☐
2. Condoms ☐
3. Withdrawal ☐
4. Vasectomy ☐
5. Other (Specify) ☐ ______________

3.0 Do you approve use of family planning methods among the male youth?

1. Approve ☐
2. Disapprove ☐
3. Neutral ☐

4. Do not know

3.1 Why ____

4.0 Who in your opinion should use family planning methods?

1. Men only
2. Women only ☐
3. Either Men or women ☐
4. Both the men and women ☐
5. Other (specify) ☐ ________________

5.0 Have you ever used any of the male family planning methods?

1. Yes ☐
2. No ☐ **If no go to 5.3**

5.1 If yes, which one? (MA)

1. Periodic abstinence ☐
2. Condoms ☐
3. Vasectomy ☐
4. Withdrawal ☐
5. Other (specify) ☐ ________________

5.2 Who suggested the use of the above method to you?

1. Self ☐

2. Female partner ☐

3. Both ☐

4. Other (specify) ☐ ____________________

5.3 If no what are the reasons?

1. Do not know where to obtain them ☐

2. Never thought about it. ☐

3. Disapprove male use of contraceptive. ☐

4. Still wants to get more children ☐

5. Not sexually active ☐

6. Other (specify) ____________________

6.0 Have you ever heard of the emergency (post coital) contraceptive pill?

1. Yes ☐

2. No ☐

6.1 If (yes) when is it most effective? ____________

7.0 Do you regard your current knowledge on contraception as adequate to prevent pregnancy (conception)?

1. Yes ☐

2. No ☐

3. KNOWLEDGE ON ABORTION

1.0 Have you ever heard of abortion?

1. Yes ☐

2. No ☐

1.1 What do you understand by the term abortion?

1. Miscarriage ☐

2. Removing the baby ☐

3. Terminating pregnancy ☐ ☐

4. Washing the stomach ☐

5. Other (specify)________________

2.0 How is the problem of abortion in your community?

1. Very common ☐

2. Common ☐

3. Rare ☐

4. Do not know ☐

3.0 Where do you think abortion services are obtained? (MA)

1. Government hospitals and clinics ☐

2. Private hospitals and clinics ☐

3. Back street premises ☐

 ☐

4. Homes ☐

5. Do not know ☐

6.Other (specify) ______________

4.0 Who are the people who help one carry out an abortion in place(s) mentioned? (MA)

1. Doctors ☐
2. Nurses ☐
3. Friends ☐
4. Relatives ☐
5. Traditional doctors ☐
6. Others (specify) ☐ ______________

5.0 What methods are used to induce an abortion? (MA)

1. Taking herbs ☐
2. Over dosage of certain drugs ☐
3. Using instruments to destroy the fetus ☐
4. Do not know ☐
5. Others specify ☐ ______________

