

Men's Roles in Women's Abortion Trajectories in Urban Zambia

CONTEXT: Given that maternal morbidity and mortality from unsafe abortion persist, especially in Africa, there is a pressing need to understand the abortion decision-making process. However, little is known about men's influence on and involvement in women's abortion decision making and care seeking.

METHODS: A qualitative study was conducted at the largest public provider of abortion-related care in Zambia. Thematic framework analysis was used to categorize and synthesize data from in-depth interviews conducted in 2013 with 71 women who received a safe abortion and 41 who received care following an incomplete (unsafe) abortion.

RESULTS: Men influenced whether women sought a safe or unsafe abortion; their actions, lack of action and anticipated actions—negative and positive—reflected broader gender inequities. Abandonment by men, and the desire to avoid disclosing pregnancy to men because of fear of their reactions or interference, were important influences on some women's decision to seek abortion, on the secrecy and urgency with which abortion was pursued and on the level of risk assumed. However, other women discussed men's positive influences on their abortion care seeking. In this setting of low awareness of the legality and availability of abortion, some men used their greater social and economic resources to facilitate safe abortion by providing information and paying for care.

CONCLUSIONS: Increasing knowledge about the legality and availability of safe abortion is vital not only among sexually active women, but also among those they confide in, including men.

International Perspectives on Sexual and Reproductive Health, 2017, 43(2):89–98, <https://doi.org/10.1363/43e4017>

By Emily Freeman,
Ernestina Coast
and Susan F. Murray

Emily Freeman is assistant professorial research fellow, Department of Social Policy, and Ernestina Coast is associate professor, Department of International Development, both at the London School of Economics and Political Science, UK. Susan F. Murray is professor of health, society and development, International Development Institute, King's College London, UK.

Calls to include men in sexual and reproductive health agendas, both as clients themselves and as actors who influence women's sexual and reproductive health outcomes,^{1,2} have been answered by research and programs focused primarily on male influences on contraceptive use and maternity care.³ Much of the early work necessarily focused on identifying and understanding the ways in which men obstruct women's attainment of sexual and reproductive health.⁴ Later work illustrated a range of male actions (and inactions) that affect women's sexual and reproductive health and well-being, as well as their self-determination and rights, in positive and negative ways.^{3,4} However, men's roles in abortion have received little attention.

Men's influences on women's abortion decision making and care seeking operate on different levels. At the structural level, men typically control the exercise of power—political, economic and social—and the institutions, laws and policies that govern access to abortion. For example, in most countries, abortion law was written and is enforced by men, and reflects assumptions about their domination in male-female relations;⁴ some laws require spousal consent if the woman seeking abortion is married (e.g., in Kuwait), while in some countries, such consent is frequently demanded even when not legally specified (e.g., in India). The consequences of abortion legislation for

women's health and well-being are indicated by the higher prevalence of unsafe abortion and associated morbidity and mortality where abortion is highly restricted.⁵

At the individual level, men may be involved in women's abortion care seeking as sexual partners, relatives or friends. In many cases, they exert their influence by withholding support, denying paternity, threatening or committing violence, or abandoning the woman.⁶ For example, studies in Ghana found that male partners' denial of paternity and subsequent withholding of financial support had a significant impact on whether women sought an abortion.^{7,8} Research from Kenya found that some men used financial power to try to persuade their partners to either terminate a pregnancy (e.g., by buying abortion drugs) or continue it (e.g., by promising financial support for the woman or child); others left responsibility for preventing pregnancies to their wives, who subsequently sought abortion without disclosing the pregnancy to them.⁹

But men may also share in decision making. A study of couples in Bangladesh found husbands who identified themselves as the sole decision maker regarding abortion, but also couples who made decisions together based on mutual preferences.¹⁰ Husbands of women in Cambodia who had had a medication abortion reported sharing the decision with their wives and were knowledgeable about

the abortion process, the physical care their wives would need and the places where services could be obtained.¹¹

In addition, men play a role in facilitating or obstructing women's efforts to obtain abortions, especially in countries where the procedure is restricted. In a Tanzanian study, almost one-third of women seeking postabortion care were accompanied by their male partner.¹² Evidence from Burkina Faso, where knowledge of the legal availability of abortion is low and providers and clients fear prosecution, young women are impelled to disclose pregnancies to male and female friends and kin to obtain information about clandestine abortion.¹³ In Nepal, where safe abortion is available but unsafe abortion remains common, the advice that husbands seek from friends, family, faith healers, pharmacists and doctors, and their securing of abortifacients, are major factors in determining whether women have safe or unsafe abortions.¹⁴

Men, however, may not recognize their influence on women's abortion care seeking or may not consider abortion a "men's issue," especially when they have no personal experience with unintended pregnancy or abortion. Some research has focused on men from a general population, rather than on those recruited via women's sexual and reproductive health care visits for abortion or contraceptives. These men may distance themselves from abortion, regarding it as being beyond their responsibility or concern;^{6,15} as a strategy women employ to resolve socially problematic pregnancies;¹⁶⁻¹⁸ or as a female-led action that excludes men, violating paternal rights and prohibiting equality between partners.¹⁹ However, Nyanzi et al. warn against using such findings to justify focusing interventions on women only.¹⁵ They argue that excluding men can enhance men's ability to distance themselves from abortion to escape social condemnation or penal consequences.

These insights suggest that public health narratives portraying unsafe abortion as a problem concerning women's choices, service access or risk exclusively fail to reflect the experiences of men who are husbands, boyfriends, family and friends, or of the women who may be influenced by them. Addressing unsafe abortion requires greater understanding of how men implicitly or explicitly influence whether women obtain safe or unsafe abortion.

