

# Male Partners' Involvement in Abortion Care: A Mixed-Methods Systematic Review

**CONTEXT:** Although some women may desire the involvement of their partners when obtaining abortion care, male partners are not routinely included in the abortion process. A review of the literature on how male involvement relates to women's abortion experiences may help guide facilities that are considering incorporating male partners in abortion care.

**METHODS:** PubMed, PsycINFO (Ovid), the Cumulative Index to Nursing and Allied Health Literature, the Latin American and Caribbean Health Sciences Literature database, and the Cochrane Library were systematically searched without restrictions through September 23, 2015, to identify qualitative and quantitative primary studies investigating male partner accompaniment during the abortion process in noncoercive situations. Analysis focused on identifying different types of male involvement and their associations with women's abortion experiences.

**RESULTS:** Some 1,316 unique articles were reviewed; 15 were analyzed. These studies were conducted in six countries and published between 1985 and 2012, primarily with observational designs. Four types of male partner involvement emerged: presence in the medical facility, participation in preabortion counseling, presence in the room during the surgical abortion procedure or while the woman is experiencing the effects of abortifacient medications, and participation in postabortion care. Studies explored relationships between type of involvement and women's access to abortion care and their emotional and physical well-being. Most findings suggested that male involvement was positively associated with women's well-being and their assessment of the experience; no negative associations were found.

**CONCLUSION:** In noncoercive circumstances, women who include their male partners in the abortion process may find this involvement beneficial.

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In 1994, the International Conference on Population and Development in Cairo established men's involvement in reproductive health as a global research priority, highlighting the need to emphasize men's shared responsibility and active participation in sexual and reproductive health and family planning.<sup>1</sup> Researchers and advocates have answered this call, and favorable outcomes have been shown when men have been active partners of women rather than passive bystanders in both pregnancy prevention and prenatal care.<sup>2–5</sup> The investment and involvement of male partners can improve women's reproductive health in such areas as the prevention of HIV,<sup>6</sup> preparedness for childbirth,<sup>7</sup> breast-feeding<sup>8</sup> and the uptake of contraceptives.<sup>9</sup> Although enthusiasm continues to grow for male inclusion in many areas of reproductive health, male partner involvement in the context of abortion services remains understudied and generally overlooked.

Abortion care may be an important area for partner inclusion because many women seeking and obtaining abortions experience complex emotions and feelings of isolation, and may desire the involvement of their partners.<sup>10</sup> In addition to the potential benefit for women at the individual level, the inclusion of male partners may improve women's access to safe abortion care more broadly.<sup>11</sup>

Because men are partners, fathers and friends, their direct experiences with abortion services may affect how they treat women and how abortion is perceived in society.

In some settings, men already play a significant role in the abortion process, although their involvement typically occurs before a woman presents for clinical care. For example, male partners participate in the decision making about whether to have an abortion,<sup>12–14</sup> and women often value having their partners' support for their decision.<sup>15,16</sup> Partners can facilitate abortion access by gathering information, locating services, providing transportation, covering or sharing the cost of abortion, and even alleviating social stigmas associated with seeking an abortion.<sup>17–19</sup> One exception is male partner involvement in the clinical process in the case of pregnancies complicated by fetal anomalies; in these instances, they may be included in counseling, procedural aspects and aftercare.<sup>20–22</sup> To our knowledge, whether men's involvement in induced abortions for non-medical indications is beneficial to women has never been examined in a systematic way.

The inclusion of male partners in abortion care, irrespective of the indication for abortion, should be considered only when women desire it. Providing safe services that are free of undue influence is of utmost importance to protect

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women who are in abusive or violent relationships, experiencing pregnancy coercion or fearful of retaliation from their partners.<sup>23-31</sup> Private services are also essential for women who cite relationship problems as their primary reason for abortion<sup>32-34</sup> and for women who do not want to involve their partner in the process.<sup>35,36</sup> Accordingly, the inclusion of male partners in abortion care requires facilities to have sufficient resources to accommodate two groups of women—those who want to be accompanied by their partners and those who wish to obtain abortion services privately and independent of partners. Some medical institutions have policies in place to protect women from coercion—for example, they require providers to ask women privately whether they are obtaining care freely.<sup>37</sup> Administrators of medical facilities with sufficient resources may consider incorporating male partners into abortion care to improve their clients' abortion experiences. In an effort to offer guidance for this practice, we reviewed the published literature to learn how male partners are involved in the abortion process under non-coercive circumstances and the relationship between male involvement and women's experiences with abortion.

## METHODS

### Article Selection

We aimed to explore the experiences of women who received abortion care at medical facilities that permitted male partner accompaniment. We defined "male partner accompaniment" as a male partner's presence during some part of the abortion process, starting with presentation to the medical facility and ending with postabortion care provided at the facility. Accompaniment included a range of actions, such as remaining in the waiting room, being present in the room during the surgical abortion procedure or while the woman is experiencing the effects of abortifacient medications, participating in preabortion counseling or ultrasound viewing, and providing emotional or practical support during the abortion process. Practical support included taking on household responsibilities, providing child care and attending to the woman's physical needs. Given the dearth of literature on this topic and lack of specificity about the characteristics of the accompanying male in many of the studies, accompanying males were assumed to be in a romantic relationship with the woman and to be the biological partner involved in the pregnancy, although we recognize that this was not always the case. We excluded studies in which women ended their pregnancies clandestinely (such as in settings where abortion was illegal) or independent of skilled providers, because we sought to provide guidance that was based on existing models of legal and safe abortion care provided in medical facilities. Articles on pregnancy termination in cases of fetal anomalies were also

excluded, because male partners are often included in these situations.

