Men in Abortion Decision-Making and Care in Uganda

Ann M. Moore[1], Gabriel Jagwe-Wadda[2], and Akinrinola Bankole[3]

[1]*Corresponding author:* Senior Research Associate, Guttmacher Institute, NY, NY, USA
[2] *Deceased, last position was as* Lecturer, Department of Sociology, Faculty of Social Sciences, Makerere University, Kampala, Uganda
[3] Director of International Research, Guttmacher Institute, NY, NY, USA

Summary

Abortion is illegal in Uganda except to save the life of the woman. Nevertheless, the practice is quite common: About 300,000 induced abortions occur annually among Ugandan women aged 15–49 (Singh et al., 2005) and a large proportion of these women require treatment for postabortion complications. In a male dominant culture as exists in Uganda where men control most of the financial resources, men play a critical part in determining whether women receive a safe abortion or appropriate treatment if they experience abortion complications. This study examines men's role in determining women's access to a safer[1] abortion and postabortion care. It draws on in-depth interviews (IDIs) carried out in 2003 with 61 women aged 18–60 and 21 men aged 20–50 from Kampala and Mbarara, Uganda. Respondents' descriptions of men's involvement in women's abortion care agreed: Men's attitudes about abortion often prevented women from involving them in either the abortion or postabortion care. Most men believe that if a woman is having an abortion, it must be because she is pregnant with another man's child. If the woman does experience postabortion complications, many men said that they cannot support a woman in such a situation seeking care because if it had been his child, she would not have had a clandestine abortion. Since money alone guarantees care, without men's support, women seeking abortion often are not able to access safer options and if they experience complications, they delay care-seeking or do not obtain care at all. These

[1] By using the term "safer," we mean to imply an abortion that is less likely to result in abortion complications. We do not use the term safe because even access to resources does not guarantee a safe abortion in Uganda.

findings point to disjunctures between men's perceptions of and women's realities about reasons for seeking abortion. Therefore, women's barriers to involving men in abortion decision-making endangers women's health and possibly their lives.

Introduction

Uganda is one of the poorest countries in the world with a per capita annual income of US$340 (World Bank, 2009). More than 85% of the population lives in rural areas, making it one of the least urbanized countries in sub-Saharan Africa (World Bank, 2009). The average family size is about 6.7 children per woman; however, the desired family size is lower (5.0 for women and 5.8 for men) (Uganda Bureau of Statistics (UBOS) and ORC Macro, 2007). This means that women and their partners are finding it difficult to prevent the pregnancies they do not want either then or at all. Thirty-three percent of births and current pregnancies occurring between 2000/2001 and 2005/2006 were wanted later and 13% were not wanted at all (UBOS and ORC Macro, 2007). This is because desired fertility has decreased more rapidly than the increase in contraceptive use. In 2005/2006, contraceptive use was low (24% of currently married women and 54% of sexually active unmarried women were using a method with traditional methods accounting for 5.8% and 7.1% of this use, respectively), yet 41% of married women do not want a child soon, or at all, though they are not using an effective method of contraception (UBOS and ORC Macro, 2007). The high level of unmet need (41%) signifies the proportion of the population at risk of an unintended pregnancy.

According to national law, abortion is illegal in Uganda except to save the life of the woman. The abortion law in Uganda is the result of laws promulgated by

English colonizers in the nineteenth century. At that time, abortion was illegal in Europe and so the laws in the territories were a natural extension of the laws at home. Since then, abortion has been legalized in Europe, but the old laws have not been revised in this former colony (Brookman-Amissah and Moyo, 2004). Very few abortions are performed legally under current restrictions. Nevertheless, the practice is quite common: About 300,000 induced abortions occur annually among Ugandan women aged 15–49, a rate of 54 abortions per 1,000 women (Singh et al., 2005). A large proportion of these abortions are carried out clandestinely and by unqualified providers under conditions deemed unsafe, that is using a procedure for terminating an unwanted pregnancy either by an unqualified individual or in an environment lacking minimal medical standards or both.

