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## Person-centred care for abortion services in private facilities to improve women's experiences in Kenya

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### ABSTRACT

Globally, access to good quality abortion services and post-abortion care is a critical determinant for women's survival after unsafe abortion. Unsafe abortions account for high levels of maternal death in Kenya. We explored women's experiences and perceptions of their abortion and post-abortion care experiences in Kenya through person-centred care. This qualitative study included focus group discussions and in-depth interviews with women aged 18-35 who received safe abortion services at private clinics. Through thematic analyses of women's testimonies, we identified gaps in the abortion care and person-centred domains which seemed to be important throughout the abortion process. When women received clear communication and personalised comprehensive information on abortion and post-abortion care from their healthcare providers, they reported more positive experiences overall and higher reproductive autonomy. Communication and supportive care were particularly valued during the post-abortion period, as was social support more generally. Further research is needed to design, implement and test the feasibility and acceptability of person-centred abortion care interventions in community and clinical settings with the goal of improving women's abortion experiences and overall reproductive health outcomes.

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### KEYWORDS

Abortion; post-abortion care; quality of care; person-centred care; patient experience; Kenya

## Introduction

Globally, access to quality abortion and post-abortion care is a critical determining factor for women's survival after an abortion. Deaths related to unsafe abortions have been estimated to account for approximately 35% of maternal deaths in Kenya, which is more than double the global percentage and that of East Africa (Magadi 2003; Evens et al. 2014). Access to abortion is still considered highly restricted in Kenya, and only permitted, if in the opinion of a trained health professional, there is need for

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emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law (Constitution of Kenya 2010).

In a study conducted in 2012, it is estimated that 464,000 women in Kenya had abortions in facilities (Mohamed et al. 2015). However, abortion incidence data remains sparse. Other research finds that women who delayed care due to perceived unsafe abortions and inadequate post-abortion care had disproportionately more severe post-abortion complications such as death, sepsis, shock, organ or system failure, generalised peritonitis and tetanus (Ziraba et al. 2015). One potential strategy to increasing safe abortion care is to improve women's experiences during abortion services. Women with positive abortion and post-abortion experiences can potentially increase both demand for and access to safe abortion services by raising awareness of the existence and desensitising the utilisation of high-quality abortion and post-abortion care, which could increase the likelihood of women seeking safer and earlier abortion-related services. Therefore, efforts to improve the clinical quality of abortion-related procedures and improve women's experiences during abortion and the post-abortion care period are critical to reducing preventable maternal deaths and morbidities from abortion-related procedures.

Global recognition of person-centred care is growing and plays a particularly crucial role in improving the quality of reproductive health services (Sudhinaraset et al. 2017) and could potentially improve the quality of abortion care. Sudhinaraset et al. (2017) define person-centred care for reproductive health as care that is, "respectful of and responsive to individual women and their families' preferences, needs, and values, and ensuring that their values guide all clinical decisions of a woman." Much of the recent literature on person-centred care focuses on maternity care and family planning services (Afulani et al. 2017; Sudhinaraset et al. 2018). Person-centred care has been shown to improve patient satisfaction and the likelihood of returning to a facility for family planning services and maternity care (Afulani et al. 2017; Sudhinaraset et al. 2018). Despite the recognition that person-centred care approaches are crucial for delivering high-quality reproductive health services, few studies have examined person-centred care practices on abortion services.

Altshuler and Whaley's review (2018) suggests that abortion services worldwide generally fail to provide person-centred care. This includes patients experiencing high distrust of health providers and institutions, lack of information or misinformation about abortion procedures, and intense community stigma. In Kenya, a strong distrust of abortion providers and health institutions is one of the main reasons that women do not seek safe abortions in Kenya. Past studies suggest that women define 'safe' abortions as 'protecting women's social integrity and reputation' rather than physical comfort or safety (Izugbara, Egesa, and Okelo 2015). Women conceptualise 'safety' beyond physical health to also include their emotional, social, reputational, relationship, and economic well-being (Izugbara, Egesa, and Okelo 2015). In fact, some women choose to avoid higher-level facilities because they keep health records and thus women fear that their health information may be shared with others (Izugbara, Egesa, and Okelo 2015). While women acknowledge that high-profile health facilities have high-quality infrastructure, equipment and providers; they may be more likely to expose women's 'secrets' that they had an abortion-related procedure (Izugbara, Egesa, and Okelo 2015).