6.0 What are the likely adverse (after effects) of abortion to the woman? (MA)

1. Death ☐

☐

2. Disability

3. Permanent loss of fertility ☐

4. Infections ☐

5. Psychological ☐

6. Others (specify) ____________________

7.0 At what stage of pregnancy is it safest to abort?

1. Early in pregnancy ☐

2. Mid pregnancy ☐

3. Late pregnancy ☐

4. Do not know ☐

5. Others (specify) ☐ ____________________

4. MALE INVOLVEMENT IN ABORTION

1.0 Who makes the decision to abort?

1. Women ☐

2. Men ☐

3. Both men and women ☐

4. Parents ☐

5.Other (specify) ☐ ____________________

2.0 What role do the male partner play in abortion procurement? (MA)

1. Coercing the female to have an abortion ☐

☐

2. Paying for the abortion

3. Accompanying the females to abortion clinic ☐

4. Psychological support after the abortion ☐

5. None

6. Do not know ☐

7. Other specify ____________________

3.0 Has any of your girlfriends/spouse ever had an induced abortion?

1. Yes ☐

2. No ☐

3.1 What role did you play?

1. Coerced the female to have an abortion ☐

2. Paid for the abortion ☐

3. Accompanied the females to abortion clinic ☐

4. Psychological support after the abortion ☐

5. None ☐

6. Others (specify) ____________________

5. PERSPECTIVES

1.0 Do you approve of abortion?

☐

1. Yes

☐

2. No ☐

☐

3. Neutral

4. Do not know ☐

1.1 Why? ____________

2.0 What is your view towards a woman who has had an abortion?

1. Positive ☐

2. Negative ☐

3. Neutral ☐

4. Do not know ☐

2.1 Give reasons for your answer ____________

3.0 Under what circumstances would you support abortion? (MA)

CIRCUMSTANCE	Spontaneous	Probe
1. If a woman was raped		
2. Threat to maternal mental health e.g. depression		
3. If there is no male support		
4. If there is contraceptive failure		
5. Inability to support child		
6. Unmarried mother		
7. Threat to maternal life		
8. If there is a chance the child will be born deformed (mentally/physically)		
9. If the woman has enough children		
10. If a girl is in school		
11. Parental pressure		
12. None		
13. Others (specify)		
Score		

4.0 Would you recommend abortion to a girlfriend/wife?

1. Yes ☐

2. No ☐

3. Not sure ☐

4.1 Why ______________________________

5.0 In your view, if a woman got unwanted pregnancy what should she do?

____

6.0 In your opinion where should abortion services be obtained if a woman decides on procuring an abortion?

1. Government hospitals and clinics ☐

2. Private hospitals and clinics ☐

3. Back street premises ☐

4. Do not know ☐

5. Others (specify) ____________ ☐

6.1 Why? ________________________________

7.0 In your opinion what role should men play in induced abortion?

1.Coercing the female to have an abortion ☐

2. Paying for the abortion ☐

3. Accompanying the females to abortion clinic ☐

4. Psychological support after the abortion ☐

5. None ☐

6. Others (specify) ______________________ ☐

8.0 Should a woman consult her boyfriend/spouse if she intends to abort?

1. Yes ☐

2. No ☐

3. Do not know ☐

9.0 Even without the man's consent should the woman still procure an abortion if she feels the need to do so?

1. Yes ☐

2. No ☐

3. Do not know ☐

10.0 From your perspective, why do you think women resort to abortion? (tick what is mentioned) (MA)

1. Unwanted pregnancy	
2. If raped	
3. Threat to maternal health	
4. If there is no male support	
5. If there is contraceptive failure	
6. Inability to support child (financial instability)	
7. The social stigma attached to single motherhood ('shame')	
8. Threat to maternal life	
9. If there is a chance the child will be born deformed (mentally/physically)	
10. If a girl is in school	
11. If the woman has enough children (reached desired family size)	
12. Parental pressure	
13. Other (specify)	
Score	

11.0 Is abortion legal in Kenya?

1. Yes ☐ ------ **If yes go to no.12**

2. No ☐

3. Do not know ☐

11.1 If (No)/do not know, should abortion be legalized?

1. Yes ☐

2. No ☐

11.2 Give reason for your answer ______________________

12.0 In your opinion what should young men do to reduce the problem of abortion among the youth? (MA)

1. Abstain from sex ☐

2. Use family planning methods ☐

3. Do not know ☐

4. Others (specify)________________ ☐

13.0 What should the government do to reduce the problem of abortion among the youth? (MA)

1. Sex education should be taught in schools ☐

2. Contraceptives should be readily available to the youth ☐ ☐

3. Safe abortion should be available to the youth ☐

4. Abortion should be legalized ☐

5. Ban on abortion should be enforced ☐

6. Do not know ☐

7. Others (Specify)________________________

14.0 Would you like to learn more about abortion and related issues?

1. Yes ☐

2. No ☐ If (No) end the interview

14.1 If (yes) what would you like to know? ____________________

15.0 Which is your preferred source of this information? (MA)

1. Radio ☐
2. Television ☐
3. Health facility ☐
4. News papers ☐
5. Posters ☐
6. Magazines ☐
7. Relatives ☐
8. Friends ☐
9. Schools ☐
10. Wife/girlfriend ☐
11. Church leaders ☐
12. Others (Specify) ☐ ______________________