Virtually all of the abortions that were performed around the time of the Singh et al. 2005 study used dilation and curettage, vacuum aspiration, saline instillation, oral induction or insertion of a substance or object in the vaginal (Prada et al., 2005). Misoprostol, commonly identified as Cytotec, was not known or available in Uganda at the time the study was conducted, even on the black market. According to knowledgeable health professionals in Uganda, of the abortions which occur annually, 50% do not result in complications; 28% result in complications treated in a medical facility; and 22% result in complications that go untreated (Singh et al., 2006). This translates into an estimated 85,000 women (or 15 of every 1000 women of reproductive age) receiving treatment for

complications from induced abortions in Ugandan health facilities each year (Singh et al., 2005).

Most abortion complication patients are treated in public facilities (Prada et al., 2005). Yet care is not always sought as quickly as it should be, resulting in more severe complications and further endangering the woman's health (Thaddeus and Maine, 1994; Atuyambe et al., 2005). Evidence from health professionals knowledgeable about postabortion care shows that about 83% of urban nonpoor women (defined as those with income levels higher than average) and 70% of rural nonpoor women are likely to receive treatment for abortion complications they may experience. Sixty-two percent of urban poor women (defined as those with income levels lower than average) and 51% of rural poor women are perceived to obtain needed care (Prada et al., 2005). A large and unknown proportion of women experience complications from abortion for which they do not seek care but from which they are nevertheless impaired in their daily functioning and quality of life.

A proportion of abortion complications, some of which get treatment and some of which do not, result in death. In 2005, the national maternal mortality ratio was estimated by the World Health Organization to be 550 maternal deaths per 100,000 live births, making Uganda a country with relatively high maternal mortality (WHO, 2007a). About 26% of maternal deaths in Uganda has been estimated to be due to unsafe abortion (Road Map, 2008). While this estimate

seems to be on a high side, it is unlikely it is less than the 17% that the World Health Organization estimated for Eastern Africa (WHO, 2007b).

Much remains unknown about the antecedents to maternal morbidity and mortality in Uganda, but one of the factors that is often named is lack of funds to pay for medical care or transportation to the health facility which hinders many women's ability to meet their reproductive health care needs (Weeks et al., 2005). Anthropological work on motherhood in Uganda demonstrates that pregnancy and all factors surrounding it are seen as a woman's responsibility as well as a test of her fortitude and strength, which may be a direct cause of women delaying abortion as well as care for postabortion complications (Kyomuhendo, 2003). Furthermore, social stigma surrounding abortion from members of the community and anticipation of abuse by medical personnel are yet more barriers to seeking safer abortions and care for abortion-related complications (Kyomuhendo, 2003). Finally, partners' attitudes or even women's anticipated perceptions of partners' reactions can delay or prevent women from seeking a safer abortion as well as seeking care for abortion complications.

In Uganda, a traditional society where men are the heads of the household and control most of the household resources, men are in effect gatekeepers to accessing less dangerous abortions and postabortion care, if needed. Men have been for the most part neglected regarding their role in pregnancy prevention and resolution, especially in sub-Saharan Africa; therefore very little is known about

their attitudes towards and their role in women's reproductive health (Kaida et al., 2005). This article examines men's and women's perspectives on men's involvement in abortion decision-making and seeking postabortion care if complications from an unsafe abortion occur.

Background

The role male partners play in women's access to reproductive health care takes places directly and indirectly, biologically and socially (Dudgeon and Inhorn, 2004). An abortion-specific example of this is that in some countries, such as Turkey, women need their husband's permission to have an abortion (Gürsoy, 1996). The relationship that the man has with the woman, i.e. whether the woman is his wife, mistress or girlfriend, most likely influences his involvement as well as his desires regarding how to manage her reproductive health. For example, whereas expectations about continued childbearing within marriage may lead a man to expect his wife to carry any pregnancy to term, if the couple is unmarried a man might be motivated to help a girlfriend with an unwanted pregnancy abort since social sanctions could be brought to bear on both of them for having a child out of wedlock.

