Role of social interpersonal communication in abortion decision making among Kenyan women

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Abstract-This study sought to examine the role of social interpersonal communication in influencing one's subjective norm and subsequently, decision making on abortion among Kenyan women. The study population was women aged between 18-49 years seeking post abortion care at various health facilities in Nakuru County. A mixed method survey research approach was adopted with quantitative data being collected using a semi-structured questionnaire and an interview guide for qualitative data. 228 were filled while 10 In-depth interviews were conducted to compliment the quantitative data. Convergent parallel data analysis was done to identify areas of similarities and contradictions. The study concluded that social interpersonal communication is significant in influencing decision making on abortion in Kenya women of reproductive.

Index Terms- Social interpersonal, Subjective norm, Post Abortion Care, decision making on abortion.

I. Introduction

Abortion is a controversial and prohibited topics in many African countries due to, cultural, social, moral, religious, and political dimensions (Van Look and Cottingham, 2002). Women and girls in Kenya face numerous barriers to controlling their fertility, experience high rates of unintended pregnancy and commonly encounter stigma associated with unintended pregnancy and abortion (Kamari, Izugbara, Ochako 2013). There is limited research on the communication dynamics taking place during a pregnancy crisis and how they arrive at the decision to either procure an abortion or keep the pregnancy. Rehnström, Lindgren and Faxelid (2018) note that gaps exist in knowledge regarding women's decision-making processes in relation to induced abortions in Kenya, with majority of the studies focusing on biomedical perspective, effects of unsafe abortion and psychological effects of abortion. However, according to the theory of planned behaviour, people's evaluations of a behaviour is determined by the subjective probability that the behaviour will produce a certain outcome. (Ajzen, 1975). Subjective norm is the perceived social pressure on an individual to execute a specific behaviour from people they consider important to them. Perceived social pressure can therefore lead to social isolation, social rejection and internalised shame.

In this study. Social interpersonal communication was measured by establishing the number of people living in the study subject's household, the relationship of the study subjects to the members of the household, the first person the study subjects consulted in case of a problem, which social groups the study subjects belonged to and with whom they discuss about their pregnancy. Decision making on abortion was measured by establishing the subjective norm i.e. the influence from other people on their decision making on abortion.

II. Material and Methods

2.1. Study design

A cross-sectional survey research design was applied where data on social interpersonal communication was collected. Specifically, the study employed a Convergent Parallel research method which aided the researcher in arriving at an integrated summary of the predictors (quantitative research), and views and personal experiences (qualitative research) on decision making on abortion.

2.2. Study area and population

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The site of study was Nakuru County and the study population was women of reproductive age (18-49 years) seeking post abortion care after at four health facilities. . However, respondents not willing to participate were excluded from the study.
To determine the study population, this research considered data collected in Kenya using the Abortion Incidence Complications Methodology (AICM) and the Prospective Morbidity Survey (PMS). The data indicated that an estimated that 38,567 of the 119,502 (32%) induced abortion complications treated in Kenya in 2012 were from the Rift Valley. (Mohamed, Izugbara, Moore, Mutua, Kimani-Murage, Ziraba, Bankole, Singh, & Egesa. 2015).

2.3 Sampling

A sample size of 367 was arrived at for quantitative and 10 key in depth interviewees all comprising of Post Abortion Care clients. According to Guest, Bunce, & Johnson (2006) a sample of 6 interviews may be sufficient to enable development of meaningful themes and useful interpretations.
This study employed a purposive (judgemental) non probability sampling technique to obtain only the hospital clients who were seeking post abortion care (PAC) after having an induced abortion. According to Patton (1990) it is important to select "information-rich cases for in depth study. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposive sampling" (p. 169).
Health providers identified the patients willing to participate in the study after they received treatment. Data collection process took a total of 8 months since number of patients attended with abortion complications could not be determined beforehand. The research team therefore had to be stationed at the faculties and recruited respondents on a continuous basis until a reasonable sample achieved. In this study, 10 in-depth interviews were conducted with PAC clients.