Person-centred care for abortion care is also a critical human rights issue. The World Health Organization highlights that global and national legislative and human rights bodies are integrating human rights with contraceptive information and services. The recommendations are, “ensure timely and affordable access to good quality sexual and reproductive health information and services, including contraception, which should be delivered in a way that ensures fully informed decision-making, respects dignity, autonomy, privacy and confidentiality, and is sensitive to individuals’ needs and perspectives” (World Health Organization (WHO) 2014, 1). In addition, Jain and Hardee (2018) discuss enhancing the quality of care framework for family planning with a rights-based approach. For instance, person-centred care and rights-based frameworks overlap with domains such as dignity and supportive care from providers in this context, which can be applicable to abortion services.

There is limited evidence on women’s perspectives of person-centred care for abortion services. Existing research suggests discordance between what women and providers report in terms of the quality of care received versus what is actually provided for abortions and post-abortion care (Fischer et al. 2005). For example, women are more likely to report longer waiting times and less likely to report being given pain medication compared to providers. Another study finds that only 45% of post-abortion clients says that providers adequately explained the surgical abortion procedure to them compared to 100% of providers (Evens et al. 2014). However, despite low levels of informational support from providers, women also reported high levels of satisfaction, with 80% of patients experiencing respectful care from their providers who were non-judgemental and compassionate (Evens et al. 2014). Examining women’s experiences of abortion-related procedures and post-abortion care through person-centred care will help inform providers how to provide optimal care for their patients.

Person-centred care is rooted in a positive perspective that highlights health and social resources and interactions between patients, providers, the health facility and the larger health system that lends itself to quality improvement strategies during service provision. The objective of this manuscript is to examine women’s experiences of abortion and post-abortion care in Kenya by applying the Person-Centered Care Framework for Reproductive Health Equity (PCRHC framework) to describe how women discuss domains of person-centred care and to better understand the gaps in women’s experiences of care. It extends the current literature on person-centred care for abortion services, including post-abortion care.

## **Methods**

### ***Design, study site, recruitment, and sampling***

This qualitative study took place in four Marie Stopes Kenya (MSK) facilities in Nairobi, Kenya and two MSK facilities in Kisumu, Kenya selected by MSK. We conducted a total of four FGDs with 19 participants and nine IDIs were conducted with women who had a safe abortion-related service after examination by a trained health professional. Women were eligible to participate if they received abortion or post-abortion services at a participating MSK facility and were aged 15-35 years.

FGDs consisted of three to five eligible women. Recruitment was done via one of two methods: 1) providers and staff overseeing discharge were briefed about the study, including inclusion/exclusion criteria. When healthcare staff saw a client that might be eligible, he/she mentioned the study and asked the woman if she was interested in hearing more; 2) MSK's Contact Centre, which calls clients as part of their standard operating procedures, introduced the study during their routine follow-up calls with post-abortion clients. If a client was interested in participating, the MSK staff referred them to a non-MSK research assistant for more information, as well as screening for eligibility. The research assistant then provided information on the study and asked a short set of questions to confirm eligibility. If eligible and willing to participate, potential participants were then taken through the informed consent process to ensure the woman understood the purposes and procedures of the study, as well as it being voluntary and that she was free to withdraw with no consequences at any time. Written informed consent was obtained for all women prior to any study procedures.

All FGDs and IDIs occurred in a private room. Three female research assistants (NO, SW, CW) participated in one week's training in qualitative methods including pilot FGDs and interviews. Two research assistants (one note-taker and one moderator) were present during FGDs while in-depth interviews were conducted one-on-one. FGDs and IDIs were tape recorded with the participant's permission. All participants consented to be recorded.

The FGDs and IDIs occurred at least two weeks post-procedure. The FGDs took approximately two hours while the IDIs took approximately one hour. Participants received transport reimbursement in the amount of 200 Kenyan shillings (approximately \$2.00 USD). Participants were also provided with airtime in the amount of 150 Kenyan shillings (approximately \$1.50 USD) and tea/snacks were offered during the FGD sessions.