Originally, we planned to focus our review on women who wanted to be accompanied. However, it was often difficult to unveil women's intentions for involving partners in their abortions. While partner involvement was a choice for some women, it may have been a matter of need or obligation for others, and the differences between intentions could not be easily determined via analysis of secondary data. We addressed this concern by excluding articles that focused on abortion care for women in violent or coercive situations (because accompaniment by a male partner was unlikely to have been the woman's choice) and by including qualitative studies. Including qualitative studies permitted us to explore what partner accompaniment meant to women as a complement to the quantitative studies, which focused on the relationships between accompaniment and prespecified outcomes, but did not directly examine how accompaniment made women feel.

We systematically searched the published literature in the medical and psychosocial databases PubMed, PsycINFO (Ovid), the Cumulative Index of Nursing and Allied Health Literature, Latin American and Caribbean Health Sciences Literature, and the Cochrane Library. Using a strategy developed by the first author under the guidance of an experienced medical librarian, we searched for three components relevant to the research question, using MeSH terms, permutations and synonyms as appropriate: "induced abortion"; "man," "male," "partner," "husband" or "boyfriend"; and "abortion experience"\* (Appendix 1, Supporting Information). Because the phenomenon we were studying did not have a commonly used term, we used additional terms for abortion experience, chosen on the basis of an examination of articles on the topic and their keywords: "support\*," "process\*," "experien\*," "satisf\*" and "accompan\*." The search strategy was intentionally broad to include all articles on induced abortion that mentioned men and had some assessment of the abortion experience.

Searches were initially conducted on July 2, 2015, without date or language restrictions, and were updated regularly through September 23, 2015. References of all included articles were hand-searched to identify additional articles. Records were managed in Endnote (Version X7), and data were stored in Excel (Version 14).

The titles and abstracts of articles yielded by the search strategy were randomly assigned to one of three reviewers and independently screened using standardized inclusion criteria. Articles were eligible for inclusion if they were published in a peer-reviewed journal; analyzed primary data (qualitative or quantitative); examined induced abortion experiences at medical facilities; discussed how male partners were involved in the abortion process; assessed how partners' involvement was related to women's abortion experiences, from the women's perspectives; and were published in English, Spanish, Portuguese or French. To refrain from making a priori judgments about male involvement

\*The Latin American and Caribbean Health Sciences Literature and Cochrane Library databases were searched using the first two components only because adding search terms yielded no results.

in abortion care in any particular region of the world, we did not impose any geographic restrictions. We excluded articles suggesting that partner accompaniment may have been forced. Articles meeting our criteria were reassigned randomly to two of the three reviewers for independent full-text review and discussion to determine if they should be included. Study authors were contacted when more information was needed to determine if a study met inclusion criteria. The third reviewer resolved any discrepancies through additional review and discussion until a consensus was reached.

### Data Collection and Article Appraisal

Two reviewers reread the included articles and independently extracted data. Using a pretested 40-item form that was developed on the basis of published standards for the reporting of data in the various types of studies represented in our sample,<sup>38–41</sup> they recorded details relevant to each study's methodology and male partner accompaniment, such as information about the medical facilities, participants' characteristics and their assessment of accompaniment. The two reviewers, both of whom were content experts, discussed the completed data extraction forms and appraised the quality of each article.

We ranked the quality of the articles as either "low," "medium" or "high," using an approach described in another mixed-methods systematic review.<sup>42</sup> To assess the quality of individual quantitative and qualitative studies, we used the domains of aims, design, eligibility criteria, recruitment, data collection, participant characteristics, data analysis, reporting of findings or outcome events, discussion of sources of bias or imprecision, ethical considerations, and research contribution. Domains unique to quantitative studies included randomization (when applicable) and method of variable assessment; the domain reflexivity\* was unique to qualitative studies. Quality was downgraded if any domains introduced bias with respect to the primary outcomes or the phenomena studied. If the two reviewers disagreed about a study's quality, consensus was achieved through discussion with a third reviewer. While no studies were excluded because of quality concerns, the quality of each article contributed to our overall confidence in the findings of the systematic review.

### Synthesis

After reviewing the studies and identifying the different types of male accompaniment, we organized and synthesized the data according to type of accompaniment—that is, when and how partners were involved in the abortion process—and summarized how different types of accompaniment were related to various abortion-related outcomes from the standpoint of the women. Meta-analysis of the quantitative findings was not possible because of a high degree of heterogeneity among the studies. Therefore, we present descriptions of study characteristics, outcome measures and individual study findings, as well as a descriptive summary of systematic review findings.