This article examines men's involvement in women's abortion seeking in Lusaka, Zambia, where safe abortion is available but unsafe abortion is widely practiced. We look specifically at the roles that men who are part of women's social networks play in the trajectories—that is, the routes or pathways—that women take when seeking a safe or unsafe abortion. Understanding men's roles is particularly salient because women's abortion trajectories can be multistep and nonlinear,²⁰ especially in low-income countries that do not provide comprehensive abortion care. Furthermore, because similar patterns of persistent unsafe abortion despite legal provision of safe abortion have been documented elsewhere (e.g., Ethiopia, India and South Africa),²¹⁻²³ our research may have implications

for understanding men's roles in abortion decision making and care seeking more widely.

CONTEXT

Zambia's Termination of Pregnancy Act (enacted in 1972 and amended in 1994) permits abortion to be carried out by a registered medical practitioner under a wide range of circumstances.* More than 75 government facilities are licensed to provide abortion services throughout the country. Services are also provided by nongovernmental organizations.^{24,25} However, at the time of our data collection in 2013, Marie Stopes Zambia, the largest nongovernmental provider, had temporarily suspended services (resuming in 2014), which reduced the number of registered providers operating. Some private medical practices are registered (by the Health Professions Council of Zambia) to provide safe abortion services, but the number of these practices and the proportion of abortions they provide are unknown.²⁶ Since 2012, a government-approved medication abortion regimen of combined mifepristone and misoprostol has been widely available for purchase in private pharmacies. In addition, the sale of unregistered pharmacological abortifacients, including so-called "Chinese drugs," is reputedly growing.²⁰

There are no nationally aggregated data on the incidence of induced abortion, safe or unsafe.²⁷ The Zambian government estimates that unsafe abortion accounts for 30% of maternal mortality and 50% of gynecologic hospital admissions.²⁸ According to regional estimates from 2012, the number of unsafe abortions nationwide is approximately 66,000 per year, of which almost 30,000 require postabortion care.²⁹ A facility-based study in three provinces examined the level of abortion-related "near-misses"—morbidity so severe that survival requires hospital treatment. It concluded that the abortion-related near-miss rate and ratio were both high: 72 per 100,000 women aged 15-49 and 450 per 100,000 live births, respectively.³⁰

In Zambia, the high prevalence of unsafe abortion likely reflects low levels of knowledge about the legal provision of abortion in the population and among health professionals,^{27,31} and high levels of stigma associated with providing and seeking abortion³² that limit the availability of abortion services even at registered facilities. As a result, obtaining an abortion, whether safe or unsafe, is frequently complex and expensive, involving public and private—and formal and informal—providers.²⁰

Zambian studies conducted in the late 1990s and early 2000s shed some light on men's influence on unsafe abortion at that time. Koster-Oyekan found that among young women in secondary school (aged 12-22 years), the decision to terminate a pregnancy was influenced by the young

*A pregnancy may be terminated if continuing it poses a risk to the life of the pregnant woman or to the physical or mental health of the woman or her existing children, or if the child born of the pregnancy would be seriously handicapped by physical or mental abnormalities (source: Termination of Pregnancy Act, Laws of Zambia, Ch. 304, 1972). The penal code was amended in 2005 to permit abortion in cases of rape or incest (source: Offenses Against Morality, Laws of Zambia, Ch. XV, Section 152(2), 2005).

women's fears of their father's reaction to the pregnancy as well as asymmetries in age, wealth and power between the young women and their partners.³³ Dahlbäck et al.'s study of abortion seeking among adolescents aged 13–19 admitted to the hospital for incomplete abortion identified both how male involvement affects women's abortion decision making and care seeking and how gender dynamics affect male involvement.³⁴ The decision to abort was frequently affected by the type of sexual relationship (e.g., nonconsensual, casual, marital), the sexual partner's reaction to the pregnancy and the associated financial implications.

METHODS

Setting and Sample

Zambia's established abortion services are concentrated in the capital, Lusaka. The city's University Teaching Hospital is the largest public provider of abortion-related services in the country, and some women travel considerable distances to obtain care there.³⁵ It is therefore a suitable setting in which to consider abortion experiences in a large, heterogeneous sample of women.

Between January and December 2013, women who had undergone induced abortion at the hospital or had received postabortion care there following induced abortion were identified by nurse-midwives as potential respondents. These women were invited to participate in in-depth interviews once they were ready for discharge; 13 declined to participate. The resulting sample included both women hospitalized for severe complications and women treated as outpatients. Respondents were aged 15–43 years. They were primarily from Lusaka (90%), although a minority had traveled from as far as Copperbelt and Central provinces, more than 120 kilometers away. We present data generated from interviews with 71 women who had received a safe abortion and 41 women who had received care following an incomplete abortion. The women were given the Zambian kwacha equivalent of US\$5 for their participation.

To understand our sample's specificity, we compared it with a sample of women aged 15–49 from the population-based 2013–2014 Zambia Demographic and Health Survey³⁶ (Table 1). Our sample included a higher proportion of current or recent students (e.g., those waiting for exam results to proceed in education) than did the general population. This is unsurprising because continuing education was a key reason for seeking abortion reported by many adolescents. The employment profile of nonstudents in our sample was as would be expected in a capital city: The proportion employed outside the family was much higher than the national average.