### ***Qualitative approach and person-centred care framework for reproductive health equity***

We used a phenomenological approach to guide the design of the study, qualitative field guides, and data analyses (Creswell 2013). A phenomenological approach aims to describe how human beings experience certain phenomena; in this study, how women experience person-centred care. We asked women to describe their experiences with abortion and post-abortion care, particularly in the domains advanced by the PCRHC framework (Sudhinaraset et al. 2017). The PCRHC framework highlights the multiple levels that impact women's quality of care, including societal level (i.e. gender norms, policies) and health-seeking behaviours such as women's expectations of care and whether she decides to seek care, and facility-level determinants (i.e. clinical and infrastructure). These factors in turn determine women's experiences of care and whether she receives person-centred care. The PCRHC framework also identifies eight domains of person-centred care that include: dignity and respect, autonomy, privacy and confidentiality, provider and patient communication, social support, supportive care, trust, and health facility environment. In this manuscript, we have adapted this framework to abortion care (see Table 2).

### ***Qualitative field guides***

Using the phenomenological approach and the domains identified through the PCRHC framework, a qualitative field guide was developed for FGDs and then modified for the IDIs. Both FGDs and IDIs were used to delve into women's experiences before, during, and after receiving an abortion, including the level of person-centred care and support expected and received during these time points. The field guides specifically asked about women's expectations of the quality of abortion care they received, how they were treated by health providers, how they felt before, during, and after getting an abortion, and the challenges women faced in getting an abortion. Through FGDs we assessed norms regarding person-centred care, social support, and community attitudes towards abortions. We explored social support (or lack thereof) from family members, partners, community members and providers. This included those who supported women when they first decided to have an abortion at the facility and after they had their procedure and explored what their idea of ideal support would look like (from whom, when, how, what type, as well as advantages and disadvantages of such approaches). The IDIs explored the same topics but were able to gather more detailed individual experiences. Field guides were developed and refined through an iterative process with the researchers and collaborators in-country including field staff, and pilot tests.

### ***Analytic approach***

Following the phenomenological approach, we describe women's experiences with person-centred care using content analysis. First, three researchers (MS, BP, AS) read all transcripts (IDIs and FGDs) to familiarise themselves with the data, including re-reading field notes and to identify major themes. Then, the team (MS, BP, AS) regrouped and discussed similarities and differences between their initial theme lists and whether any themes were specific to the data collection type (IDI versus FDG). No major thematic or content differences were found between IDIs and FGDs, meaning the initial thematic review did not yield certain themes only in IDIs but not in FGDs or vice versa. Therefore, the study team decided to continue with joint analysis of all transcripts and created a set of emerging themes, such as person-centred care or expectations of care, from this first thematic analysis. Thematic codes, based on the PCRHC framework previously described, were developed under each theme as appropriate and applied to the data. After this second round of thematic content analysis, the study team reconvened and added additional emerging or recurrent themes and appropriate codes to the nested framework. Some codes, where significant overlap was noticed, were combined. A third round of thematic analysis was conducted using the revised codes after which no more additional themes or codes were found. Qualitative data analysis was completed using Atlas.ti software [version 8.3.0].

### ***Ethical approval***

This study was approved by the Committee for Human Research of the University of California, San Francisco (UCSF study number: 15-18008), the Kenya Medical Research Institute (KEMRI protocol number non-KEMRI 526) and the Marie Stopes International's Ethics Review Board (MSI protocol number: 004-17AM).

**Table 1.** Sociodemographic characteristics of study participants ( $n = 28$ ).

| Characteristic                              | Focus group<br>discussants ( $n = 19$ ) | In depth<br>interviewees ( $n = 9$ ) | Total<br>( $n = 28$ , %) |
|---|---|--------------------------------------|--------------------------|
| <b>Age</b>                                  |   |                                      |                          |
| 18-25 years                                 | 11 (57.9)                               | 5 (55.6)                             | 16 (57.1)                |
| 25 years and older                          | 8 (42.1)                                | 4 (44.4)                             | 12 (42.9)                |
| <b>Marital Status</b>                       |   |                                      |                          |
| Single                                      | 19 (100)                                | 8 (88.9)                             | 27 (96.4)                |
| Married                                     | 0 (0)                                   | 1 (11.1)                             | 1 (3.6)                  |
| <b>Religion</b>                             |   |                                      |                          |
| Protestant                                  | 8 (42.1)                                | 6 (66.7)                             | 14 (50)                  |
| Catholic                                    | 11 (57.9)                               | 2 (22.2)                             | 13 (46.4)                |
| Muslim                                      | 0 (0)                                   | 1 (11.1)                             | 1 (3.6)                  |
| <b>Highest level of education completed</b> |   |                                      |                          |
| Primary                                     | 2 (10.5)                                | 0 (0)                                | 2 (7.1)                  |
| Secondary/vocational                        | 8 (44.1)                                | 0 (0)                                | 8 (28.6)                 |
| University                                  | 9 (47.4)                                | 9 (100)                              | 18 (64.3)                |
| <b>Occupation</b>                           |   |                                      |                          |
| Salaried worker                             | 4 (21.1)                                | 5 (55.6)                             | 9 (32.1)                 |
| Self-employed                               | 4 (21.1)                                | 2 (22.2)                             | 6 (21.4)                 |
| Unemployed                                  | 2 (10.5)                                | 2 (22.2)                             | 4 (14.3)                 |
| Student                                     | 9 (47.4)                                | 0 (0)                                | 9 (32.1)                 |

