



# EXPLORING MALE ENGAGEMENT IN PREMARITAL ABORTION

Perceptions and Lived  
Experiences of Young Women  
and Men in New Delhi, India



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# EXPLORING MALE ENGAGEMENT IN PREMARITAL ABORTION

Perceptions and Lived Experiences of Young Women  
and Men in New Delhi, India

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2018



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# Foreword: A Story of Men Stepping Up

For far too long issues pertaining to sexual and reproductive health (SRH) have been viewed as issues of concern for women alone. As a result, women have too often been left with an overwhelming share of the contraceptive burden. Add to that, the conservative agenda in some parts of the world that seeks to roll back women's right to choose both – to terminate a pregnancy and to have access to a full range of family planning and reproductive health services.

Men are far less likely to avail themselves of health services or treatment (much to the detriment of women, children and men) and to use reproductive health services and contraceptives in general. Similarly, in the context of heterosexual relationships, the burden to test, manage and treat sexually transmitted infections including HIV is usually left to women. Further, few men speak out as allies on the issues.

And what about abortion? Are men involved? Are they as likely as women to support abortion rights? Few studies have directly examined men's roles in women's abortion decisions and experiences, or men's own experiences related to abortion. This study is part of a small but growing body of research looking at how men are involved, and importantly, how they can become more involved as supportive, respectful partners.

What this study suggests is that many men are involved in ways that are supportive: accompanying women to services, seeking medicines, procuring information, and yes, being sources of emotional support. While the

relationships described in the research show many indications of men adhering to traditional scripts of control, domination and coercion, they also show numerous examples of being engaged, emotionally supportive, caring and connected. We saw in the research, example after example of men stepping up to be their better selves and pushing against restrictive gender norms. For some of the men interviewed, the study was the first time they had spoken about their own fears, feelings and stress related to the decision to seek an abortion.

What the data suggests is that men can be the supportive and involved partners we want them to be, if informed, engaged and if service providers and others (namely family members and male peers) are also supportive both of men's involvement and of women's rights.

Promundo and ICRW believe it is possible – and an urgent mandate – for advocates to push for greater male involvement to affirm women's rights and to point to the many opportunities for engaging men in ways that reinforce women's reproductive choices and benefit men.

We would like to thank Jane-Kato Wallace from Promundo and Sapna Kedia from ICRW Asia for their immense contribution to this study and we hope that this study generates interest for further research on male involvement in abortion care.

**Gary Barker, Executive Director, Promundo-US**  
**Ravi Verma, Regional Director, ICRW Asia**

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We are deeply grateful to all our participants who voluntarily participated in the study and shared their intimate personal stories with us. These narratives have helped fill an initial gap in existing evidence on engaging men in premarital abortion care.

We are thankful to our study partner Tyagi Foundation, New Delhi, whose team patiently helped us in identifying study participants and pushed themselves to meet our sample size. We thank Mahtab Ali, who coordinated the study and the liaison with community-based organizations and providers.

We would like to acknowledge with deep gratitude the support and guidance provided by Sudha Tewari, President, Parivar Seva Sanstha (PSS) in developing the recruitment strategy for the study, for providing access to her team and PSS clinics, and giving her valuable feedback and inputs on this report. We would also like to thank Komal Kaushik, Deepika Sharma and

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We are extremely grateful to Kathryn Reitz, Director, Human Research Protection Program, ICRW for a thorough review of our research protocol and related documents, and her assistance with securing ethical approval for the study. We would like to thank ICRW's Institutional Review Board (IRB) for their valuable feedback at the beginning of the study. We would also like to thank the IRB at Sigma Research and Consulting in New Delhi for their review and feedback.