In the minimal research which has been done with men on abortion in Africa, research has identified men's unease with abortion spanning from Burkina Faso to Zimbabwe. A recent qualitative exploration of men's attitudes and involvement

in abortion in Burkina Faso found that men do not want women to have abortions so women have them secretly so as to minimize difficulties that could accompany telling the man about the abortion (Rossier, 2007). Qualitative data collected with men in Zimbabwe found that men viewed abortion as a sign of illicit sexual activity (Chikovore et al., 2002). The authors of the Zimbabwe study framed men's attitudes towards abortion within men's attitudes towards control over women and concluded that men felt anxious and vulnerable regarding their role in society due to shifting gender roles and greater rights accorded to women (Chikovore et al., 2002). Abortion is a concrete manifestation of the shift towards smaller families and greater female autonomy and thus the site of a great deal of social tension and censorship. In their study, women stated one of the reasons they did not disclose their abortion intentions or experiences to their male partners was because they feared violence (Chikovore et al., 2002).

In the only research done to date with men in Uganda on abortion, Nyanzi et al. found that due to abortion's illegal status in the country, their respondents, motorbike taxi drivers, felt it necessary to dissociate themselves from the practice in public spaces (2005). Yet in private spaces they reported being involved in abortions. This notwithstanding, the motorbike taxi drivers expressed a great deal of tension and conflict over abortion as it relates to notions of respectability, family and shame. The study participants reported that relationships do not survive the event of an abortion due to guilt, broken trust and inherent conflict

(Nyanzi et al., 2005). This study did not look beyond the event of the abortion to men's role in addressing abortion complications.

The research project under which these data were collected set out to understand how women in a setting such as Uganda where abortion is illegal and the abortion rate is high attempt to induce abortion and if complications ensue, how they go about seeking postabortion care, if at all. The motivation behind the study was to try to capture abortion complications among women who never make it to a health care facility to treat their postabortion complications. The results of the primary research question are written up elsewhere (Jagwe-Wadda et al., 2006). What became apparent when analyzing the data is the critical role men play in determining women's access to a less dangerous abortion as well as appropriate postabortion care. Dudgeon and Inhorn's review of male involvement in women's reproductive health did not discuss men's involvement in women's access to safe abortion or appropriate postabortion care (Dudgeon and Inhorn, 2004). Men, as key gatekeepers to modern medical care, in this case abortion-related care, is the subject of this analysis.

Methods

This report draws on data collected via in-depth interviews (IDIs) carried out in 2003 with women and men who reside in Kampala, an urban district and the capital city of Uganda, and Mbarara, a largely rural district in the west. In each

district, one subcounty/division was selected at random and within each subcounty, two parishes were selected. Households were identified with the assistance of women community leaders who had women and men residing in them who were between the ages of 18-60. Once households were identified, the study coordinator arbitrarily selected potential respondents. Less than one in 10 respondents who were approached to participate in the in-depth interviews refused to participate. The refusals were from individuals who were engaged in an activity at the time they were approached such as tending a shop or farming. In Kampala, the data were collected in the Luganda language and in Mbarara, the data were collected in the Runyankole language.

The respondents were 61 women of the community aged 18–60 and 21 men of the community aged 20–50. Based on how the sample was recruited, most of the respondents were lower-income. The interviewer obtained informed consent from each respondent before proceeding with the interview. On average, the IDIs took between 30 and 60 minutes. Within this sample, the men were better educated than the women, and most of the sample was married/in a union and Christian (see Table 1). As we did not collect detailed information on socio-economic status, we did not conduct a class-based analysis of the data.

INSERT TABLE 1 HERE

The IDIs asked about respondents' personal experiences with abortion and abortion complications as well as about the abortion experiences of community members including men's attitudes towards abortion, reactions to women who have abortions, men's role in helping women have abortions and treat abortion complications and what men could do to help women avoid health complications from unsafe abortion. As can be seen from the topics of the IDIs, this work does not deal with reasons for unintended pregnancy or the reason for seeking an abortion. It is focused on the abortion experience exclusively.

The taped interviews were transcribed by hand, first into the language in which they took place and then translated into English. The English translations were reviewed before they were entered into a word processing document. The text was coded using N6 qualitative software (QSR, Melbourne, Australia, 2001). The main issues explored were outlined in the coding (node) structure, the data were thematically coded into that structure, and analyses were conducted on the nodes of interest. Two authors reviewed each other's analyses to ensure consistency and agreement on interpretation of the results. The paper draws almost exclusively on the quotes from men.