A thematic synthesis approach was used to combine and analyze the qualitative data from included studies. We used the Confidence in the Evidence from Reviews of Qualitative research (CERQual) approach to determine our level of confidence (high, moderate, low or very low) in each qualitative finding that arose from the synthesis.<sup>43</sup> The CERQual approach evaluates qualitative studies using the domains of methodological limitations, relevance, coherence and adequacy of data. This systematic review is reported following PRISMA statement guidelines.<sup>44</sup>

## RESULTS

### Study Characteristics

Our database search yielded 1,287 articles after removal of duplicates; our search of the references of included articles yielded another 29 articles (Appendix 2, Supporting Information). A total of 116 full texts were screened, and 15 articles, encompassing 13 unique studies published between 1985 and 2012, were included for this review (Table 1). Articles that were excluded after the full-text screening lacked information about the relationship between partners' involvement and women's experiences, provided the male perspective only or assessed male involvement only prior to the clinical encounter.

The countries represented in this review are Canada, Egypt, India, Sweden, the United Kingdom and the United States. The populations of women studied differed because of wide variation in the social contexts of study locations. For example, in Sweden, national guidelines mandate that abortion providers offer counseling to both pregnant women and their partners, when appropriate, irrespective of marital status, and there are few restrictions on induced abortion in early pregnancy.<sup>45</sup> By contrast, in Egypt, induced abortion is heavily restricted and premarital sex is taboo; researchers are therefore limited to studying married women undergoing surgical management of incomplete abortion without determining whether the abortion was induced.<sup>46</sup> Nevertheless, the exposures and outcomes investigated tended to be similar.

The study designs were primarily quantitative; seven were purely cross-sectional. Five articles presented qualitative findings as part of mixed-methods or exclusively qualitative study designs. Study participants tended to be younger than 25 and had varying experience with prior pregnancies and varied relationship statuses. The Swedish studies that looked exclusively at "home abortion" (the administration of mifepristone in a clinical setting and misoprostol in a nonclinical setting, such as the patient's home) were an exception; in these studies, women tended to be older than 30 and to have given birth previously.<sup>47–49</sup> These studies also had the strictest inclusion criteria for participation, such as participants' geographic proximity to the hospital and a higher level of maturity. In all cohort and

\*Reflexivity was defined as the way in which researchers' attributes (professional background, subjective views and relationships with participants) may have influenced their research.

**TABLE 1. Selected characteristics of studies examining male partners' involvement in abortion care, by type of involvement**

Study	Design; sample	Location; year	Setting; type of abortion	Characteristics	Phenomenon studied	Quality
<b>Presence in medical facility</b>						
Mejor et al., 1985 <sup>53</sup>	Cross-sectional; N=247	Buffalo, NY; 1983	Freestanding family planning clinic; first-trimester surgical abortion	42% ≤19 years old; 78% unmarried; 26% had given birth; 29% had had an abortion; 34% accompanied by male partner	Relationship between presence of partner in waiting room and women's coping with abortion	Medium
Cozzarelli et al., 1994 <sup>54</sup>	Cohort; N=291	Buffalo, NY; 1990	Freestanding family planning clinic; first-trimester surgical abortion	Mean age, 23 years old; 75% unmarried; 41% had had an abortion; 37% accompanied by the partner involved in the pregnancy	Effect of male partner accompaniment on women's postabortion distress	Medium
Kalyanwala et al., 2010 <sup>55</sup>	Cross-sectional; N=549	Bihar and Jharkhand, India; 2007–2008	16 freestanding family planning clinics; first- and second-trimester surgical abortion	Mean age, 20 years old; 100% unmarried; 75% in the first trimester; 72% accompanied by male partner	Circumstances of pregnancy and responsibilities of male partners in accessing abortion services	Medium
Kalyanwala et al., 2012 <sup>56</sup>	Qualitative; N=26	Bihar and Jharkhand, India; 2007–2008	Four largest facilities of 16 freestanding family planning clinics; first- and second-trimester surgical abortion	Mean age, 19 years old; 100% unmarried; 54% accompanied by male partner	Roles of male partners in relation to obstacles experienced in accessing abortion services	Low
<b>Participation in preabortion counseling</b>						
Becker et al., 2008 <sup>51</sup>	Cross-sectional and qualitative; Ns=774 and 22	Baltimore, MD; 2005–2006	Freestanding family planning clinic; first-trimester surgical and medication abortion	38% 20–24 years old; 27% had had an abortion; 100% accompanied by male partner	Assessment of preabortion couples' counseling	Low
<b>Presence where the abortion was occurring</b>						
Abdel-Aziz et al., 2004 <sup>56</sup>	Cross-sectional; N=205	King's Lynn, Norfolk, United Kingdom; 2001–2002	Hospital-based abortion clinic; inpatient first-trimester medication abortion	Mean age, 26 years old; 88% unmarried; 55% had given birth; 31% had had an abortion; 16% had had a miscarriage; 56% accompanied by husband or partner	Association between partner's presence and satisfaction with and acceptability of medication abortion	Medium
Kopp Kallner et al., 2012 <sup>57</sup>	Cross-sectional; N=395	Stockholm, Sweden; 2004–2007	University hospital-based family planning clinic; first-trimester medication abortion	Median age, 32 years old; median parity, 1; median prior abortions, 1; median miscarriages, 0; 85% accompanied by partner or friend	Association between partner's or friend's presence and acceptability of home abortion*	Medium
Elul et al., 2000 <sup>52</sup>	Qualitative; N=22	New York City; 1998	Freestanding family planning clinic; first-trimester medication abortion	Unknown	Description and assessment of home administration of misoprostol	Low
Kero et al., 2009 <sup>48</sup>	Cross-sectional and qualitative; N=100	Umea, Sweden; 2006–2008	University hospital; first-trimester medication abortion	Median age, 32 years old; 27% not married or cohabiting; 80% had given birth; 47% had had an abortion; 22% had had a miscarriage; 75% accompanied by male partner	Description and assessment of home abortion	Medium
Kero et al., 2010 <sup>49</sup>	Cross-sectional and qualitative; N=23	Umea, Sweden; 2006–2008	University hospital; first-trimester medication abortion	Median age, 37 years old; 22% not married or cohabiting; 96% had given birth; 35% had had an abortion; 26% had had a miscarriage; 100% accompanied by male partner	Women's perceptions of male partners' involvement during home abortion	Medium
Guilbert et al., 1997 <sup>57</sup>	Cross-sectional; N=100	Quebec City, Canada; 1993	University hospital-based family planning clinic; first- and second-trimester surgical abortion	Mean age, 24 years old; 82% unmarried; 31% had given birth; 25% had had an abortion; 95% in the first trimester; 29% accompanied by husband or boyfriend	Association between support person's presence and satisfaction with surgical abortion	Low