2.4 Data collection, Processing and Analysis

The quantitative data on social interpersonal communication and decision making was collected from the post abortion care clients using a semi structured questionnaire. The tool was self-administered whereby women of reproductive age accessing post abortion care at the health facilities filled out the questionnaires by themselves. According to Campbell et al., (1999) use of self-administered questionnaires is particularly useful in collection of data on sensitive topics such as sexual behaviour**.** On the other hand, qualitative data was collected using an in-depth interview guide that comprised of open ended questions to capture a more detailed perspective of the subject.
The study employed the binary logistic regression method to conduct multivariate analysis. The regression was conducted at 95% confidence interval and interpretation done using odds ratios, confidence intervals and p-values.
Qualitative data from 10 in-depth interviews with PAC clients were summarized based on thematic areas. Parallel convergence data analysis was employed.

2.5 Ethical Consideration

Ethical clearance for the study was sought from Kenyatta National Hospital Ethics and Research Committee, National Commission for Science, Technology and Innovation Nakuru County Commissioner, County Director of Education, County Director of Health and the respective heads of participating health facilities.

III RESULTS AND DISCUSSION

3.1 Response Rate

Out of the 340 questionnaires administered, a total of 228 women (67%) agreed to participate in the study. According to Babbie (2004) response rates of 60% is good. 10 women seeking PAC services were identified and consented to participate in the in-depth interviews.

3.2 Social interpersonal communication with family, peers and social group members

Respondents in the study were asked to indicate the number of people they lived with in the same household. Table 3.1 presents the findings.

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Table 3.1: Members of Household

Category	Frequency (n)	Percentage (%)
One	12	5
Two	6	3
Three	42	18
Four	30	13
Five	30	13
Six	66	29
Seven	24	11
Eight	18	8
Total	**228**	**100**
Descriptive statistics		
Mean = 5	Variance = 3.3656	Coeff. of Var = 37.08%
Mode = 6	Std. dev = 1.8346	

The mean number of persons per household was 5 (mean = 5). Most of the households had 6 people (Mode =6). However, the distribution was associated with significant disparities with 37.08% variation about the mean.

The study also enquired whom the women consulted when they had a general problem.

Table 3.2: Consultation in case of a general problem

Individual	Frequency	Percent
Husband/boy friend	54	24
Friend	108	47
Mother	30	13
Father	12	5
Sister	6	3
Brother	6	3
Grand parent	6	3
In laws	6	3
Total	**228**	**100**

As shown above, women in Nakuru mainly consulted a friend (47%) in case of general problems. Immediate family members were the least consulted.

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Membership in social groups
The study sought to find out the social group the respondents belonged to. Results are as shown in Figure 3.1

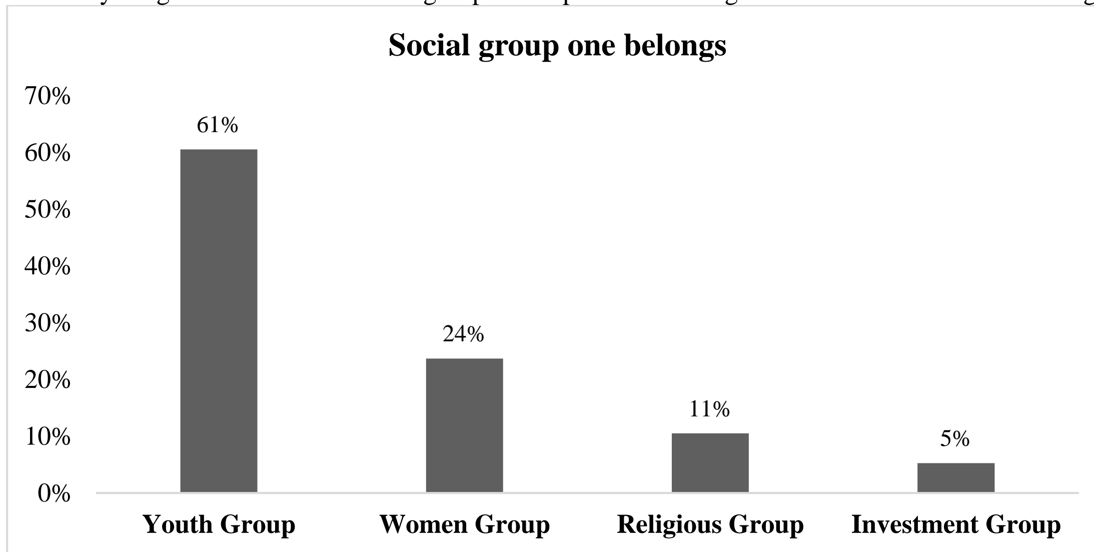

Figure 3.1: Social Group

Figure 3.1showed that 61% of the respondents belonged to youth groups, 24% were in women groups, 11% belonged to religious groups while 5% were members of investment groups, meaning that all the respondents belonged to a social network group. This confirms the importance of social groups and the need to belong and conform in society. These findings agreed with those of Gayen and Raeside (2010) who found that the informal social networks of women are important even in influencing their behaviour including contraception use.