The interviews were conducted in a private office in the study hospital by female research assistants fluent in the respondents' languages (Nyanja, English and Bemba), and typically lasted 30 minutes. Prior to the interview, respondents documented their informed consent to participate by signature or thumbprint. A novel two-interviewer approach was used: One assistant asked open-ended questions in a

TABLE 1. Percentage distribution of women aged 15–43 who received either a safe abortion or postabortion care at University Teaching Hospital, Lusaka, Zambia, 2013, and of female respondents aged 15–49 to the Zambia Demographic and Health Survey, 2013–2014, by selected characteristics

Characteristic	University Teaching Hospital (N=112)	2013–2014 DHS (N=16,411)
Age		
15–19	24.3	22.1
20–24	28.7	18.3
25–29	13.9	17.1
30–34	15.7	15.1
≥35	17.4	27.3
Highest education level completed		
None	na	8.4
Nursery/kindergarten	12.4	na
Primary	36.3	46.8
Secondary	35.4	39.7
≥secondary	15.9	5.1
Religion		
Catholic	27.0	18.2
Protestant	69.4	80.4
Muslim	1.7	0.6
Other	0.9	0.6
Missing	0.9	0.2
Current/recent student*		
Yes	78.5	30.7
No	21.5	69.3
Employment (nonstudents)		
Not working†	27.3	45.7
Work for family member	3.9	7.1
Work for someone else	42.9	10.1
Self-employed	25.9	37.1
Total	100.0	100.0

*Percentage of females aged 15–19 reporting either current or recent school attendance. †Includes women who perform unpaid domestic labor, those who are unemployed and those who are seeking work. Notes: Percentages may not add to 100.0 because of rounding. na=not applicable.

conversational style to facilitate the respondents' comfort and narrative flow, while a second assistant noted all of the steps taken by a woman from the time of pregnancy recognition to when she sought care at the hospital (her abortion trajectory), as well as the people involved at each step. Toward the end of the interview, the second assistant asked supplementary closed-ended questions to ensure the interviewers fully understood the respondent's abortion trajectory and to establish her social and demographic characteristics (education, religion, occupation, ownership of household material goods). Our research instrument is publicly hosted online by the Consortium for Research on Unsafe Abortion in Africa for reference and for other researchers to use.³⁷ It was developed for this study and was pretested with six respondents. All but two of the 112 respondents gave permission for their interview to be audio recorded and transcribed. During the two non-audio-recorded interviews, both interviewers took detailed notes, which were subsequently merged to produce a single interview record for each of those respondents.

Independent ethical review was granted by the Research Ethics Committees at the London School of Economics and the University of Zambia.

Analysis

The interviews aimed to explore what influenced whether women attended the study hospital for a safe abortion or for care following an incomplete abortion. Thematic framework analysis was used to systematically categorize and synthesize the qualitative data the interviews generated.³⁸ All transcripts were read and reread for salient themes. This exercise highlighted the importance of considering the part played by men in women's abortion trajectories. Our analysis of male involvement, presented here, began with identification of relevant recurring themes and related subthemes from an inductive content analysis of a random subsample of 10% of the transcripts. These themes were then mapped to ensure that there was conceptual clarity and no obvious omissions or overlaps.

A framework chart (matrix) was drawn up using the themes. It included space for a log of all of our interpretive observations, separated from the data. Data from all of the transcripts were sorted and synthesized into the matrix using descriptive summaries of the interview data, respondents' words and phrases, and information about the context in which they were expressed under each thematic heading. The matrix remained flexible so that any previously unconsidered themes could be added.

With the matrix complete, we reviewed each individual respondent and subtheme column to identify patterns in the presence and nature of male involvement in women's abortion decision making and care seeking. We considered a range of factors that could influence why and how men were or were not included in women's abortion trajectories. This included the type of relationship that led to the pregnancy (stable relationship, new relationship, insecure relationship, no relationship or nonconsensual relationship) and the women's age, wealth and education. More abstracted, explanatory analysis that linked analytic themes and accounted for all cases in the sample was developed by making comparisons down the matrix (across cases, looking at similarities and differences in respondents' experiences) and across the matrix (within cases, looking at how themes are linked within an individual's narrative), and by asking questions about the data that emerged during the construction of the matrix. The key themes are reported below. Along with the in-depth qualitative analysis, basic descriptive statistical information is offered to highlight the broader patterns in the data.

RESULTS

Women's reports of male participation in their abortion decision making and care seeking were roughly equally split between those of men who knew about the pregnancy and were actively involved in a woman's abortion trajectory (49%; not shown), and those of men who had no direct involvement or who were not aware that the care they helped the woman obtain was related to abortion (42% and 8%, respectively). Women's abortion trajectories

were influenced by men who were present and those who were absent (or unaware). Men's actions, lack of action or anticipated actions had implications for the direction, complexity and timing of women's abortion-related care seeking, for both safe and unsafe abortions.

Men's Absence

Some women simply did not mention men at all. For other women, men's absence was an important factor in their abortion decision making or care seeking. Women who had received postabortion care at the hospital were more likely to report that no men were knowingly involved in their abortion trajectories than to discuss men's involvement (63% vs. 35%). Almost three-quarters (72%) of women who reported that men were actively and knowingly involved in their abortion decision making and care seeking had received a safe abortion at the study hospital.

We identified a variety of situations in which men's absence influenced both whether women continued their pregnancy and whether abortion was pursued safely or unsafely. These absences were all ultimately the results of male behaviors: They were caused either by men's active rejection of paternity or the relationship, or by women choosing to exclude men because of fear of men's interference with the abortion decision-making process or their reaction to the pregnancy, based on men's previous behavior.