Laizon et al., 2000 <sup>88</sup>	Cross-sectional† N=197	Montreal, Canada; 1991–1993	Three community clinics that share abortion services; first-trimester surgical abortion	61% 15–19 years old; 59% unmarried; 14% had given birth; 28% had had an abortion; ≤60% accompanied by male partner	Helpfulness of partner's presence during surgical abortion	Low
Makenzius et al., 2012 <sup>85</sup>	Cross-sectional‡ N=798	Central Sweden; 2009	13 family planning clinics; first-trimester medication abortion at home or hospital, first-trimester surgical abortion and second-trimester medication abortion at hospital	Median age, 25 years old; 26% not married or cohabiting; 42% had given birth; 35% had had an abortion; 68% first-trimester medication abortion; 29% first-trimester surgical abortion; ≤80% accompanied by male partner	Association between being given the option to be accompanied by partner during surgical abortion and satisfaction with abortion services	Medium
<b>Participation in postabortion care</b>						
Abdel-Tawab et al., 1999 <sup>86</sup>	Randomized controlled trial; N=293	Southern Egypt; year not stated	Six hospitals providing postabortion care; first- or second-trimester surgical abortion	61% <30 years old; 77% had given birth; 43% received postabortion care at >12 weeks of gestation; 100% accompanied by husband	Effect of husbands' postabortion counseling on women's physical and emotional recovery	Medium
Veiga et al., 2011 <sup>59</sup>	Cohort; N=114	Vancouver, Canada; 2009	Hospital-based family planning clinic; first- and second-trimester surgical abortion	Mean ages, 25 years old (unaccompanied women) and 27 years old (accompanied women); 41% had had an abortion; 29% accompanied by husband or boyfriend	Effect of accompaniment by support person in recovery room on emotional well-being	Medium

\*Home abortion refers to the administration of mifepristone in a clinical setting and misoprostol in a nonclinical setting, such as the patient's home. †The study had a cohort design, but accompaniment was examined in a cross-sectional design. ‡The study collected qualitative data, but accompaniment was analyzed quantitatively in the cross-sectional design. Note: Superscript numbers refer to the reference list.

randomized controlled trials except for one, participants in control groups did not differ significantly from those in the exposed or intervention groups with respect to reported characteristics.

The abortion methods in the included articles varied: Eight articles involved surgical abortion only, five involved medication abortion only and two involved both methods. The majority of the articles investigated abortion care in the first trimester; five included second-trimester abortions (four of these described surgical abortion). Six articles evaluated the relationship between male partner accompaniment and women's abortion experiences as the primary objective. The four types of male accompaniment that emerged from analysis of the included articles were presence in the medical facility, participation in pre-abortion counseling, presence where the abortion was occurring (i.e., during the surgical abortion or while the woman was experiencing the effects of abortifacient medications), and participation in postabortion care (undergoing post-abortion counseling or being present in the recovery room). The most common phenomenon explored was accompaniment during misoprostol administration for medication abortion.

All of the articles were of low or medium quality. Most quantitative articles were limited by imprecisely defined exposures and outcomes, low response rates or high drop-out rates. The qualitative studies tended to have insufficient descriptions of their methods, raising concern about the validity of their findings.