3.3 Consulting on abortion
Respondents were further asked to indicate whether they had consulted anyone during their decision making to terminate their pregnancy. Results are presented in Figure 3.2

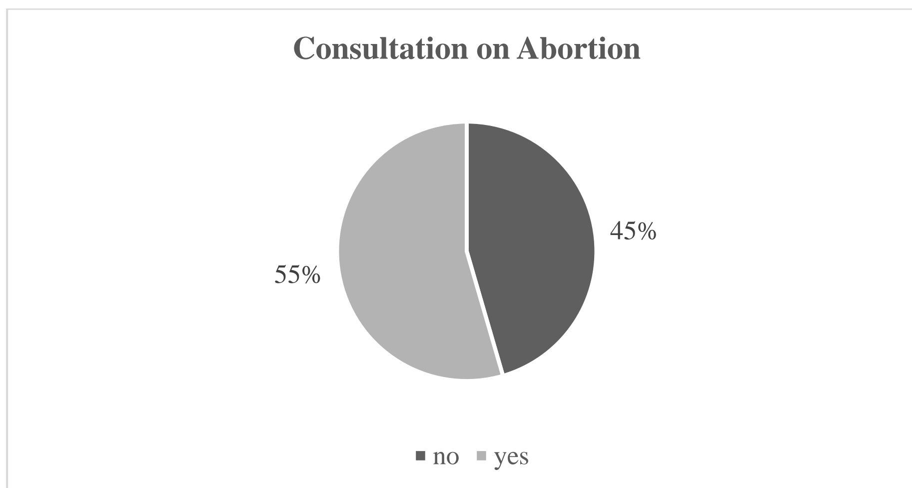

Figure 3.2 Consultation on Abortion Decision

Figure 3.2 illustrates that 126 (55%) of respondents consulted someone on the decision to terminate the pregnancy while 102 (45%) did not consult anyone on the same decision These findings disagree with Puri, Ingham and Matthews (2007) that women, did not reveal unintended pregnancies and abortion intentions to their husbands, families, or friends and that instead some tried to secretly self-induce abortion.

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Respondents reporting having consulted someone on the decision to terminate the pregnancy were further asked to state the person who they consulted. Table 3.3 presents the findings.

Table 3.3: Persons Consulted on Abortion Decision

Person(s)	Frequency	Percent
Friend	66	52
Health provider	18	14
Husband/boyfriend	24	19
Relative	18	14
Total	**126**	**100**

The results revealed that out of the 126 that consulted 52% of the respondents consulted their friends on decision to terminate the pregnancy, 14% consulted health provider and relatives while 19% consulted their boyfriends.
These findings agreed with those of Harries (2007) who found that women in the process of making a decision to have abortion avoided discussions with the partner and instead talked to women friends and their mothers perceiving them to be more understanding and supportive.

3.4 Subjective norm
The study went further to establish the perceived social impact on women with unplanned pregnancies and weather this influenced their decision to terminate the pregnancy. Respondents were requested to indicate their levels of agreement on a five-point likert scale. (1 = strongly disagree, 2 = Disagree 3 = Neutral, 4 = Agree, 5 = strongly agree) was used. For the purposes of interpretation 4 and 5 (agree and strongly agree) were grouped together as agree, 1 and 2 (strongly disagree and disagree) were grouped as disagree while 3 was neutral. The results of this study are as depicted in Table 3.4.

Table3.4: Perceived Social Impact

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
It is a taboo in my family for a young woman to have a baby out of wedlock	0 (0%)	7 (3%)	11 (5%)	141 (62%)	68 (30%)
It is a taboo in my community for a young woman to have a baby out of wedlock	7 (3%)	14 (6%)	30 (13%)	134 (59%)	43 (19%)
It is a taboo in my religion for a young woman to have a baby out of wedlock	7 (3%)	18 (8%)	18 (8%)	160 (70%)	27 (12%)
Termination of pregnancy is due to fear of punishment, rejection and isolation in, my family level	0 (0%)	18 (8%)	0 (0%)	134 (59%)	75 (33%)
Termination of pregnancy is due to fear of punishment, rejection and isolation by my spouse/boyfriend	0 (0%)	73 (32%)	30 (13%)	98(43%)	30 (13%)
Termination of pregnancy is due to fear of punishment, rejection and isolation in my social group	5 (2%)	68 (30%)	5 (2%)	125 (55%)	23(10%)
Termination of pregnancy is due to fear of punishment, rejection and isolation in my religious group	7 (3%)	43 (19%)	18 (8%)	137 (60%)	23(10%)