Results

Men's attitudes toward abortion

When questioned generally about men's attitudes towards abortion, male respondents stated that men are not supportive of women having abortions. The reasons they give for being against women having abortions is that they do not agree with the practice; they believe that the aborted child could be an important member of society; that the woman could die undergoing the abortion, and they fear that they themselves might be arrested. As was found by Chikovore et al. in Zimbabwe (2002), men stated that if a woman is having an abortion, it must be because she is trying to hide the pregnancy from an affair. Other reasons that came up less frequently were that poor men feared having to bear the costs of abortion and treatment for abortion complications; it may be the woman's only opportunity to have a child; and men who have AIDS would like to have three or four children before they die.

Interviewer (I): Do you think men in this community are supportive of a woman's desire to stop a pregnancy?
Respondent (R): No, they are not supportive because one who aborts could die and more so, the aborted baby is also a human being.
—Rural male aged 28, Muslim

Some men want children and getting a child is not something easy. Some men die without producing a single child. Some men want babies and if a woman gives birth, he feels proud to get someone to call him Father.
—Urban male aged 32, Protestant

Men's responses largely reflect the prevailing socio-cultural norms and values and the legal environment, all of which are strongly against abortion. However, men made exception for young women in school. Consistent with Nyanzi et al.'s findings, the majority of men believed it to be acceptable for schoolgirls to get an abortion (2005). Men's support under this circumstance seemed to be largely motivated by self-interest as the reason men gave for being in support of a schoolgirl's abortion was that the man responsible could be brought up on defilement (rape) charges if the schoolgirl is found to be pregnant as the age of consent in Uganda is 18 (Nyanzi et al., 2005).

The social stigma against abortion for anyone but schoolgirls as well as the generally pro-natalist outlook of Ugandans, particularly among men and within marriage, can serve as a disincentive for a woman to speak with her partner about abortion. The perception held by both men and women in the sample was that women frequently do not let men know about abortions, especially if the woman is married.

I: Do women discuss with their husbands or partners about their unwanted pregnancy?

R: It is not common for your wife to tell you. May be if she is a prostitute/concubine. She can tell you, "I did not want this pregnancy so let us

abort." But for a woman who you married and stay with in the home, she cannot tell you about aborting.

--Rural male aged 33, Catholic

Women respondents described abortion as the woman's secret. One woman who helped her friend abort explained how they kept the secret from her partner:

I: Did the man who impregnated her come to know that she aborted?

R: We planned and deceived him. Before she aborted, she got some fever and the man knew about it. After she aborted we told him that she had a miscarriage.

--Rural female aged 50, Muslim

Similar to women's experiences in Burkina Faso (Rossier, 2007), women in Uganda, such as the situation related above, are inclined to keep the abortion a secret to minimize problems that may come with telling the man.

Men's involvement in postabortion care

Approximately half of women who obtain abortions in Uganda will need postabortion care in her lifetime (Singh et al., 2006). (For an explanation of common abortion complications in Uganda, see Prada et al., 2005.) Since many women keep abortion a secret, men described how they may not even know that a woman is experiencing abortion complications.

I: What do men do when their wives/partners experience health problems after stopping a pregnancy?

R: Many men don't get to know that their women are having complications resulting from stopping a pregnancy. They only see the women sick, thinking it's malaria. This causes the woman many problems and she can even die. She can be given treatment for malaria and the real complication isn't treated at all.

--Urban male aged 44, Catholic

As this quote demonstrates, some women maintain their secret at the cost of their lives—underscoring the severity of the consequences women perceive may come about as a result of having had an abortion. This desperation to keep an abortion a secret is also one of the primary reasons respondents said that women delay seeking care for complications.

If a woman who did not involve her partner begins to experience complications, not only does she have to weigh the consequences of revealing that she has had an abortion but at that point, it also becomes unavoidable to reveal that she made the decision to have an abortion without informing her partner. The primary reason men and women gave for women telling men about abortion complications was because of the need to get money from him to help pay for treating the complications. It is possible that a woman may be able to secure financial support from other sources than their partner to treat abortion complications, either through her own income or through the assistance of

others. Yet in a country as poor as Uganda, there are very few who have any resources to spare. Women who have the assistance of their male partners, particularly in a society where males generally hold much greater power, are much more likely to be able to get safer abortions and appropriately treat their abortion complications. Having money was specified as a prerequisite to getting treated at clinics (private health units). Respondents said that money also speeds up the treatment one receives at the hospital (public health units where treatment is supposed to be free). While cost estimates were made conditional on the type of complication the woman was experiencing, they ranged from 3,000 Ugandan shillings to 200,000 Ugandan shillings (equal to about US$1.50 to US$110).