Although we did not perform a meta-analysis for the quantitative findings, we were able to perform a thematic synthesis of the qualitative findings from qualitative and mixed methods studies, which yielded four review findings (box). On the basis of the CERQual approach, we had low or very low confidence in the review findings from the qualitative studies, primarily because of minor to substantial methodological limitations and substantial concerns regarding adequacy of the data. Confidence in a finding was very low when the finding appeared in only one article and that article had methodological weaknesses.<sup>50-52</sup>

### Types of Male Accompaniment

•**Presence in the medical facility.** Four articles examined male partners' presence in medical facilities and its associations with women's postabortion coping<sup>53,54</sup> or access to abortion care.<sup>50,55</sup>

The two studies investigating postabortion coping were conducted at the same American private family planning clinic seven years apart. Major et al. aimed to determine if a woman's psychological characteristics (i.e., whether she attributed the unwanted pregnancy to her character or her behavior), her expectations for coping or her ability to find meaning in the pregnancy were associated with her ability to cope after a first-trimester abortion.<sup>53</sup> The association between accompaniment (partner's presence in the waiting room) and women's postabortion coping was a secondary outcome; accompanied women were significantly more

likely than unaccompanied women to have difficulty with coping 30 minutes after their abortions. No difference was observed at a three-week follow-up visit, although only 40% of women returned.

Since the study by Major et al.<sup>53</sup> did not establish whether the presence of the partner contributed to poor coping, Cozzarelli et al. designed a cohort study to investigate accompaniment directly.<sup>54</sup> Coping was assessed at the same time points as in the study by Major et al.; the proportion of women returning for the three-week visit was similarly low (38%). Postabortion depression scores were low for all women, and accompaniment was not found to be associated with coping 30 minutes or three weeks after the abortion. Women's low self-efficacy was related to postabortion distress, but accompaniment was not. Additionally, accompaniment was positively associated with women's reports of their degree of relationship commitment, their partner's supportiveness of the decision to have an abortion, and their feeling that their partner had been supportive since learning of the pregnancy and could be relied on for support in the future. However, the authors did not determine if women's perceptions of support from their partners during the abortion process meant that the women actually received support; nor did they describe the various forms of support that the women received.

Kalyanwala et al., in a cross-sectional and a qualitative study, explored the abortion experiences of young unmarried women in freestanding abortion clinics in northern India, focusing on access to services.<sup>50,55</sup> Because premarital sex is taboo in India, the authors hypothesized that these women would have had difficulty turning to family members for help and would therefore have been compelled to turn to their male partners for assistance in obtaining an abortion. The hypothesis was substantiated by findings in the cross-sectional study that it was rare for women to come to the abortion clinic alone and that being accompanied by a male partner, in particular, was associated with increased access.<sup>55</sup> Women accompanied by a male partner had abortions earlier in pregnancy than women accompanied by a family member, neighbor, acquaintance, stranger, teacher or employer. The study did not specify whether accompaniment occurred because the women needed a male partner to facilitate access to an abortion or because they wanted their partners' emotional support, but it did show that a significantly larger proportion of women in the first trimester than of women in the second trimester reported receiving emotional support from the partner (91% vs. 70%).

In a nested qualitative study, Kalyanwala et al. found that many women needed their partner to facilitate accessing abortion care, but some also valued his presence on an emotional level.<sup>50</sup> Moreover, emotional support was often linked to financial support. The findings were exemplified by the narrative of a 23-year-old unmarried woman who had obtained a first-trimester abortion: "[My boyfriend] gave me 100% support.... Even when I was talking to the doctor, he was there, as I always feel comfortable with him,

## Summary of review findings on male partners' involvement in abortion care

### PRESENCE IN MEDICAL FACILITY

#### Postabortion coping

Male partner accompaniment does not appear to be associated with women's psychological distress after an abortion.

Sources:

*Major et al., 1985*<sup>53</sup>: Accompaniment was treated as a proxy for social support. Accompanied women were significantly younger than unaccompanied women and, before the abortion, expected to cope less well. After age and expectations were controlled for, they were significantly more depressed than unaccompanied women 30 minutes after the abortion, but the two groups did not differ in the report of physical complaints; coping responses did not differ between groups at a three-week follow-up.

*Cozzarelli et al., 1994*<sup>54</sup>: There were no overall differences between accompanied and unaccompanied women in levels of immediate or three-week postabortion depression; self-efficacy was inversely related to postabortion distress at the two time points, independent of accompaniment.

#### Access to abortion care

Male partner accompaniment may be associated with improved access to abortion care.

Source:

*Kalyanwala et al., 2010*<sup>55</sup>: Compared with women who had a second-trimester abortion, women who had a first-trimester abortion were more likely to have confided in their partners about the pregnancy, to have received emotional support from their partners and to have been accompanied to the clinic by their partners. There was no difference in financial support.

#### Significance of accompaniment

Male partner accompaniment may represent financial and emotional support to women. Confidence in this finding from synthesis of qualitative studies is very low.

Source:

*Kalyanwala et al., 2012*<sup>50</sup>: Male partners were more likely than family members or parents to have provided emotional or financial support and to have accompanied women to the abortion clinic. Women found comfort in their partners' involvement.

### PARTICIPATION IN PREABORTION COUNSELING

#### Assessment of counseling

Providing couples preabortion counseling when desired by both partners may be valued by women. Confidence in this finding from synthesis of qualitative studies is very low.