The influence of men's absence reflected societal-level gender inequities that played out differently for women across ages and levels of wealth and education. Although age did not determine whether women reported men's involvement in their abortion trajectory, the nature of men's noninvolvement seemed to differ across age-groups. For example, instances of partner rejection or violence in response to pregnancy emerged more frequently in younger women's narratives than in those of older women, while older women were more likely than younger women to report having excluded their partners. Wealthier women and more educated women more frequently reported that men played a role in their abortion trajectories (69% and 67%, respectively) than reported that men had no role (27% and 28%), or that the men involved did not know about the pregnancy or the abortion (4% and 6%). In contrast, poorer women and less educated women were more likely to report that no men had a role (57% and 52%, respectively) than to report that men were knowingly involved in the abortion decision making and care seeking (30% and 38%); 14% and 9% of these women, respectively, reported that the man involved did not know about the pregnancy or abortion. Women of all backgrounds acknowledged gendered opportunity and social costs of pregnancy and future parenthood, which were complicated by other social inequities they experienced.

• *Men's rejection of paternity or relationship.* Thandi, age 21, and her boyfriend ended their relationship a month before she realized she was pregnant. She had hoped the pregnancy would reunite them, but instead he "denied

[her],” telling her to abort or raise the child on her own. Thandi felt she had no choice but to terminate the pregnancy:

“I talked to him over [the pregnancy], but unfortunately, he just could not accept the responsibility of it and said that he will not be part of it—that I should either remove it or [I] will be on [my] own.... I cannot raise a child on my own. Though I needed my child, I never had a choice.”

Partner rejection as a result of the pregnancy was a common reason why the men who had previously been important in women’s lives were absent from their abortion trajectories. In these cases, men’s denial of paternity or discontinuation of the relationship became a catalyst for what was to follow. Respondents’ narratives document substantial negative social, educational and financial implications of pregnancy and parenting without a partner for a woman and her family. Consequently, some respondents reported that abortion reflected the lack of the option to continue a pregnancy, rather than an active choice to end it, and frequently presented abortion as their partner’s decision, made in absentia.

It was much more common for women in insecure relationships—those that ended either before or after the pregnancy, often as a direct result of the pregnancy—to report that no men were knowingly involved in their abortion trajectories than to report that men did have a role (68% vs. 29%). In contrast, women in stable (marital or nonmarital) relationships more frequently discussed men’s involvement in their abortion trajectories than their absence (59% vs. 28%).

Narratives about partners’ abandonment highlight the fluidity of concepts of “unintended” or “unwanted” pregnancy. Pregnancies that were initially wanted, and sometimes intended, became unwanted or unsustainable when the possibility of having to raise a child without a partner arose. This had implications for women’s abortion trajectories when, for example, negotiation about the pregnancy and the possibility of continuing it caused delays in care seeking, as illustrated in the case of 24-year-old Jennifer.

Jennifer was unemployed and lived with her older sister. When she became pregnant by her partner of six months, she spent two months attempting to convince him that they had a positive future together before he left her. Eventually she went to a pharmacist who sold her drugs for a medication abortion. She was subsequently taken to the study hospital in pain and with heavy bleeding. Jennifer described the negotiation and delays as follows:

“When I told [my partner] that I am not attending [menstruating], he thought I was joking and was saying that [I was] just lying to him. So, I told him again that I was not [menstruating] and this was going to be my second month of not [menstruating], but still he was busy arguing with me.... I told him that I was worried and do not know what to tell people at home. He just said I was just joking and left. I also let go and stopped arguing with him [because] he never wanted anything to do with

the pregnancy.... I really wanted to keep it, but so many issues were occurring at home.... I was just being shouted at every day over the pregnancy. [My sister] said that she didn’t have money to take care of the child. She even told me that she did not want me at her home anymore.”

•*Fear of men’s interference with abortion decision.* Other women purposefully excluded their partners from abortion decision making because of the responses they anticipated. Based on their partners’ previously expressed fertility preferences and beliefs about motherhood, these women decided not to discuss their abortion in an attempt to avoid pressure to continue a pregnancy they did not want. Their need to maintain secrecy was often the reason they had a clandestine, unsafe abortion.

For Lynn (age 21) and Halima (age 35), pregnancy entailed a loss of personal autonomy. They understood that excluding their partners from the abortion decision was necessary for self-determination. Lynn was poor, already a mother and not working, but had plans to start college. When she discovered she was pregnant, her husband told her she would no longer be able to pursue her education. She subsequently secured abortifacient pills from a friend in secret. Halima’s husband was frequently adulterous and would regularly disappear with the family’s money, leaving Halima unable to feed herself and her children. Her desperation to avoid raising a fifth child with him caused her to attempt abortion by inserting a stick into her cervix. Both women subsequently needed and received care for incomplete abortion at the study hospital.

Women’s desire to exclude men from their abortion decision making also reflected men’s roles in controlling women’s fertility. Against her husband’s wishes, Alice, age 25, secretly took oral contraceptives to prevent a fourth pregnancy that would exacerbate her chronic respiratory illness. On discovering her pregnancy, Alice took a full packet of contraceptive pills in the hope that this would induce abortion. This caused severe symptoms, but not wanting to involve her husband, she delayed seeking care until her grandmother could take her to a clinic. The emergency postabortion care she received at the study hospital reflected both her unsuccessful attempts to prevent pregnancy in light of her husband’s fertility preferences and her subsequent desire to pursue abortion clandestinely.

•*Fear of men’s reaction to pregnancy.* In cases such as Alice’s, the anticipated conflict was over a woman’s desire not to become pregnant. For other women, the problem was that they anticipated disapproval of the pregnancy and feared punishments, including beatings, from male authority figures.

For a number of younger, unmarried women, fear of their fathers’ or uncles’ reactions to pregnancy influenced their decision to terminate it; keeping the pregnancy and abortion secret from these men was their paramount concern. Thandiwe, age 22, was living in university halls and training to be a lawyer. When she became pregnant unexpectedly, she discussed the

pregnancy with a male friend, but felt she could not reveal it to her father:

Thandiwe (T): So, my friend advised me, he was like “No, looking at your status, the way your father talks and all that, and I know definitely you will have nowhere to go” and that’s how I decided to come to [the study hospital].