Men unequivocally stated that if the man finds out that the woman terminated a pregnancy without his knowledge, he cannot support her no matter what health problems she experiences. Part of the perceived offence was that the woman has done something abominable, since abortion is highly stigmatized and seen as something evil. Further offence was taken at terminating a pregnancy that the man may have wanted. (As was presented in the introduction, men and women differ on ideal family size in Uganda with men wanting, on average, 0.8 more children than women (UBOS and ORC Macro, 2007)). Men also perceived that a woman having an abortion must be trying to hide the evidence of an affair. Lastly, men also expressed unhappiness that a woman would make a decision to have an abortion without consulting them.

I: Now during that time when the man figures out that the woman has developed these complications, how does he support the woman?

R: In our culture here when the woman develops these complications when she didn't inform her husband, then the man may even separate with the woman or the man may opt not to support the woman in any way and the woman has to support herself.

--Urban male aged 50, Catholic

Not having money was mentioned by a couple of men as a reason why males may not provide support for their partners who experience abortion complications. Men explained that sometimes men even deny responsibility for the pregnancy because they do not have money to help the woman with postabortion complications. This adds emotional injury to physical injury as it is socially disgraceful to have the man deny responsibility for the pregnancy since it implies that the woman had additional sexual partners and that she had been unfaithful.

Numerous men interpreted the fact that a woman had an abortion as a sign that she did not love her partner anymore and did not want to have a(nother) child with him. Men used this as justification for not supporting a woman if she experiences complications.

I: What do men do when their wives/partners experience health problems after stopping a pregnancy?

R: It depends on whether you agreed upon having the abortion or not. If you agreed, you try to buy her food and drinks to restore her energy. If you did not agree to have an abortion, she takes the responsibility for her action because that means she doesn't want you any more.

--Rural male aged 43, Catholic

I: What do men do when their wives experience health problems after stopping a pregnancy?

R: Some men usually send these partners to their homes [parents' home].

I: Why?

R: Because since this woman is not willing to produce my child then the best thing is for her to go back to her parents.

--Urban male aged 22, Bahai Faith

Yet women's reasons for having abortions did not adhere to men's perceptions of infidelity or lack of women's interest in their partner. The women in the sample who had experienced an unwanted pregnancy gave as reasons for the pregnancy being unwanted that their previous child was still young, she was in school and that she had a conflict-filled relationship with her husband. Rather, women stated that women may decide to keep the abortion secret because they figure other people, including the partner, are not likely to see the need for the

abortion. This research thereby uncovers a disjuncture between the perceptions of men and the realities of women regarding why a woman would terminate a pregnancy. That misunderstanding holds serious consequences for the woman's health as it directly impacts her ability to involve her partner in her abortion experience.

Conditions under which men are supportive

In cases where men have a prior knowledge of the abortion or are involved in the decision-making, they described helping women make doctors' appointments, providing financial support such as buying her medicine, arranging for transportation or take her to a facility for treatment, and buying her food.

For me, if I agree with my partner to abort…I go to the clinic/hospital and buy her medicine. If it requires taking her to the hospital I take her. If it requires buying her energy building foods, I can buy them.

—Rural male aged 43, Catholic

As a man, if you really love your wife, especially those who are married, the man has that duty to support the women in this matter. You have to seek treatment for her. You don't just leave her to seek treatment herself. You don't just leave her like that! This is one of the responsibilities of the husband in the home.

—Urban male aged 40, Protestant

This second quote draws attention to the distinction men might make regarding their level of responsibility according to their relationship to their partner since this respondent emphasizes the duty of a husband to provide care for his wife.