Source:

*Becker et al., 2008*<sup>51</sup>: The vast majority of women accepting couples counseling found it to be a positive experience. Women reported that they valued receiving support from their partner, having a partner who is informed and with whom they can communicate, and being able to share decision making related to abortion.

### PRESENCE WHERE THE ABORTION WAS OCCURRING

#### Satisfaction/acceptance

Male partners' physical presence during the surgical abortion procedure or while the woman is experiencing the effects of abortifacient medications may be associated with a positive assessment of the abortion process. It may also represent emotional or practical support; however, confidence in this finding from synthesis of qualitative studies is low.

Sources:

*Abdel-Aziz et al., 2004*<sup>56</sup>: Having emotional support from a husband or partner during a medication abortion was not associated with women's satisfaction, but it was associated with their willingness to use this method again if needed or to recommend it to a friend or relative.

*Kopp Kallner et al., 2012*<sup>47</sup>: Having an accompanying person (friend, partner) present was positively associated with the acceptability of home abortion,\* but was not associated with feeling that the abortion experience was less difficult than or as difficult as expected.

*Elul et al., 2000*<sup>52</sup>: Having someone (friend, relative, partner) present for a medication abortion in case of emergency and for emotional support was comforting to most women.

*Kero et al., 2009*<sup>48</sup>: Some women valued the presence of their support person in clinical settings for emotional support and appreciated having their abortion at home because it extended the influence of the supportive partner.

*Kero et al., 2010*<sup>49</sup>: One of the main reasons women chose home abortions was to receive emotional and practical support from their partners. All of the women used positive terms in describing their partners' participation while they experienced the effects of misoprostol.

*Guilbert et al., 1997*<sup>72</sup>: The adequacy of preparatory information about the nature and duration of a surgical abortion procedure, and the presence of someone during the procedure, was positively correlated with patient satisfaction.

*Lauzon et al., 2000*<sup>58</sup>: Most women felt that the presence of their male partners was helpful during their surgical abortion and would advise men to accompany their partners.

*Makenzius et al., 2012*<sup>45</sup>: The option of having a close person present during a surgical abortion procedure had a positive association with overall satisfaction.

#### Pain management

Male partner accompaniment during the abortion may not have an association with women's degree of pain. Also, it does not appear to ease the pain of medication abortion; however, confidence in this finding from synthesis of qualitative studies is very low.

Sources:

*Elul et al., 2000*<sup>52</sup>: Support people could do little to ease the pain associated with medication abortion.

*Kero et al., 2009*<sup>48</sup>: Physical symptoms during medication abortion did not differ between accompanied and unaccompanied women.

*Makenzius et al., 2012*<sup>45</sup>: Women given the option of having someone close present during surgical abortion were not significantly more satisfied with pain relief than others.

### PARTICIPATION IN POSTABORTION CARE

#### Recovery

Postabortion counseling of husbands may not increase the quality of support they provide or improve the recovery of their wives.

Source:

*Abdel-Tawab et al., 1999*<sup>46</sup>: Husbands' receipt of postabortion counseling was not associated with an increase in the likelihood that they provided high instrumental or emotional support to their wives during recovery and, thus, was not associated with wives' physical or psychological recovery.

#### Anxiety and emotional support

Male partners' presence in the recovery room may help relieve anxiety and provide emotional support.

Source:

*Veiga et al., 2011*<sup>59</sup>: Although there was no significant difference in preprocedure anxiety levels between accompanied and unaccompanied women, the former had a significantly greater decrease in anxiety postprocedure; they also were more likely to report that they received all the support that they needed. Nearly all accompanied women found their support person helpful, thought having support made it easier for them to go through the abortion and would choose to be accompanied in the recovery room if they had to have another abortion. Few women felt that other people's support persons made them uncomfortable or contributed to a lack of privacy.

\*Home abortion refers to the administration of mifepristone in a clinical setting and misoprostol in a nonclinical setting. Note: Superscript numbers refer to the reference list.

like [he is] my husband. Earlier, I was feeling very scared about the money that would be spent on getting [the abortion] done.... My boyfriend gave the money.”

•**Participation in preabortion counseling.** Only one study, by Becker et al., conducted in a freestanding clinic in the United States, explored the inclusion of male partners in preabortion counseling.<sup>51</sup> Twenty-seven percent of the 774 women obtaining abortions were accompanied by a male partner, and 42% of those underwent couples counseling after the consent of both partners. Counseling entailed information about abortion procedure options and post-abortion contraceptives and a discussion of topics raised by the couple. Twenty-five percent of couples completed questionnaires after the counseling session. Some women expected their partners to be involved at various parts of the abortion process—12 out of 22 expected partner participation in preabortion counseling, five expected it during the abortion procedure and four expected it during contraceptive counseling, although partners' presence during the procedure was not allowed at this clinic. Following the counseling session, a majority of women were satisfied with couples counseling (19 out of 22). Qualitative data revealed that including male partners in preabortion counseling made women feel emotionally supported, as shown in the following comments by unidentified speakers: “It was reassuring to have him there” and “He gave me support and talked me through it.”<sup>51</sup> Some women appreciated receiving information jointly with their partners; as one woman explained, “He got to hear all side effects so that he will be aware of anything I may go through.” And some noted that counseling allowed them to share the decision to end the pregnancy. One woman stated, “I felt like it was our decision.”<sup>51</sup>