## Results

The sociodemographic characteristics of the 28 women who participated in the study are stratified by data collection type (IDI or FDG) in [Table 1](#). Overall, the vast majority of women (27) were single, average age was 25 years (18-35 range), and over 64% (18) completed or currently enrolled in post-secondary education. All of the women (9) interviewed individually were university-educated and half were salaried. Almost one third of all women reported being students, most from the FDG contingent, and over half reported being salaried or self-employed workers (15). Nearly all women (27) were Christian (Protestant or Catholic).

Due to substantial overlap among the domains, we combined four of the eight original domains from the PCRHC framework into two dominant domains: 1) trust, privacy and confidentiality and 2) communication and supportive care. Health facility environment emerged as a common theme across the domains. For instance, when a woman was asked if she received emotional support, she said, "Yes, as I said from the facility itself..." which illustrated the overlap between health facility environment and supportive care. We therefore incorporated this theme within each domain. We present findings across five dominant domains: 1) dignity and respect; 2) autonomy; 3) communication and supportive care; 4) trust, privacy and confidentiality; and 5) social support ([Table 2](#)).

### *Dignity and respect*

The dignity and respect domain referred to the ability of women to receive care in a respectful and caring setting from their healthcare providers (Sudhinaraset et al. 2017). During women's narratives about their abortion experiences, some women shared their desire for dignified, respectful, and non-judgemental interactions with their providers. One woman stated, 'I expect them [healthcare providers] to treat us like human

**Table 2.** Domains and definitions of person-centred care for abortion.\*

| Domain                             | Definition   |
|------------------------------------|--|
| Dignity & respect                  | Dignity & respect refer to the ability of women to receive care from their healthcare providers in a respectful and caring setting. It captures typologies of physical and verbal abuse.   |
| Autonomy                           | Autonomy refers to healthcare providers who respect women's views, support women to make educated decisions about their own care and obtain informed consent prior to procedures.  |
| Communication and supportive care  | Communication & supportive care refer to healthcare providers providing compassionate care through clear explanations of procedures, purpose of treatments, and expected side effects. They confirm that women understand their explanations by using appropriate language for women to understand and ensuring patient care and safety. |
| Trust, privacy and confidentiality | Trust, privacy and confidentiality refers to women's perceptions of competence in their healthcare providers and facility. Privacy refers to both the environment in which women's care is provided and during procedures/physical examinations and to ensuring medical records are kept confidential.                                   |
| Social support                     | Social Support refers to the extent women have access to a companion of choice when receiving abortion care and emotional support from their existing social networks, especially during the post-abortion period.   |

\*Adapted from Person-Centered Care Framework for Reproductive Health Equity (Sudhinaraset et al. 2017).

\*\*Health facility environment, one of the domains in the Person-Centered Care Framework for Reproductive Health Equity (Sudhinaraset et al. 2017), was a common theme across the domains and is therefore incorporated as relevant within each domain.

beings, to understand' (woman, FGD, May 2017). Women's testimonies indicated that dignified and respectful care from providers may vary depending on the healthcare setting. Generally, women seemed to feel more dignified and respected when seeking abortion-related procedures at private clinics compared to government hospitals. Often, women contextualised their positive experiences within their negative experiences of receiving undignified and disrespectful care at government facilities as elucidated in the following quote from a woman in an FGD:

'... If you go for an abortion to another hospital or you try to get the pills [medication abortion] from let's say a pharmacy... [they] would just think on the negative things about you, like you are doing something so illegal... here [private clinic] I guess you are good, because they will treat you well because they understand what you are going through'. [woman, FGD, June 2017]

Another woman shared her experience when a provider follows through with post-abortion follow-up care:

'[...] They [healthcare providers] still care after the abortion, like you know if it's some other place [other facility] maybe after you are done [with the procedure], you are done, but they take their time to call after you go home. That's something big'. [woman, FGD, June 2017]

## **Autonomy**

The autonomy domain encompassed healthcare providers supporting women in their decision-making related to their abortion care (Sudhinaraset et al. 2017). We found that most women preferred individualised support from providers. Autonomy appeared of primary importance to the women we spoke with during the abortion decision-making process and following her abortion, specifically post-abortion family planning, rather than during the actual abortion-related procedure.