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Table 3.4 shows that 92% of all the respondents agreed that having a baby out of wedlock was a taboo in their family, 78% agreed that it was a taboo in their community and 82% agreed that it was a taboo for a young woman to have a baby out of wedlock in their religion. This confirms that there are social dilemmas that face society in terms of normative behavior of having a child out of wedlock. (Hyam, 2002).
Majority of the respondents (92%) reported fear of punishment, rejection and isolation at the family level as the reasons for termination of pregnancy. The findings are in tandem with Fife and Wright (2000) who asserted that perceived social impact included social isolation i.e., feelings of loneliness, uselessness and inferiority to peers and others; social rejection i.e., feelings of stigma and discrimination at work and in society generally; and internalised shame, i.e., the psychological experience of social rejection.
The results further showed that 55% of the respondents agreed that termination of pregnancy was due to fear of punishment, rejection and isolation by their spouse/boyfriend. The findings are in agreement with responses from the case studies where the respondents gave various reasons for terminating the pregnancies.

Respondent: "I *was not going to face my parents with yet another baby even before I am done with school. My boyfriend promised to take care of me but I couldn't trust him to do so considering he didn't last time".* On the other hand, Lucy said *"Fear of dropping out of school and being chased away from home"*

These findings agreed with that of Loeber (2008) who found that the commonest reason why women decided to have abortion was because of relationship problems. Rejection from a man pushed the woman into opting for abortion. The study suggests that if close social contacts (spouse, boyfriend) are not pleased with the pregnancy or the relationship a decision for abortion may be made.
The results further showed that majority of the respondents 65% of the respondents agreed that termination of pregnancy was due to fear of punishment, rejection and isolation in their social group. These findings agreed with that of Engelbrecht (2005) who found that unwanted pregnancy causes an internal distress with the fear of rejection from parents as well as the social stigmatism that goes with being a teenager and pregnant.
The results further showed that 70% of the respondents agreed that termination of pregnancy was due to fear of punishment, rejection and isolation in their religious group. Finally the respondents were asked if they had an abortion due to fear of the negative impact from family and friends because of an unplanned pregnancy by responding with either agree or disagree.

Table 3.5: Respondents overall perceived social impact

Variable	Category	Frequency (n)	Percentage (%)
	Total	**228**	**100**
Abortion due to fear of negative impact	Agree	126	55
	Disagree	102	45
	Total	**228**	**100**

Table 3.5 shows that 55% of respondents agree that they feared the social impact they would have to face from family and friends if they were discovered to be pregnant. These findings agreed with that of Levandowski (2012) who argued that the main reason for women to terminate the unwanted pregnancy was due to stigma and fear of rejection in the society.
It was also clear that from the case studies the respondents indicated that cultural values had a role to play in the decision to terminate pregnancy. Some of these cultural values were as stated:

Respondent 1: "*the community will see me as a loose girl if I have 2 babies while still at home"* another
Respondent 2: *"… the cultural values played a big role in decision making very much, even though it is said that somebody can get a baby then come back to school, getting a baby before finishing school is still a big thing and most girls do not even come back."*

3.5 Social interpersonal communication and decision making on abortion

Decision making on abortion was measured using subjective norm. The outcomes association with social interpersonal communication were measure using the Pearson chi-square test of association at 95% confidence level. P-values less than 0.05 for the independent and dependent variables were considered statistically significant at 95% confidence level.