•**Presence where the abortion was occurring.** Eight articles, five of which focused on medication abortions, examined the relationship between male partner accompaniment in the physical space where the abortion was occurring and women's abortion experiences.<sup>45,47-49,52,56-58</sup> Abdel-Aziz et al. conducted a cross-sectional study in a hospital in the United Kingdom where partners of women obtaining first-trimester medication abortions could join the women in the ward.<sup>56</sup> They found that a partner's emotional support during the abortion process was associated with the acceptability of the abortion method (as assessed by women's reporting that they would recommend the method to a relative or friend, or would use it again themselves, if needed), but not with women's satisfaction with it (based on a visual analog scale). Few women contributed to the comparison groups, however, because 90% of women either were satisfied or found the method acceptable.

The other four articles focused on medication abortion examined the administration of misoprostol at home and also found, in general, positive relationships between partner's presence and women's experiences. A cross-sectional Swedish study, by Kopp Kallner et al., evaluated the acceptability of first-trimester home abortion (by

measuring women's future preference for administering misoprostol at home instead of at the hospital), and found that having a support person present at home was positively associated with acceptability.<sup>47</sup> Analysis of qualitative data from an American study by Elul et al. and the Swedish studies by Kero et al. showed that women valued the presence of the partner during medication abortion for emotional support,<sup>49,52</sup> for enabling them to share an intimate experience;<sup>48,49</sup> and for practical support, such as attending to child-care needs.<sup>49,52</sup> For example, in reference to taking mifepristone in a clinic, one Swedish woman recalled, “I searched for my husband's eyes ... wanted him to confirm it.... He nodded, and I swallowed the pill.... We did it together.”<sup>48</sup> Another woman, talking about her partner's presence while she was experiencing the effects of misoprostol, reflected, “[He] allowed me to be on my own when I wanted and stayed close with me when I needed it.... [He] took care of the daughter.”<sup>49</sup> Also, Kero et al. found that some women selected medication abortion because it allowed them to involve their partner in the process and that women had a positive assessment of their partner's involvement after the abortion.<sup>48,49</sup>

On the basis of the CERQual approach, we had low confidence in the qualitative review finding that partner's presence during medication abortion may represent emotional or practical support, because of concerns about methodological limitations of the individual studies and the adequacy of data despite the high coherence and relevance of the data. The data are not adequate because Kero et al. and Elul et al. had small sample sizes and narrow eligibility criteria (Elul et al. was conducted in the context of a clinical trial, though eligibility criteria and a description of participants were not included).

Cross-sectional studies by Guilbert et al. and Makenzius et al., conducted at family planning clinics in Canada and Sweden, respectively, found that either having a support person present or being given the option to have one present during surgical abortion was associated with satisfaction with care.<sup>45,57</sup> As in the Abdel-Aziz et al. study, satisfaction was measured as an ordinal variable and tended to be high.<sup>57</sup> In Lauzon et al., a Canadian study set in community clinics, 85% of women described having a male partner present during the abortion procedure as helpful and would advise other men to accompany their partner during an abortion.<sup>58</sup> The majority of participants were younger than 20 and nulliparous.

Three of these studies also investigated whether the presence of a partner (or other support person) during the abortion was associated with women's perceptions of less pain; none showed such a relationship.<sup>45,48,52</sup>

•**Participation in postabortion care.** Two studies evaluated the role of partner accompaniment in postabortion care by measuring outcomes related to women's emotional recovery, physical recovery or both.<sup>46,59</sup> Abdel-Tawab et al. performed a randomized controlled trial in six hospitals in Egypt to determine if counseling patients' husbands before discharge led to greater instrumental

and emotional support\* at home, which would thereby improve patients' physical and psychological recovery one month later. Women in the control group (whose husbands did not undergo counseling) did not differ from those in the intervention group with respect to relevant characteristics except that they were significantly more likely to be in the second trimester of pregnancy; the authors do not discuss how this difference may affect findings. The authors found that women who reported receiving a high level of emotional support from their husbands were significantly more likely to also report good physical and psychological recovery. However, rather than the counseling intervention, other variables, such as whether the pregnancy was planned, were associated with husbands' provision of emotional support. Furthermore, counseling did not alter the quality of instrumental support provided, and receiving instrumental support was not associated with good recovery. The authors note that Egyptian men do not typically provide instrumental support, and thus counseling was unlikely to have affected their behavior.

Veiga et al. performed a cohort study in a hospital-based family planning clinic in Canada to assess if inviting support people to the recovery room after a surgical abortion decreased patients' anxiety and made them feel supported.<sup>59</sup> These authors were influenced by Becker et al. to include support people in the clinical abortion process.<sup>51</sup> They compared experiences with services before and after implementation of a policy to allow male partners and other support people in the recovery room. The study did not ascertain whether all patients whose abortions predated the policy would have wanted to be accompanied to the recovery room; by design, all those obtaining abortions once the policy was in place wanted to be accompanied. Women in the later phase of the study reported a significantly greater decrease in anxiety levels after the procedure than those in the earlier phase; they also were significantly more likely to report that they received all the support they needed and that they found their support people helpful.