In the discussions about their experiences leading to their abortion choice, many women highly valued autonomy and reported that a woman knew her situation best. One woman in a FGD wished that providers could, 'Just listen and find out why you exactly why you want to do it [abortion], so that way maybe they [providers] can guide you' (woman, FGD, May 2017). This quote demonstrated her desire to engage in a meaningful discussion about her circumstances and receive personalised health information from a trusted and trained provider.

Women repeatedly expressed their preference that clinic staff and providers ask them for their preferences based on their personal circumstances. Some women shared positive examples of making informed choices because their providers listened to them during their decision-making process and even asked about their circumstances during the clinic registration period or pre-abortion counselling. As one woman explained, 'I saw the lady [health professional at clinical registration] I explained my situation. She told me there are two options and I picked one [...] I wanted to make sure that the one that I choose would be beneficial for me' (woman, age 33, salaried worker, IDI, October 2017).

Autonomy emerged as an important theme during discussion about post-abortion family planning with providers. Similar to decision-making leading up to the abortion, women also described feeling more comfortable when providers listened and inquired about women's own preferences on family planning, rather than pressuring women into making family planning decisions, including the type of method, particularly when they were not ready. According to one woman, receiving additional information specific to her circumstances helped her make an informed decision:

[...] You know I was scared about everything even the contraceptives and all that, so when they [health providers] told me everything, they gave me the information and the type of contraceptives, then their effects...' [woman, age 24, salaried worker, IDI, October 2017]

In summary, women who shared overall positive experiences also shared experiences of feeling independent and free to make decisions. The domains of autonomy and dignity and respect intersected as many women seemed to experience more autonomy when trusted providers respectfully engaged them in active decision-making suited to their individual circumstances.

### ***Communication and supportive care***

The communication and supportive care domain referred to health providers providing informational support to women about their procedures, purpose of treatments, and expected side effects in a respectful manner that is specific to the woman's circumstances, including using appropriate language to ensure that women understand (Sudhinaraset et al. 2017). A number of women characterised providers as supportive when they provided accurate information about potential pain and other physical side effects of the particular abortion procedure, explained post-abortion family planning options, and/or tailored their communication to women's specific needs.

In FGDs and IDIs, a few women referred to the abortion procedure as one of 'trauma.' One woman recommended that health staff should, 'listen to the person very

carefully [because ...] you have trauma and all [...] then ... give you clear information' (woman, FGD, May 2017). Transparent and personalised communication from the provider appeared as a key component of communication and supportive care.

During the abortion process, women seemed to appreciate when providers made efforts to learn about them as individuals by asking questions based on their unique circumstances. Reflecting upon her experience of receiving abortion care, one woman who was pregnant due to a failed family planning method explained that she appreciated that her provider took the time and care to communicate clearly and actively listen to her situation:

'... That was the first procedure [to remove the IUD], after which they asked me if I was comfortable to carry on with the pregnancy or not. Then I told them, 'no that's why I was on the contraceptives and I never wanted a pregnancy so they advised me'... They again asked me if I want to terminate it, so I terminated it, I agreed to terminate it [...] The person who was handling me I think gave me the best quality. We discussed at length on these procedures'. [woman, FGD, May 2017]

However, communication and supportive care also emerged from women's stories about misinformation or misrepresentation of what to expect for abortion procedures or lack of communication about the normal physical effects from the surgery, medications, and/or potential complications that could arise. In the following excerpt, one woman shared her experience:

'I was mad because that was something [breast pain as side effect of medication abortion] they were supposed to tell me. I was not used to it and I have never known it before ... so they should have given me the drug [for pain management] because ... they knew that I will also feel pain in my breast... the way I was very mad at [the health providers], that is why I have not even gone back there and I won't go back there'. [woman, FGD, May 2017]