APPENDIX 3

FOCUS GROUP DISCUSSION (FGD) MODERATOR'S GUIDE

Introduction:

Thank you for coming. I am Kenneth Ngure from the University of Nairobi. With me is ---- ____ from _____. The purpose of this discussion today is to learn what you think about termination of pregnancy (abortion). The information you provide will help in planning for ways of reducing the problem of abortion.

I would encourage you to speak as freely and frankly as possible. The responses you give in this discussion will be confidential. We would also like to record your answers both by writing and using a tape recorder to help in the analysis of your answers. Do you mind this?

Please note that there is no direct benefit in participating except that the information will be useful to policy makers.

The discussion will take about one hour. Do you all agree to participate in this discussion? Note that you may leave at any time during the discussion.

1. **Preamble**
   - What are the common health problems in the community?
   - What are the common reproductive health problems?

- What are the consequences of unwanted pregnancies?
- What is the magnitude of the problem of abortion in this community?
- Among whom are abortion cases most prevalent? (Probe on age, income, educational status)
- Why are abortions common among this group(s)? (Identify the common characteristics)

2. Abortion

- What are the different reasons why a woman terminates pregnancy? (Probe on reasons that are men related)
- Where do women go to obtain abortion services? (Probe on cost, quality and accessibility)
- Who conducts abortion?
- How are abortions conducted? (Probe on both traditional and modern methods)
- Who do young men talk to get advise on what to do if their girlfriends have unwanted pregnancies?
- What is it that men fear about abortions?
- What role do men play in abortions? Explain.
- How do men perceive a woman who has procured an abortion? (Probe on the reasons for this perception)
- What does the current Kenyan Law State on abortion?
- What is your opinion on this law?

3. **Recommendations**

- What should young men do to reduce the problem of induced abortion?
- How can we get the male youth to participate more in reproductive health?

APPENDIX 4

CONTRACEPTIVE KNOWLEDGE SCORE SHEET

Questions	**No knowledge** **(Zero points)**	**Good knowledge** **(2 points)**
Fertile period in a woman's menstrual cycle	DNK	Option1 (Mid-cycle)
Male contraceptive methods	DNK=0 points One method =1 point	2 or more methods
Ever heard of emergency contraceptive pill	No	Yes
When is the emergency contraceptive pill most effective	DNK/Any other option	Option 3 (Immediately after intercourse)

Notes:

1. **This score sheet was purposed to separate the participants arbitrarily into two groups those with good knowledge and inadequate knowledge only for the purpose of cross-tabulation.**
2. **It is based on a point system.**
3. **Those with good knowledge answered rightly to two or more options hence scoring 4 or more points.**
4. **Those with poor knowledge scored less than 4 points.**