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Table 3.6: Association between social interpersonal communication and subjective norm

Social interpersonal communication verses attitude towards abortion	P-Value	Test Statistic, Pearson Chi (df)
Relationship with members of household	<0.0001	49.42 (6)
First person to consult in case of a problem	<0.0001	22.93 (5)
Social group one belongs to	0.001	16.85 (3)
Whom you discuss about their pregnancy	0.002	14.64 (3)

Table 4.3 represents the association between social interpersonal communication and subjective norm. Subjective norm was measured based on people considered importance to the respondents to the point of influencing their decision-making on abortion. The relationship with members of the household and the first person the respondents consult in case of a problem were highly significantly associated with the subjective norm (P-value = <0.0001). In addition, social group they belong to and whom they discuss about their pregnancy was also significantly associated with the subjective norm (P-value = 0.001 and 0.002) respectively. The findings also agree with those from the in-depth interviews who indicated in regards to whose views mattered most in the decision to carry a child to term or terminate before term were Participant 1: "*My parents. Though not directly, their reaction and actions speak loudly", and Participant 2; "My family and friends"*

3.5 Logistic regression analysis between health message exposure and decision making on abortion

Multivariate analysis for the significant variables was used to examine the influence of social interpersonal communication and subjective norm through binary logistic regression.

Table 3.5: Influence of social interpersonal communication on subjective norm

Characteristic	Odds ratios	P-value	95% Confidence Interval
Relationship with members of household			
Husband (Reference)	1		
Friend/Peer	0.667	0.491	0.210-2.116
Mother	0.067	<0.0001	0.019-0.238
Father	0.444	0.151	0.147-1.346
Sister	1.000		
Children	0.278	0.016	0.098-0.788
Grand parent	1.000		
First person to consult in the family in case of a problem			
Husband (Reference)	1		
Mother	1.257	0.498	0.649-2.436
Father	0.533	0.174	0.214-1.320
Sister	0.267	0.015	0.092-0.776
Brother	1.000		
Grand parent	1.000		
Social group one belongs to			
Youth group (Reference)	1		
Women group	0.804	0.501	0.425-1.518
Religious group	0.643	0.320	0.269-1.535
Investment group	1.000		
Whom you discuss with about your pregnancy			
Spouse (Reference)	1		
Friend/Peer	3.333	<0.0001	1.725-6.441
Family member	4.000	0.016	1.290-12.402
Group member	2.000	0.283	0.564-7.087

Table 3.5 shows how social interpersonal communication influenced subjective norm. Subjective norm was measured by respondents reporting whether people of importance to them influenced their intention to procure an abortion. A respondent with close relationship with the mother is 93 percent less likely consider approval by other people of importance to them on their decision making on abortion (OR=0.067; 95% CI=0.019-0.238) compared to a respondent whose close relationship is with a husband. In addition, a respondent whose close relationship is with their children is 72 percent less likely to consider approval by other people of importance to them on their decision making on abortion (OR=0.278; 95% CI=0.098-0.788) compared to a respondent with close relationship with a husband.

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In terms of consulting when there is a problem, a respondent who first consults the sister in case of a problem is 73 percent less likely to have approval by people of importance to them on their decision making on abortion(OR=0.267; 95% CI=0.092-0.776) compared one who first consults the husband.

IV. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The study findings indicated that a majority of the respondents consulted their friend in case of a general problem, belonged to a youth group, discussed with their friends about their pregnancy. Subjective norms, which are the perceived social pressures, communicated verbally and none verbally was major push factors in abortion decision-making process. The pressures included fear of bringing shame to the family, isolation from peers in the society and rejection by partner. It is for the same reasons that the women opted to seek services in facilities that were far from where they lived. These study findings further indicated that communicating with self and with others within one's social networks to arrive at a decision on how to proceed therefore was inevitable and hence affected the decision-making phase, making the process dynamic and situation specific. This therefore implies that decision making on abortion is as a result of intra and interpersonal communication at various stages. Those involves in the process include peers, friends, husbands, boyfriends, family members, those of the same religion, social groups and even the health providers.
Logistic regression analysis results revealed that social interpersonal communication influenced decision making on abortion. Specifically, the social group that one belonged to, the relationship with members of the household, first person to consult in case of a problem and whom the respondents discussed with about their pregnancy influenced subjective norm.

The study concludes that social interpersonal communication greatly influences the decision making on abortion and that all women want to belong. The fear of rejection and isolation among other social sanctions and the need to conform to societal expectations overrides the need for personal health safety.

Recommendations

There is need for community groups to understand the role they are playing in pushing women to have abortions. This will help shift the focus from the women who are viewed as victims, to addressing the push factors like stigma towards women with unplanned pregnancies. This can be achieved through community health communication campaigns in religious groups and women and youth groups, schools and families.
In addition, interpersonal approaches that engage community leaders and influencers may counteract negative social norms and associated stigma. Collaborative actions of government, NGOs and private partners should capitalize on this potential power of communities to reduce abortion among women and teenager girls.

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