The lack of transparent or clear communication seemed to emerge with post-abortion family planning. A few women noted how incomplete information from their providers on family planning methods and side effects resulted in scepticism about any family planning method. Some women explained that health providers would simply tell them that they should start family planning post-abortion, without explaining the appropriate family planning options and thus neglecting to consider the patient's preferences. One woman recalled her post-abortion family planning care experience with her provider:

'[...] After you have abort[ion] they tell you "we want you to take family planning," they don't give you a reason as to why I should go for family planning, and 'yes it's advisable you should,' but according to me I fear the side effects of you know, family [planning], I can use E pills. That is family planning, but there are this family planning of coils, injections, they should explain to me and tell me the side effect of this things, you know they don't tell you or they don't even tell you which one is suit for you'. [woman, FGD, May 2017]

Another woman spoke about the interaction with her provider who clarified common misconceptions about abortion and fertility, 'We are just terminating this [pregnancy], but in case you want to be pregnant again, you will still [be able to] get pregnant.' You know such most people don't have that information. The information

is good' (woman, age 32, salaried worker, IDI, October 2017). This woman seemed to appreciate the clarification from her provider that her abortion will not affect her fertility in the future.

In summary, when women experienced communication and supportive care from their providers, they seemed to feel acknowledged as an individual, heard, supported and respected. Women also highlighted specific challenges including how that lack of communication or miscommunication about abortion and post-abortion care, including post-abortion family planning options, can negatively impact women's experiences. Providers openly communicating the potential side effects during the abortion and post-abortion seemed to calm and reassure women, and for some, also encouraged their trust in providers.

### ***Trust, privacy and confidentiality***

The domains of trust, privacy and confidentiality often overlapped in women's narratives, which included women feeling complete trust with their providers who care for her as a person, prioritised her privacy during her care, and provided reassurance that her health information was kept confidential. Trust, privacy and confidentiality from providers appeared especially important given the mistrust from the community that many women experienced during their abortion experiences.

Many women often prefaced their descriptions of needing or experiencing privacy, trust and/or confidentiality within a context of mistrust and lack of privacy starting from their communities. As one woman shared in the following quote, 'People can be snitches and they can pretend that they are there for you, but really they are not even your friends. You just don't trust anyone at that point' (woman, FGD, May 2017). Another woman during an IDI shared that, 'Privacy, because it's not an easy thing, that you can just out it [abortion] in public, [...] because someone will say, everyone will say that I aborted [and] not understand why I aborted. There are those fears also ... so the first quality it's there should be privacy' (woman, age 27, self-employed, IDI, October 2017). This quote contextualises the lack of trust women fear, and sometimes experience, in their communities for having an abortion and highlighted the major role providers can play in providing trustworthy and confidential care during the abortion process.

Among participants who mentioned trust and privacy related to their abortion, all referenced the health providers or clinics and that the information or procedures they gave should always be accurate, direct, and private. For example, one woman shared her experience with her trusted provider, 'Because even when you call them [provider], they tell you, "we know, how can we help you?" and it's private, you know, [they] can maybe offer to deliver you the pills in a private place' (woman, FGD, May 2017). Here, she was confident that her privacy was respected by her provider and seemed to appreciate that her provider would help her access the care that she needed in a private setting.

In summary, some women shared positive instances of trust, privacy and confidentiality during their abortion care experiences with providers and these stories narrated the importance of establishing and maintaining confidentiality as a means to establish

trust and rapport. However, components of the trust, privacy and confidentiality domain most often emerged in a way that was absent from women's experiences in their communities, where they often faced or feared breaches of trust when or if they disclosed their abortion procedure.

### ***Social support***

While the previously discussed domains focused on the woman's interaction with her healthcare providers, the social support domain referred to the extent to which a woman felt supported by her social network such as her partner, friends, and family during her abortion experience (Sudhinaraset et al. 2017). This domain encompassed a woman feeling that she had emotional support from her existing social network, as well as access to a companion of her choice when receiving care, such as accompanying her to the facility for her procedure. In the local context of intense stigma, for many women, this particular domain seemed to help ease their stress and anxiety.