Interviewer (I): How is your father?

T: My father is really—I can say harsh. And sometimes when he is talking, I feel like he can go after me and then he can just disown me.

I: Okay, does he know what you are going through?

T: He doesn’t know.

I: What do you think he would have done if he knew?

T: He would have actually stopped me from going to [university], and I would have been sent to my mother [in a rural village].... So, I looked at it in the form of my education—who will pay for me? And at the moment, I am almost done getting my diploma, so I looked at it in those lines.

In some cases, fear of a male authority figure’s response to pregnancy led to desperate attempts to obtain an abortion. When Mary, a 17-year-old student, became pregnant and her boyfriend of three years failed to demonstrate his commitment to her or to raising a child sufficiently for her, Mary’s mother forced her to drink an herbal abortifacient, after which she was admitted to the study hospital with incomplete abortion. Both Mary and her mother were motivated by fear of what the mother’s husband would do if he discovered the “unowned” pregnancy.

In the case of Bulongo, age 28, two feared men were absent yet present in her decision making—her abuser and her husband. Bulongo became pregnant after being raped at work. She explained that she might have continued the pregnancy and presented the child as belonging to her husband, but the perpetrator looked so different from him that she did not think she would be believed. Fearing that her account of rape would be doubted and that she would be condemned for adultery by her husband and her faith community, she told no one about her ordeal. The actions of her attacker and the anticipated reaction of her husband determined Bulongo’s initial need to seek abortion, the urgency and secrecy with which she pursued it, and the escalation of methods employed to obtain it; she tried unknown pharmacological abortifacients, then an unsuccessful medication abortion and finally a surgical abortion.

Men’s Active Involvement

In other cases, boyfriends and husbands, as well as other men (male family members, friends and in-laws), actively helped women to obtain an abortion. These men were most influential when they acted as shared decision makers or sounding boards, and as facilitators to obtaining care by paying for an abortion, arranging it or accompanying a woman to obtain it. When actively involved in these ways, men were most frequently a positive influence on women’s abortion decision making and care seeking, and helped facilitate access to safe abortion. Conversely, none

of the 41 women in our study who used unsafe abortion methods reported that they had done so on the basis of men’s advice or instruction, or with men’s knowledge, support or financial assistance.

• *Men’s participation in abortion decision making.* Some women turned to uncles, brothers or male friends for advice. Thandiwe, a student, sought the advice of a classmate because he was “married and has experienced such things around him.” However, husbands and boyfriends featured more commonly in respondents’ narratives.

Six respondents reported that men had had a strong influence on their decision to abort. A few of these women reported that the suggestion to abort had been a man’s but felt that the decision had been the right one; others reported that a partner or male family member had taken the decision away from them altogether. For example, when 15-year-old Precious became pregnant as a result of rape by her parents’ tenant, her father beat her before telling her she must abort:

“I was told that there was no way that I would take care of this child.... I was asked how I would care for that child, where I would find clothes and how I would finish school.... My father was very upset with me.”

Three respondents reported that they had convinced their partners that abortion was the appropriate course of action for their pregnancy. More commonly, however, in situations in which men were involved, women described a more balanced process in which the decision to seek abortion was mutually initiated and made. Whether they were in stable relationships (marital or nonmarital) or in consensual casual or short-term relationships, these women, older and younger, reported that they had made abortion decisions with their partner, recognizing sex, pregnancy and childbearing to be shared ventures.

For example, Tamara, age 43, and her husband already had six children and were using an IUD when they conceived. They agreed that they could not afford another child. Similarly, university students Nataizya, age 19, and her boyfriend decided together to seek an abortion:

“He asked if I could keep it and if I could face that, and then we talked about it. Then we decided it’s better [if] we don’t bring problems to the [family members paying for our education].... He came to see me so that we [could] talk about it and decide what we were going to do. We talked about it for like two weeks, then we decided to have a termination.”

With the support and knowledge of the significant men in their lives, women’s need to seek clandestine, unsafe abortion was diminished. Both Tamara and Nataizya sought safe abortions directly from the study hospital.

• *Men’s roles in seeking abortion and postabortion care.* Respondents who decided with their partner to abort the pregnancy typically reported that their partner continued to be involved when they obtained services. These men provided emotional support, facilitated abortion by seeking and providing information about

where services could be obtained, and accompanied respondents to access care. Most frequently, men supplied the money for transportation and treatment.

When Cynthia, age 19, thought she might be pregnant, her fiancé arranged for a pregnancy test and accompanied her to a clinic. They decided together to seek abortion so that Cynthia could finish school and pursue her plan to become a nurse. Her fiancé suggested that she accompany him to his appointment for circumcision at a sexual health clinic so that they could also ask about accessing abortion. Having received counselling about abortion and a referral to the study hospital from the clinic, Cynthia's fiancé accompanied her during her stay and paid for the abortion procedure and other expenses.

Although financial assistance was the most commonly reported type of male involvement, men's ability to obtain information about safe abortion services appeared to be most influential in determining whether a woman ultimately had a safe or unsafe abortion. Respondents reported very little awareness of the legality and availability of abortion services. Access to safe services at the study hospital depended on knowing, or knowing someone who knew, that such services were available. For some respondents, partners, male friends and brothers were instrumental in getting this information. Nataizya's boyfriend searched the Internet to find a safe abortion provider. Several other men used extended social networks to get the private telephone number of a doctor at the hospital. As Teresa, age 22, recounted, "[My boyfriend] just called me today and told me to come to [the hospital]; he said that one of his friends had connected him to someone [there]."