Discussion

In Uganda, abortion culturally challenges women's predominant identity of being a mother. Abortion is a threat to pronatalism and secret abortion is a threat to men's dominance in the home. In a situation such as Uganda where abortions are almost always carried out clandestinely, as was found in Zimbabwe by Chikovore et al. (2002), not being able to get the man's financial and logistical support for carrying out the abortion increases the probability that the woman will have to resort to a less safe abortion which increases her chances of getting complications. The fact that men interpreted abortion to be a sign of infidelity in Uganda, just as in Zimbabwe, led Chikovore et al. (2002) to conclude in the case of Zimbabwe that married men are more concerned with women's sexuality and their own feelings of vulnerability and lack of control over female sexuality than they are with women's health. The fact that men categorically said they could not support a woman requiring postabortion care who had had an abortion without their knowledge and consent also demonstrates a prioritization among Ugandan men of control over female sexuality that trumps possibly saving that woman's life. While this paper did not directly test Kyomuhendo's hypothesis that in Uganda, all pregnancy-related problems are treated as a woman's fault and a

sign of her failing, the fact that men were so quick to absolve themselves of any responsibility related to women experiencing abortion complications lends credence to her hypothesis.

When women experience abortion complications, as about half the women who abort in Uganda do, women who have aborted clandestinely face the excruciating choice of revealing to her partner that she had an abortion without his knowledge or she can try to self-treat, most likely through the use of traditional, less effective methods. Women respondents, as well as women they knew about who had postabortion complications, related adopting a wait and see approach in the hopes that they would not have to reveal their abortion to their partner. While the woman is waiting to see if she'll get better, her health, her future fertility and even her life are being threatened. Just a Chikovore et al. identified in Zimbabwe, but which applies to the Ugandan just as well, "The silence and secrecy imply that abortions and related complications and even death may occur without men knowing the cause" (2002, pg. 329).

While male respondents did not present a uniform view that men constitute barriers to women's health care access, they presented at best scenarios of men's involvement that were highly conditional and which suggest that men often misunderstand women's abortion-seeking motivations. While it is possible that men were expressing more rigid anti-abortion sentiments than they actually held to distance themselves from abortion, men's anti-abortion sentiments and

subsequent behaviors were verified by the women interviewed in the sample. Men's expressed stand on this issue may also reflect their tendency to see themselves as the custodians and enforcers of the cultural norms and values in a largely patriarchal society like Uganda, especially if they perceive that tradition is being undermined by women rejecting traditional roles of reproduction. Nevertheless, there might be a difference in what men are willing to voice support for versus what they might do or have already done for women in their lives when facing such a situation even when not all the conditions they cite for their involvement have been met.

Chikovore et al. (2002) point out that women's silence around their abortion experiences misses an important demonstration of how women exercise their agency. "Without disregarding the vulnerability of women and the male violence within patriarchal structures, emphasizing women's powerlessness risks concealing other capabilities of women, which can be the basis for promoting women's health" (pg. 329). Women's experiences of clandestine abortion seeking, resourceful pursuit of postabortion care and the use of girlfriends and other female family members to carry this out is a demonstration of women's agency and a subversion of men's domination (Jagwe-Wadda et al., 2006) that can be easily overlooked because of women's fear in speaking about abortion.

In the patriarchal social structure present in Uganda, women's reproductive health needs are subject to the perceptions of male policymakers, male service

providers and male partners. The neglect of men as agents and clients of family planning has been identified as a cause of the limited impact of many family planning programs (Ezeh, 1993; Agyei & Migadde, 1995) as men play a critical role in reproductive decision-making in sub-Saharan Africa (Fayorsey, 1989; Mbizvo & Adamchak, 1999). Involving men in family planning holds the potential of reducing unintended pregnancy and thereby the demand for abortion. Work that Kaida et al. (2005) carried out in Mpigi district, Uganda, found that men have limited knowledge about family planning and that there is poor spousal communication about family planning in general, yet men want to be involved in family planning. The authors concede, however, that there remains a disjuncture between men's stated willingness and the reality of their actual participation in family planning programs (Kaida et al. 2005).

There is a need to increase men's understanding of reasons why women elect to have abortions so as to minimize the disjuncture between men's perceptions of abortion and women's experiences.