Women's narratives about social support often occurred within the backdrop or context of community stigma and intense internalised stigma related to abortion. All focus group discussants and interviewees shared some experience with stigmatisation. Several women described their strong feelings of personal guilt with their abortion decision in this context. One woman described her internal struggles with guilt:

'The guilt, like, I was just feeling pain and anger inside me, like "why am I doing this to my baby?," you know, it was such pain, before even giving out, that abortion, for me it was just painful to let go of her, because I even knew of her sex, it was painful for me'. [woman, FGD, July 2017]

During FGDs and IDIs, most women reported that when they experienced sufficient social support, they felt better equipped to handle the emotional, physical stresses of the procedure and recovered quicker. In this context, when asked to describe what support meant to them, most women described support as emotional support, such as comforting words from partners, family members or friends as well as actions, such as physical presence during their abortion procedure. Many women specified feeling safe and secure because their partner was aware of their abortion and women referenced partners who accompanied them to the clinic and others whose partners checked on them and reassured the woman on her decision. For example, the following excerpt captured the impact from a supportive partner who accompanied one woman to the clinic as well as assure her emotional safety and security:

'[...] Even now I feel like am safe, because even him [partner] ... he excused his job and arrived here [facility] earlier than me [the clinic before her abortion], you see? It means he is well concerned about me, and he is so supportive, everything, so I feel safe when am with him'. [woman, age 24, casual labourer, IDI, October 2017]

However, a few women mentioned the challenges with unsupportive partners who were absent or refused to acknowledge the pregnancy or abandoned the woman during her abortion experience. One woman, for instance, described her experience when her partner refused to accompany her to the facility, '[...] Okay that day I was afraid, I was seriously afraid and I was alone. So even him he wanted to come he was afraid and he said no' (woman, age 28, salaried worker, IDI, October 2017). The lack of

support from this woman's partner seemed to intensify her feelings of fear and further reinforced her isolation.

Women also appreciated informational support from their female friends, particularly from women who had previously experienced an abortion. For instance, one woman was referred to a clinic by her friend, 'She had actually gone through the same procedure so she referred me to this place [private clinic] so yeah at least I was confident that the procedure was going to go well' (woman, age 31, salaried worker, IDI, October 2017). This referral from her girlfriend seemed to ease her anxiety prior to her visit to the clinic.

During the post-abortion period, many women highlighted the value of follow-up whether in-person, phone calls, or text messages. For instance, one woman stated that her friend provided critical support to her, 'The only person who supported me was my best friend because she called me every hour to check "have you eaten?" ... "are you okay?"' (woman, age 33, salaried worker, IDI, May 2017). Another woman in a FGD emphasised the need for social support during the post-abortion period:

[...] They [women who had an abortion] need to be assured that life will be fine, life is okay, it's something that you are not the only one who goes through it, even after the abortion you can still live, you can still live your life well and it's not something that, it's like the end of life[...]. [woman, FGD, June 2017]

In summary, with adequate social support, many women seemed to feel more confident in their reproductive health decisions, experienced reduced fear and anxiety about the abortion procedure, and felt supported during post-abortion recovery. Their overall experiences appeared to improve when they perceived adequate support from their social networks.

## Discussion

We applied person-centred care to abortion care to explore women's narratives about their abortion experiences at private clinics in Nairobi and Kisumu, Kenya. This study is one of the first studies to examine women's abortion care using a person-centred care perspective. We found that abortion care overlapped most with the person-centred domains of autonomy, communication and supportive care, and trust, privacy, and confidentiality, which shares similarities with Hyman and Kumar's woman-centred model for abortion care which includes reference to choice, access, and quality (Hyman and Kumar 2004). Leonard and Winkler's quality of care framework for abortion care included an element on provider and women interaction, which encompassed these person-centred care domains and emphasised the importance of providers not being judgemental during their interactions with women (Leonard and Winkler 1991). A US study also found that the way in which patients were treated by the provider was one of the significant predictors of a woman's abortion experience (Taylor et al. 2013). In Nepal, women who had experienced second-trimester abortions shared that empathy from providers and counselling contributed to positive experiences, while privacy, confidentiality and the presence of a support person from their family were important factors in improving their abortion experience (Regmi and Madison 2009).