In the absence of or as a supplement to support from partners, male family members and friends played key roles in facilitating access to abortion care. When 17-year-old Gertrude discovered she was pregnant by her boyfriend of three years, she did not disclose the pregnancy to him but instead told the uncle with whom she lived. Her uncle recommended abortion so that she could finish school. He accompanied her to a clinic and then to the hospital to obtain a safe abortion, and paid for her treatment.

Some men had no involvement in the abortion decision or attempt but were instrumental in securing care following an unsafe incomplete abortion. These men instigated care seeking in response to the respondents' obvious illness, accompanied them to health facilities, and paid for travel and the costs of their care. Chikondi, age 30, had two children with her husband. She did not discuss with us why she wanted to end her most recent pregnancy and did not tell her husband that she had taken illegal abortifacients. When she woke up bleeding, her husband rushed her to a local clinic and paid for her treatment before she was referred to the hospital. Chikondi's brother, a taxi driver, drove her and her husband to the hospital, waited while Chikondi was treated and paid the charges incurred there because her husband had spent all of his money at the clinic.

According to the respondents, very few of the men helping in such cases were told the purpose of the care

they were supporting or that the woman had attempted abortion unsafely. However, it is unclear how much these men knew of what was happening or if they preferred not to know. For example, when the overdose of oral contraceptives Lynn, age 22, took to secretly abort caused her to bleed heavily, her husband rushed her to the hospital, waited for her and paid for her treatment. Lynn said, "I just told him that I fell in the bathroom when bathing and I started bleeding.... He didn't really believe what I told him."

DISCUSSION

As research in Sub-Saharan Africa shows, men's involvement in women's trajectories to safe or unsafe abortion mirrors inequitable power relations between genders.^{6,17} We, too, found that socially constructed gender roles influenced men's involvement in abortion decision making at the individual level. Our respondents' abortion trajectories, and the absence or presence of men in them, reflected gendered differences in economic and social power, norms about fatherhood and motherhood, and the implications of pregnancy and childbearing for men and women's lives (e.g., future opportunities for education, career and relationships). In contrast to studies among men in the general population, we found that men's absence from women's abortion trajectories did not appear to reflect attempts to distance themselves from a problematic procedure. Instead, it reflected either a male partner's voiced and explicit desire to avoid responsibility for pregnancy and caring for a child, or a woman's desire to avoid the anticipated reaction of a partner or male authority figure. Both situations reflected gender inequity and influenced whether women's abortions were safe or unsafe by causing delays in care seeking or by increasing women's desire to terminate pregnancies without the knowledge of these men.

Gender inequity also enabled men to use their privileged access to social and economic resources to facilitate safe abortion or care following unsafe abortion. When directly involved in women's abortion trajectories, men were most commonly providers of financial assistance for care seeking. However, in a context in which general awareness of the legality and availability of abortion is low and public information is scarce, men's ability to seek information about where safe abortion could be obtained was especially influential in determining how and if women obtained safe abortions.

In addition, we found instances of gender equity in relationships that influenced trajectories to safe abortion. For some respondents and their partners, sex, pregnancy, the abortion decision and obtaining an abortion were shared concerns. Older and younger women in both longer- and shorter-term partnerships reported this.

Limitations

Our study of male involvement in abortion focuses on women's personal relationships with men, and it does not examine the actions of men acting in professional

roles (e.g., doctors) or shaping the context of abortion (e.g., as policymakers or lawmakers) or include men's own perspectives on their involvement in women's abortion experiences. The extent to which interviews focused on men was dictated by respondents' narratives rather than by specific questioning. This approach avoided an imposed overemphasis on men's roles and allowed us to gain a sense of the saliency of men's involvement in respondents' experiences. However, it may also mean that male participation is underrepresented in the interview narratives and our analysis. Further research with men whose sexual partners have sought abortion would yield interesting complementary data that could contribute to a fuller understanding of men's roles in abortion decision making and seeking.

The analysis we present focuses on the underresearched role that male partners, family members and friends play in abortion care seeking; the roles played by other women, although important, are not included.

Although we interviewed women from a wide range of ages and social backgrounds, our recruitment strategy could not capture every woman obtaining abortion-related care at the study hospital. The research assistants worked weekday daytimes, and thus missed women who were discharged during the night or weekends. It is possible that this, and our focus on women who disclosed directly or indirectly that they had sought abortion, means we missed experiences of male involvement that differ from those we present. However, in light of the heterogeneity of experiences we did capture, we are confident that our data and analysis present a meaningful range.

Finally, our hospital-based sample excludes women who had unsafe abortions with no complications, women who sought non-hospital-based postabortion care, women who died as a result of unsafe abortion complications and women who sought safe abortion in private health care facilities. The roles played by men in these women's trajectories may be different from those reported by the women we interviewed.

Conclusion

Our research suggests that in addition to implementation of broader strategies to increase gender equity, there should be interventions to address unsafe abortion that are aimed at a much wider audience than women at risk of unwanted pregnancy. It is clear from our research, and research in other African settings (e.g., Ghana,⁷ Kenya³⁹ and Nigeria⁴⁰), that a range of male actors is directly and indirectly involved in abortion decision making and care seeking. Knowledge about the legality and availability of safe abortion is vital for women seeking abortion and for the men and women in whom they confide. Future research might usefully consider how to best equip both women and men with knowledge about effective contraception and the availability of safe and legal abortion in their settings.