APPENDIX 5

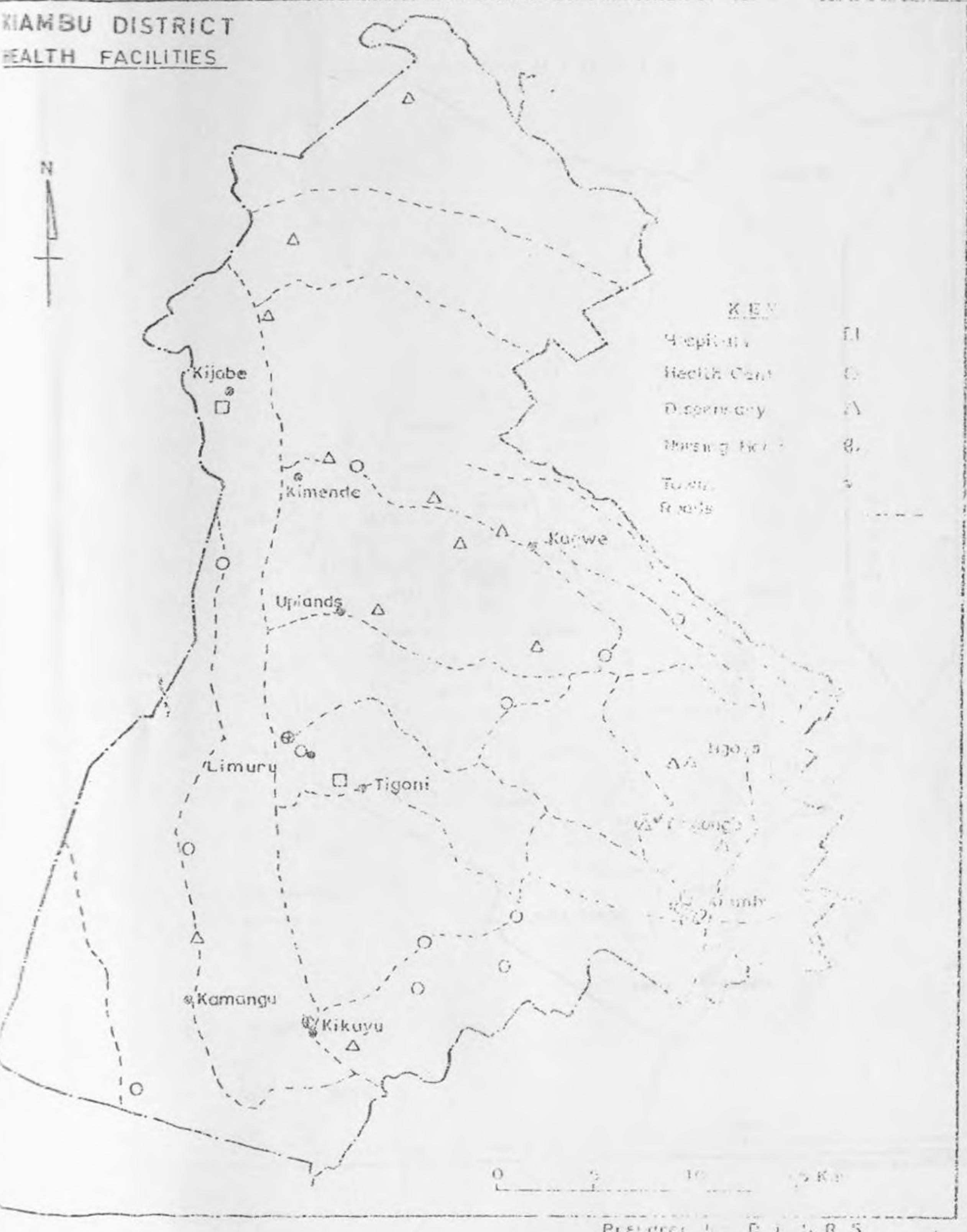
ABORTION KNOWLEDGE SCORE SHEET

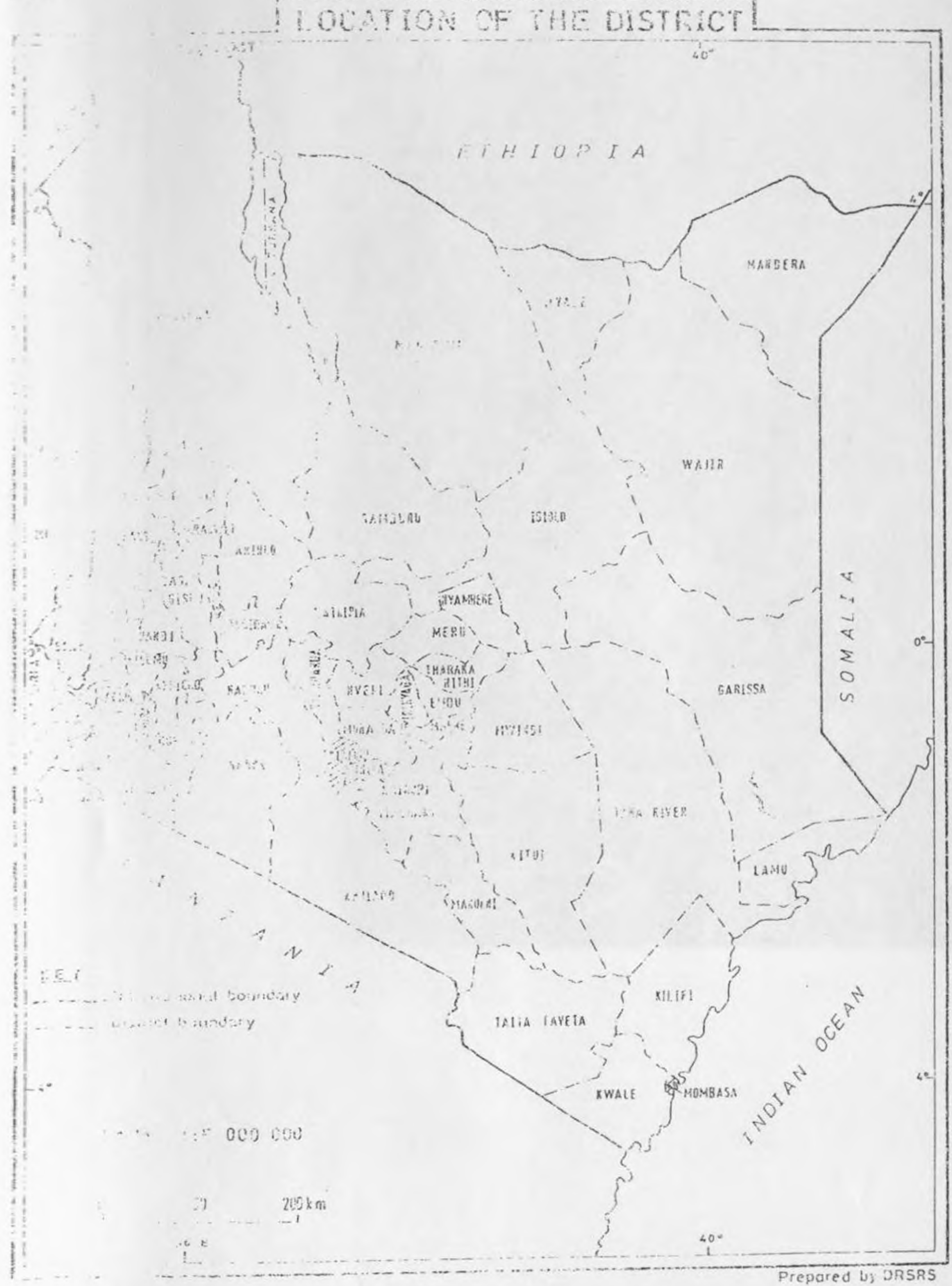
Questions	No Knowledge (Zero points)	Moderate knowledge (One point)	Good knowledge (Two points)
Ever heard of abortion	No		Yes
Understanding of the term abortion	Do not know	Other options	Option 3 (Terminating pregnancy)
Where abortion services are obtained	Do not know	Any one option	More than one option
Persons who perform abortion	Do not know	Any one option	More than one option
Methods used to induce abortion	Do not know	Any one option	More than one option
Adverse effects of abortion	Do not know	Any one option	More than one option
Safest stage to abort	Do not know	Other options	Option one (Early pregnancy)
Legality of abortion in Kenya	Do not know	Legal	Not legal

Notes:

1. This score sheet was purposed to separate the participants arbitrarily into three groups those with no knowledge, poor knowledge and good knowledge. Only for the purpose of cross-tabulation.
2. It is based on a point system.
3. Those with no knowledge scored zero points.
4. Those who scored less than 8 points had moderate knowledge.
5. Those with good knowledge scored 8 or more points.