Women in this study shared their challenges tackling stigma, as highlighted in the social support domain, and revealed that abortion is still highly stigmatised (Herek 2009; Nack 2013). Women seeking abortion care not only experienced physical trauma from the procedure, but also often suffered additional emotional impact due to the added layer of stigmatisation from their communities, as well as self-stigmatisation. The study found that person-centred care for abortion services is important at each stage of the abortion process. Specifically, women shared experiences of strong communication and supportive care from their providers at the time of their abortion, which also contributed to autonomy in making reproductive health decisions. In addition, women emphasised the importance of social support during the post-abortion period and appreciated the support from their partners, friends and family members. Lack of person-centred post-abortion services may contribute to barriers in accessing safe abortions (Brookman-Amissah 2004), such as lack of trust, privacy and confidentiality at facilities (Izugbara, Egesa, and Okelo 2015) and possibly delaying care for post-abortion complications, post-abortion family planning uptake, and/or lead to preventable maternal deaths.

This study confirms that person-centred domains for abortion care can be adapted from the PCRHC framework (Sudhinaraset et al. 2017). The overarching themes that emerged from these domains reveal that respectful, dignified and competent care from healthcare providers that respond to the needs expressed by women, enabled women's own decision-making and overall improved experiences. This unique overlap in abortion care underlines the importance of and components to positive provider-patient interactions through dignified, respectful and clear communication tailored to the woman's specific needs and thus supporting women to feel independent in their reproductive health decisions.

These findings also point to the important role of a woman's social network. Social support also surfaced as a major feature in women's abortion and post-abortion experiences. Women revealed examples of feeling social support from non-providers, namely their partners and their friends. Our qualitative evidence demonstrated that those women who felt like they had support from their social networks appeared more confident and able to handle their post-abortion care experiences. Previous qualitative evidence suggests that women who experienced higher levels of social support felt better equipped to handle perceived stigma and have improved psychosocial outcomes (Mohamed, Diamond-Smith, and Njunguru 2018).

### **Limitations**

There are limitations to our study. It included women who received abortions from private facilities near urban areas in Kenya. It is possible that women who sought services from private facilities may be higher educated with better employment opportunities and presumably from higher socio-economic backgrounds to be able to access and afford services more easily compared to women who might have had no option but to go elsewhere. It was challenging to recruit women and this may have led to biased sampling because women who are willing to share their experiences may be different than other women. Many sought these services at a private clinic to

reduce risk of stigma and discrimination. However, that also impacted our ability to recruit for interviews and focus groups, and therefore led to our mix of qualitative methods in order to ensure a large enough sample size to assess person-centred care among women who had recently had an abortion.

### ***Programme implications***

A number of programmatic recommendations are clear from the evidence presented in our study. Strong social support from women's communities seemed important to reduce feelings of isolation and stigmatisation, especially during the post-abortion period. In Mexico, an evaluation of a support intervention found that participants were able to shift their perspectives of their abortion experiences as empowering (rather than negative experiences) when they had supportive environment to share their stories (Belfrage, Ortiz Ramirez, and Sorhaindo 2019). Another way to support women as they heal, is by means of accessible post-abortion support interventions that are multi-level and which includes a combination of individual, group (i.e. women's existing social networks or peers), and health facility/community-level strategies such as mobile phone support via phone calls or text messages from nurses, and virtual support groups in communities.

In India, a study on behaviour change interventions suggested leveraging existing community networks to combat community stigma surrounding abortion (Banerjee et al. 2012). Many aspects of patient-centred evidence-based interventions used for other health issues may be transferrable to social support for abortion (Upadhyay, Cockrill, and Freedman 2010). Additionally, enabling providers to integrate person-centred care with their expertise may simultaneously help gain patient trust, and thereby better equip them to provide informational support to women about their procedures, medications, side effects, and clearly communicate at each step of service provision. If women genuinely feel seen and heard by their providers, they will likely have more positive experiences as exemplified by women's stories in this study. Alternatively, a harm reduction approach may provide women more reproductive autonomy, particularly in legally restrictive settings such as Kenya. Such interventions include secure hot-lines or mobile-based platforms for women to access abortion-related information and referrals (Hyman et al. 2013). In Kenya, programmes and interventions that recognise the challenging social context of abortion care while also supporting women and providers are desperately needed.

### **Conclusion**

While the findings from this study are not necessarily generalisable to all women who have had an abortion, they offer instructive insight into person-centred abortion care in private facilities in the Kenyan context. Further research is needed to design, implement, and test the feasibility and acceptability of interventions in community and clinical settings to improve women's experiences during abortion and post-abortion care, including post-abortion family planning. Building on these findings, these evidence-

based actions will have the potential to improve reproductive health outcomes and help prevent maternal deaths from unsafe abortions in low-resource settings.

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