REFERENCES

1. Collumbien M and Hawkes S, Missing men's messages: Does the reproductive health approach respond to men's sexual health needs? *Culture, Health & Sexuality*, 2000, 2(2):135–150.
2. Caldwell JC, Basu AM and Klugman B, The International Conference on Population and Development, Cairo, 1994. Is its *Plan of Action* important, desirable and feasible? *Health Transition Review*, 1996, 6(2):95–99.
3. Greene ME and Biddlecom AE, Absent and problematic men: demographic accounts of male reproductive roles, *Population and Development Review*, 2000, 26(1):81–115.
4. Dudgeon MR and Inhorn MC, Men's influences on women's reproductive health: medical anthropological perspectives, *Social Science & Medicine*, 2004, 59(7):1379–1395.
5. Berer M, National laws and unsafe abortion: the parameters of change, *Reproductive Health Matters*, 2004, 12(Suppl. 24):1–8.
6. Kaye DK, Community perceptions and experiences of domestic violence and induced abortion in Wakiso district, Uganda, *Qualitative Health Research*, 2006, 16(8):1120–1128.
7. Kumi-Kyereme A, Gbagbo FY and Amo-Adjei J, Role-players in abortion decision-making in the Accra Metropolis, Ghana, *Reproductive Health*, 2014, 11(1):70.
8. Schwandt HM et al., Pathways to unsafe abortion in Ghana: the role of male partners, women and health care providers, *Contraception*, 2013, 88(4):509–517.
9. Izugbara C and Egesa C, The management of unwanted pregnancy among women in Nairobi, Kenya, *International Journal of Sexual Health*, 2014, 26(2):100–112.
10. Gipson JD and Hindin MJ, "Having another child would be a life or death situation for her": understanding pregnancy termination among couples in rural Bangladesh, *American Journal of Public Health*, 2008, 98(10):1827–1832.
11. Petitet PH et al., Towards safe abortion access: an exploratory study of medical abortion in Cambodia, *Reproductive Health Matters*, 2015, 22(44, Suppl. 1):47–55.
12. Rasch V and Lyaru MA, Unsafe abortion in Tanzania and the need for involving men in postabortion contraceptive counseling, *Studies in Family Planning*, 2005, 36(4):301–310.
13. Rossier C, Abortion: an open secret? Abortion and social network involvement in Burkina Faso, *Reproductive Health Matters*, 2007, 15(30):230–238.
14. Centre for Research on Environment Health and Population Activities and Program for Appropriate Technology in Health, *The Influence of Male Partners in Pregnancy Decision-Making and Outcomes in Nepal: Executive Summary*, 2007, http://crehpa.org.np/wp-content/uploads/2017/05/executive_summary_january_2007.pdf.
15. Nyanzi S, Nyanzi B and Bessie K, "Abortion? That's for women!" Narratives and experiences of commercial motorbike riders in south-western Uganda, *African Journal of Reproductive Health*, 2005, 9(1):142–161.
16. Moore AM, Jagwe-Wadda G and Bankole A, Men's attitudes about abortion in Uganda, *Journal of Biosocial Science*, 2011, 43(1):1–15.
17. Izugbara CO, Otsola KJ and Ezeh AC, Men, women and abortion in central Kenya: a study of lay narratives, *Medical Anthropology*, 2009, 28(4):397–425.
18. Chikovore J et al., 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*, 2002, 34(3):317–332.
19. Macleod CI and Hansjee J, Men and talk about legal abortion in South Africa: equality, support and rights discourses undermining reproductive "choice," *Culture, Health & Sexuality*, 2013, 15(8):997–1010.
20. Coast E and Murray SF, "These things are dangerous": Understanding induced abortion trajectories in urban Zambia, *Social Science & Medicine*, 2016, 153:201–209.

21. Singh S et al., The estimated incidence of induced abortion in Ethiopia, 2008, *International Perspectives on Sexual and Reproductive Health*, 2010, 36(1):16–25.
22. Amnesty International, *Barriers to Safe and Legal Abortion in South Africa*, London: Amnesty International, 2017.
23. Chatuvedi S et al., Availability and distribution of safe abortion services in rural areas: a facility assessment study in Madhya Pradesh, India, *Global Health Action*, 2015, 8(1), doi:10.3402/gha.v8.26346.
24. Marie Stopes International, Zambia: where we work, 2016, <https://mariestopes.org/where-we-work/zambia/>.
25. International Planned Parenthood Federation, Planned Parenthood Association of Zambia, no date, <http://www.ippf.org/about-us/member-associations/zambia>.
26. Likwa RN, The quest for abortion data for policy decision-making in Zambia: abortion statistics in the HMIS, paper presented at the Africa Regional Conference in Abortion: From Research to Policy, Addis Ababa, Ethiopia, Nov. 29–Dec. 2, 2016.
27. Macha S et al., Increasing access to legal termination of pregnancy and postabortion contraception at the University Teaching Hospital, Lusaka, Zambia, *International Journal of Gynaecology & Obstetrics*, 2014, 126(Suppl. 1):S49–S51.
28. Ministry of Health (MOH), *Standards and Guidelines for Reducing Unsafe Abortion Morbidity and Mortality in Zambia*, Lusaka, Zambia: MOH, 2009.
29. Parmar D et al., Cost of abortions in Zambia: a comparison of safe abortion and post abortion care, *Global Public Health*, 2017, 12(2):236–249.
30. Owolabi OO et al., Incidence of abortion-related near-miss complications in Zambia: cross-sectional study in Central, Copperbelt and Lusaka Provinces, *Contraception*, 2017, 95(2):167–174.
31. Cresswell JA et al., Women's knowledge and attitudes surrounding abortion in Zambia: a cross-sectional survey across three provinces, *BMJ Open*, 2016, 6(3):e010076.
32. Geary CW et al., Attitudes toward abortion in Zambia, *International Journal of Gynaecology & Obstetrics*, 2012, 118(Suppl. 2):S148–S151.
33. Koster-Oyekan W, Why resort to illegal abortion in Zambia? Findings of a community-based study in Western Province, *Social Science & Medicine*, 1998, 46(10):1303–1312.
34. Dahlbäck E et al., Pregnancy loss: spontaneous and induced abortions among young women in Lusaka, Zambia, *Culture, Health & Sexuality*, 2010, 12(3):247–262.
35. Phiri DS, Comparison of characteristics of women requesting termination of pregnancy and those presenting themselves with incomplete abortion within the University Teaching Hospital, unpublished dissertation, Lusaka, Zambia: Department of Community Medicine, School of Medicine, University of Zambia, 2002.
36. Central Statistical Office (CSO), MOH and ICF International, *Zambia Demographic and Health Survey 2013–14*, Rockland, MD, USA: CSO, MOH and ICF International, 2015.
37. Consortium for Research on Unsafe Abortion in Africa, Pregnancy termination trajectories in Zambia: the socio-economic costs, 2015, <http://www.abortionresearchconsortium.org/>.
38. Ritchie J and Lewis J, *Qualitative Research Practice: A Guide For Social Science Students and Researchers*, London: Sage Publications, 2003.
39. Osur J et al., Social networks and decision making for clandestine unsafe abortions: evidence from Kenya, *African Journal of Reproductive Health*, 2015, 19(1):34–43.
40. Obiyan M and Agunbiade O, Paradox of parental involvement in sexual health and induced abortions among in-school female adolescents in southwest Nigeria, *Sexuality & Culture*, 2014, 18(4):847–869.