The necessity of involving men in reproductive health programs was reinforced at the International Conference on Population and Development held in Cairo in 1994, at the Fourth World Conference on Women held in Beijing the following year (Family Care International (FCI), 1999), and internally, in Uganda's 1995 National Population Policy (Ministry of Finance and Economic Planning, 1995). One worrisome possible consequence of increasing men's involvement in

women's abortion decision-making and their care seeking for postabortion care is that men might then try to influence women's abortion decision-making. Efforts have been made in other country contexts including Egypt and Tanzania to utilize men's involvement to proactively improve women's postabortion care-seeking (Abdel-Tawab et al., 1999; Rasch and Lyaruu 2005). Therefore, while it is important to proceed cautiously in efforts to increase men's involvement, models exit to encourage male involvement in abortion.

If men were not so judgemental/out of touch with women's reproductive needs and choices, then perhaps women's need for secrecy would not be so great. Until men are willing to support women's choices—perhaps if they gain greater compassion for women's burdens, fears, and constraints—this secrecy may be tantamount to protecting women's safety. We hope the day will come when men express greater compassion for women's reproductive predicaments and participate as respectful collaborators in women's reproductive health.

In the Burkinábe context, Rossier noted that men's attitudes about abortion have not kept pace with women's lived experiences. She argues, "Abortion is kept a secret by women, not because it is a form of transgression nor from an awareness of having committed a socially condemned act, but in order to manage their public image in a society where social norms have not caught up with actual behavior" (Rossier, 2007: 237). The same could perhaps be said of Uganda since in December 2003, Uganda signed the African Charter on Human and People's Rights on the Rights of Women in Africa. That charter specifies that

women have the right to control their fertility; to decide whether to have children; to decide on the number and spacing of their children; to obtain adequate, affordable and accessible health services; and to access medical abortion in cases of sexual assault, rape, incest, danger to the mental and physical health of the mother, and danger to the life of the mother or the fetus (African Union, 2003). Uganda's endorsement of the African Charter suggests that Uganda's abortion law, as Rossier suggests, may be out of step with prevailing public will and that the time may be ripe to revisit the legal provision of abortion in Uganda.

Study Limitations:

There are some limitations of this study that merit noting:

• In a setting such as Uganda where not only is abortion illegal, it is also highly stigmatized, peoples' discomfort talking about it is understandable yet it makes grasping an accurate picture of abortion more challenging.

• Men were asked about abortion in general and were not queried about how their reactions might differ depending on their relationship to the woman even though men's involvement most likely changes depending on their relationship to that woman (Rasch and Lyaruu 2005).

References

Abdel-Tawab, N, Huntington, D., Hassan, E.O., Youssuf, H. & Nawar, L. (1999) Effects of husband involvement on postabortion patients' recovery and use of contraception in Egypt. In Huntington D. & Piet-Pelon, N.J. (eds) *Postabortion Care: Lessons from Operations Research*. Population Council, New York, pp. 16-37.

African Union. (2003) *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*. At: <http://www.achpr.org/english/_info/women_en.html>. Accessed 26 January 2006.

Agyei, W. K. A. & Migadde, M. (1995) Demographic and sociocultural factors influencing contraceptive use in Uganda. *Journal of Biosocial Science* **27**, 47–60.

Atuyambe, L., Mirembe, F., Johansson, A., Kirumira E.K., & Faxelid, E. (2005) Experiences of pregnant adolescents – voices from Akiso district, Uganda. *African Health Sciences* **5,** 304-309.

Brookman-Amissah, E. & Moyo, J.B. (2004) Abortion law reform in Sub-Saharan Africa: no turning back. *Reproductive Health Matters* **12** (24 Supplement), 227–234.

Chikovore, J., Lindmark, G., Nystrom, L., & Mbizvo, M.T. (2002) The hide-and-seek game: Men's perspectives on abortion and contraceptive use within marriage in a rural community in Zimbabwe. *Journal of Biosocial Science* **34**, 317-332.

Dudgeon, M.R. & Inhorn, M.C. (2004) Men's influences on women's reproductive health: medical anthropological perspectives. *Social Science and Medicine* **59**, 1379-1395.

Ezeh, A. C. (1993) The influence of spouses over each other's contraceptive attitudes in Ghana. *Studies in Family Planning* **24**, 163–174.

Family Care International (FCI). (1999) *Meeting the Cairo Challenge: Progress in Sexual and Reproductive Health.* FCI, New York.

Fayorsey, C. (1989) Family planning in Africa; the relevance of gender issues. In *Developments in Family Planning Policies and Programmes in Africa*. Regional Institute for Population, Legon, Ghana, pp. 194–229.