## DISCUSSION

This review encompasses investigations of abortion care in several cultural contexts and different types of medical facilities; it covers the use of abortion methods in facilities and at home among women of varying ages, relationship statuses and reproductive histories. Despite these differences, the included studies explored similar exposures, and some found similar results with respect to male partner accompaniment. Four types of partner involvement emerged from the study, showcasing the ways partners have been incorporated in abortion care.

Although the evidence is not high-quality, findings suggest that the inclusion of male partners in abortion care

under noncoercive circumstances has a positive relationship with women's abortion experiences. Most studies showed that having a partner involved in the process was positively associated with women's emotional comfort and assessment of the experience. None noted any negative associations. In addition, accompanying women during the abortion process created opportunities for partners to offer financial and practical support. Other individuals, such as friends and family, also provided these types of support.

Our review focused narrowly on male partner involvement and its relationship to women's experiences, but the included studies also touched on broader issues surrounding accompaniment. For example, both Becker et al. and Veiga et al. reported that staff felt skeptical about the utility of partner accompaniment.<sup>51,59</sup> Furthermore, Veiga et al. reported that although the majority of accompanied women did not feel a lack of privacy or discomfort because of the presence of someone else's support person in the recovery room, a few unaccompanied women found it problematic.<sup>59</sup> Some studies suggested that men have their own needs in abortion care when they accompany women. For example, Lauzon et al. and Elul et al. found that a minority of male partners experienced distress, particularly when they saw their partners in pain,<sup>52,58</sup> and Veiga et al. found that male partners were more likely than family and friends to feel obligated to accompany women.<sup>59</sup> Lastly, Makenzius et al. suggested that women's experiences may be shaped, in part, by the quality of their partners' experiences, particularly if the partners' experiences were negative.<sup>45</sup> These selected findings elucidate areas for future research on accompaniment.

Our review of the literature also brought out some of the limitations of the existing evidence. Several studies had low recruitment rates or significant dropout rates, which limited the authors' ability to generalize findings about their study populations. Ten of the 15 articles did not indicate whether accompanied women wanted their partner present during the abortion process, even in circumstances in which women may have had less choice (e.g., women depended on their partner for transportation to access abortion care or the partner was already present if the abortion took place at home). Women who had little choice in the matter may have been affected differently by their partner's presence than women who desired such presence, and this difference may have influenced outcomes. Also, several studies did not specify the type of partner who accompanied the woman or even whether the male who accompanied her was her intimate partner, a friend or a family member. Thus, no conclusions can be drawn about how women's abortion experiences are related to the presence of different types of support people.

Moreover, some studies compared accompanied and unaccompanied women to determine the association between accompaniment and a particular outcome. This comparison has limited applicability in practice, because women who sought abortion care alone may have been alone intentionally. A high-quality study would enroll women and their partners and confirm that both partners

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\*Emotional and instrumental support were measured in a questionnaire completed by the women on their husband's reactions to the lost pregnancy and his concern for their physical and emotional needs, and whether he helped with household duties and bought and prepared food.<sup>46</sup>

desire to experience some aspect of the abortion process together. Because randomizing women to be accompanied or to be unaccompanied is likely unacceptable, a cohort study may be conducted at different points in time, such as before and after a site-wide inclusion of male partners, as in the study by Veiga et al.<sup>59</sup> Qualitative methods may also help to explore what partner accompaniment in abortion care means to women and their partners to determine appropriate variables and outcomes. We need new measures because evaluating satisfaction has limited application; women tend to be satisfied with abortion services because they have resolved their pregnancies,<sup>60–62</sup> so it is difficult to detect other modifiable variables, with smaller effects, that contribute to satisfaction.

### Limitations

Limitations of this systematic review included language constraints that were due to our available resources, publication bias and the possibility of selection bias if additional literature on this topic was available outside of the peer-reviewed literature (e.g., in scholarly dissertations, in popular print media or on the Web). Developing a search strategy and screening articles for inclusion was difficult because of the heterogeneity of descriptions of male partner accompaniment in abortion care. Consequently, if article titles or abstracts did not clearly indicate a focus on male participation, this review was more likely than ones with well-defined exposures and interventions to miss relevant articles. There may be other ways that partners are involved in abortion care that did not make it into this review. Despite these limitations, we found a broad range of studies with unifying characteristics, such as male partners' being potential sources of emotional support to women ending their pregnancies.

### Conclusion

Overall, the body of literature on male involvement in abortion care, and especially on how women perceive male involvement, is rather limited. There may also be other ways men can be involved that have not been studied. Yet, the inclusion of male partners is a research topic worth pursuing. If inclusion enables men to better comprehend the experiences of their partners, it may not only strengthen couples' relationships, but also help men become stronger advocates for women in general. This potential advocacy is particularly important because men are key actors in determining social norms and policies in many regions of the world. Understanding the roles of male partners in abortion care is the first step to pursuing these broader aims.

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