RESUMEN

Contexto: Dado que, especialmente en África, persiste la morbilidad y mortalidad materna derivada del aborto inseguro, hay una necesidad apremiante de comprender el proceso de toma de decisiones asociado con el aborto. Sin embargo, es poco lo que se sabe sobre la influencia e involucramiento de los hombres en la toma de decisiones de las mujeres y en la búsqueda de atención médica relativa al aborto.

Métodos: Se condujo un estudio cualitativo en la institución pública proveedora de servicios relacionados con el aborto más grande de Zambia. Se usó análisis de marco temático para categorizar y sintetizar datos de entrevistas en profundidad realizadas en 2013 con 71 mujeres que recibieron servicios de aborto seguro y 41 que recibieron atención posterior a un aborto incompleto (inseguro).

Resultados: Los hombres ejercieron influencia sobre las mujeres en cuanto a la búsqueda de un aborto seguro o inseguro; sus acciones, la falta de acción y las acciones anticipadas –negativas y positivas– revelaron amplias inequidades de género. El abandono por parte de los hombres y el deseo de evitar la revelación del embarazo a los hombres debido al temor de sus reacciones o interferencias, influyeron de manera importante tanto en las decisiones de algunas mujeres a la hora de buscar un aborto, como en el secreto y urgencia con que se procuró el aborto y el nivel de riesgo asumido. Sin embargo, otras mujeres hablaron acerca de la influencia positiva de los hombres en su búsqueda de atención relativa al aborto. En este entorno de baja conciencia sobre la legalidad y disponibilidad del aborto, algunos hombres utilizaron sus amplios recursos sociales y económicos para facilitar el aborto seguro al proporcionar información y pagar por los servicios.

Conclusiones: Aumentar el conocimiento sobre la legalidad y disponibilidad del aborto seguro es vital, no solo entre las mujeres sexualmente activas, sino también entre las personas en las que ellas confían, incluidos los hombres.

RÉSUMÉ

Contexte: Étant donné la persistance de la morbidité et de la mortalité maternelles entourant l'avortement non médicalisé, en Afrique surtout, le besoin de comprendre le processus décisionnel de l'avortement est impérieux. On en sait cependant peu sur l'influence des hommes et leur implication dans la décision des femmes d'avorter et leur recherche de soins.

Méthodes: Une étude qualitative a été effectuée dans les locaux du plus grand prestataire public de soins liés à l'avortement en Zambie. L'étude a procédé par analyse de cadre thématique pour catégoriser et synthétiser les données d'entretiens en profondeur menés en 2013 avec 71 femmes qui avaient obtenu un avortement médicalisé et 41 ayant reçu des soins suite à un avortement incomplet (non médicalisé).

Résultats: La décision d'obtenir un avortement, médicalisé ou non, est influencée par les hommes. Leurs actes, leur inaction et leurs actes anticipés–négatifs comme positifs–sont le reflet de plus vastes inégalités de genre. L'abandon par les hommes, de même que le désir d'éviter de révéler une grossesse aux hommes de peur de leur réaction ou ingérence, influencent fortement la

décision prise par certaines femmes de se faire avorter, le secret et l'urgence de l'obtention de l'avortement et le niveau de risque assumé. D'autres femmes décrivent cependant l'influence positive des hommes sur leur recherche de soins suite à un avortement. Dans ce contexte de faible sensibilisation à la légalité et à la disponibilité de l'avortement, certains hommes utilisent leurs plus grandes ressources sociales et économiques pour faciliter l'avortement médicalisé, par l'apport d'information et l'acquittement du coût des soins.

Conclusion: La connaissance accrue de la légalité et de la disponibilité de l'avortement médicalisé est vitale, non seulement parmi les femmes sexuellement actives, mais aussi parmi les personnes à qui elles se confient, y compris les hommes.

Acknowledgments

Funding for this research was provided by Economic and Social Research Council/Department for International Development grant ES-167-25-0626.

Author contact: e.freeman@lse.ac.uk