Greene, M. E. (2000) Changing women and avoiding men: Gender stereotypes and reproductive health programmes. *IDS Bulletin* **31**, 49–59.

Gürsoy, A. (1996) Abortion in Turkey: A matter of state, family or individual decision. *Social Science and Medicine* **42**, 531–542.

Jagwe-Wadda, G., Moore, A.M, Woog, V. (2006) *Abortion morbidity in Uganda: evidence from two communities.* Occasional Report. No. 26. Guttmacher Institute, New York.

Kaida, A., Kipp, W., Hessel, P., and Konde-Lule, J. (2005) Male participation in family planning: results from a qualitative study in Mpigi District, Uganda. *Journal of Biosocial Science* **37**, 269-286.

Kyomuhendo, G.B. (2003) Low use of rural maternity services in Uganda: impact of women's status, traditional beliefs and limited resources. *Reproductive Health Matters* **11**, 16– 26.

Mbizvo, M. T. & Adamchak, D. J. (1991) Family planning knowledge, attitudes and practice of men in Zimbabwe. *Studies in Family Planning* **22**, 31-38.

Ministry of Finance and Economic Planning. (1995) *National population policy for sustainable development.* Kampala, Uganda.

Nyanzi, S., Nyanzi, B. and Bessie, K. (2005) 'Abortion? That's for women!' narratives and experiences of commercial motorbike riders in South-Western Uganda. *African Journal of Reproductive Health* **9,** 142–161.

Prada, E., Mirembe, F., Ahmed F.H., Nalwadda, R. & Kiggundu, C. (2005) *Abortion and post-abortion care in Uganda: a report from health care professionals and health facilities.* Occasional Report, No. 17. The Alan Guttmacher Institute, New York.

Rasch, V. & Lyaruu, M.A. (2005) Unsafe abortion in Tanzania and the need for involving men in postabortion contraceptive counseling. *Studies in Family Planning* **36**, 301-310.

Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2006-2015. (2008) The Republic of Uganda.

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

Singh, S., Moore, A.M., Bankole, A., Mirembe, F., Wolf, D. & Prada, E. (2006) *Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences.* Guttmacher Institute, New York.

Singh, S., Prada, E., Mirembe, F. & Kiggundu, C. (2005) The incidence of induced abortion in Uganda. *International Family Planning Perspectives* **31,** 183–191.

Thaddeus, S. & Maine, D. (1994) Too far to walk: maternal mortality in context. *Social Science and Medicine* **38,** 1091–1110.

Uganda Bureau of Statistics (UBOS) and Macro International Inc. (2007) *Uganda Demographic and Health Survey 2006.* UBOS and Macro International Inc., Calverton, Maryland, USA.

Weeks, A., Lavender, T., Nazziwa, E. & Mirembe, F. (2005) Personal accounts of 'near-miss' maternal mortalities in Kampala, Uganda. *British Journal of Obstetrics and Gynaecology* **112**, 1302–1307.

World Bank. (2009) *World Development Report 2009: Reshaping Economic Geography.* The World Bank, Washington, D.C.

World Health Organization (WHO). (2007a) *Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank.* WHO, Geneva.

World Health Organization (WHO). (2007b) *Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003*. WHO, Geneva.

Table 1. Characteristics of the study (in-depth interview) participants

	Women	Men
Total N	61	21
Age		
18-24	13	3
25-39	19	11
40-49	10	7
50-60	19	0
Residence		
Urban	31	10
Rural	30	11
Education*		
None	4	0
< secondary	35	8
≥ secondary	22	12
Marital status		
Married/In union	34	17
Not married/Not in union	27	4
Religion		
Muslim	18	9
Christian	41	11
Other	2	1

* For one male respondent, education level not specified [Q not asked]

Acknowledgements
The authors would like to thank Ellen M.H. Mitchell, Grace Bantebya Kyomuhendo, Annika Johansson, Stella Neema, Patty Skuster, Susheela Singh, Vanessa Woog, and Elena Prada, for their constructive comments and suggestions on an earlier version of this manuscript. This work was made possible by the Netherlands Ministry for Development Cooperation, the World Bank and the UK Department for International Development.