No. 6





Prepared by DRSRS

CONDITIONS

1. You must report to the District Commissioner of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least ~~four (4)~~ two bound copies of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.

GPK 7092—6m—11/96

REPUBLIC OF KENYA

RESEARCH CLEARANCE PERMIT

(CONDITIONS—*see* back page)

PAGE 2

THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss KENNETH KAIRU NGURE

of (Address) NAIROBI UNIVERSITY

P.O. BOX 30197, NAIROBI

has been permitted to conduct research in

Location,

KIAMBU District,

CENTRAL Province,

on the topic PERSPECTIVES OF MALE YOUTH ON INDUCED ABORTION

for a period ending 31ST DECEMBER19 2002

PAGE 3

Research permit No. MOES&T 13/0

Date of issue 14-06-2002

Fee received SHS 500

Applicant's Signature

A. C. KA

For Permanent Secretary

Ministry of Education Science and Technology

FOR Permanent Secretary

Office of the

EDUCAT

P. O. Box 30040, Nairobi

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

Telegrams: "EDUCATION", Nairobi
Telephone: Nairobi 334411
When replying please quote
Ref No. MOES&T 13/001/32C108/3
and date

JOGOO HOUSE "B"
HARAMBEE AVENUE
P.O. Box 30040
NAIROBI

14th June, 2002

Kenneth Kairu Ngure,
Nairobi University,
P.O. Box 30197,
NAIROBI.

Dear Sir,

RE: RESEARCH AUTHORISATION

Please refer to your application for authority to conduct research on "Perspectives of Male Youth on Induced Abortion". I am pleased to inform you that you have been authorised to conduct research in Kiambu District for a period ending 31st December, 2002.

You are advised to report to the District Commissioner and the District Education Officer, Kiambu District before embarking on your research project.

You are further advised to avail two copies of your research findings to this office upon completion of your research project.

Yours faithfully,

A.G. KAARIA
FOR : PERMANENT SECRETARY/EDUCATION

cc

The District Commissioner
Kiambu District

The District Education Officer
Kiambu District

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25th June, 20 02

All District Officers
KIAMBU DISTRICT

RE RESEARCH AUTHORISATION - KENNETH KAIRU NGURE

This is to inform you that the above named who is a student at the University of Nairobi is authorised to conduct a research on "Perspectives of Male Youth on Induced Abortion" in this District for a period ending 31st December, 2002.

Please accord him the necessary assistance to enable him complete his project in time.

DISTRICT COMMISSIONER
P.O. Box 32
KIAMBU

J. K. MAIKARA
for DISTRICT COMMISSIONER
KIAMBU

CC

District Education Officer
KIAMBU

Medical Officer of Health
KIAMBU

MINISTRY OF EDUCATION SCIENCE AND TECHNOLOGY

DISTRICT EDUCATION OFFICE
P O BOX 9
KIAMBU.

KBU/107/VOL.9/212

24th June, 2002

TO WHOM IT MAY CONCERN

This is to confirm that Mr. Kenneth Kairu Ngure of University of Nairobi has been given authority to conduct research on"Perspectives of Male Youth on Induced Abortion". The research will be conducted in the following locations of this district;

1. Kiambaa location
2. Karuri sub-location
3. Muchatha sub-location

Any assistance accorded to Mr. Ngure will be high appreciated.

PETER A.G. NAMU
for: DISTRICT EDUCATION OFFICER - KIAMBU

c.c.

The District Commissioner
KIAMBU DISTRICT.

The District Officer
KIAMBAA DIVISION