# List of Abbreviations

FGDs	Focus Group Discussions
ICRW	International Center for Research on Women
IDIs	In-Depth Interviews
INR	Indian Rupees
KIIs	Key Informant Interviews
MA	Medical Abortion
MBA	Master of Business Administration
MTP ACT	Medical Termination of Pregnancy Act, 1971
NGO	Non-Governmental Organization
OBCs	Other Backward Castes
PCOS	Polycystic Ovary Syndrome
PSS	Parivar Seva Sanstha
SA	Surgical Abortion
SCs	Scheduled Castes
SRH	Sexual and Reproductive Health
STs	Schedules Tribes

## Executive Summary

Male involvement in relation to abortion services remains a largely understudied area, more so in instances of unintended premarital abortions. Abortion care is an important area for involvement of men. In addition to the potential benefit for individual women, male involvement may at a broader level improve women's access to safe abortion and quality care since men are partners, brothers, fathers and friends, their experiences with abortion services affect how women are treated and how abortion is perceived in society. In case of an unintended pregnancy before marriage the role played by men becomes more crucial because social stigma associated with premarital sex, particularly in a context like India, heightens a woman's vulnerability, isolation and alienation.

In India, unsafe abortion is the third leading cause of maternal death, contributing eight percent to all such deaths annually. Even though unmarried women in India have the legal right to access abortion services, they face challenges because of the secrecy, shame and stigma associated with premarital sex and abortion.

Evidence on the vulnerability of young unmarried people (men and women) is sparse. Most existing studies provide insight only into how premarital abortion is perceived and do not throw light on the premarital abortion journeys of young men and women. Though these studies highlight that men play a role in their partners' decision to abort an undesired pregnancy, they do not provide insights on what men think and feel and why. Little is known about the socio-economic and gender dynamics –

particularly from men's perspective – that underlie the process of a couple or woman's decision-making around safe abortion services.

This qualitative study aims to fill a substantive gap – in terms of knowledge, applied research and advocacy – by investigating young men's attitudes, perceptions and experiences as partners in relation to premarital abortion in New Delhi.

Qualitative research methods were adopted for this exploratory study. Seventeen in-depth interviews (IDIs) with male and female abortion seekers, six focus group discussions (FGDs) with young men and women and 15 key informant interviews (KIIs) with experts and service providers in New Delhi were conducted, using semi-structured questionnaires, between February-July 2018. To unpack the socio-economic factors that influence the perceptions, attitudes and experiences of young people, participants were selected from diverse socio-economic contexts. Participants were largely recruited in partnership with Tyagi Foundation, a non-governmental organization (NGO) in New Delhi that provides sexual-reproductive health services.

Since gender is one among the many axes of identity and social discrimination (such as caste, class, education, etc.) that define and influence individuals, the use and analysis of gender in this research is intersectional. The research explored these interlocked identities and how they influence participants' respective experiences.



Discussions with IDI, FGD and KII participants revealed that premarital sex among young men and women is a widely prevalent open secret, whose incidence seems to have increased. Participants, with a few exceptions, viewed premarital sex as immoral and therefore inappropriate. Marriage continues to hold the place of an ideal institution for the expression of sexuality and maintenance of caste/faith endogamy. Although dominant social norms prohibit premarital sex for men and women, men's defiance of such a norm is tolerated or even accepted while women's defiance is unacceptable. Men were seen as much more 'naturally' sexual in comparison to young women. In contrast, women are expected to be repositories of sexual abstinence and social morality, and thus, there was very little mention of female sexual desire. Participants shared that men usually feel a sense of pride about their sexual encounters and feel encouraged to share it with their peer groups. However, young women experience more fear and stigma in relation to sex. This is largely due to the patriarchal imperative that women be virgins before marriage.

Given the social taboo around premarital sex, an unwed pregnancy is seen as a matter of great shame and disrepute for a woman as well as the family. Due to this stigma, unmarried youth do not have the choice to continue with a pregnancy in India. Therefore, the decision to undergo an abortion is considered necessary. Interestingly, even though most young men and women more or less agreed with the social norm against premarital sex and thought that it is wrong, they were flexible about their opinion and choices. This is so because they viewed sex as a legitimate and natural need. Young men and women constantly navigate between accepting themselves as 'sexual beings' and conforming to social norms that restrict sexual expression. The extent to which young people break away and question these norms impacts how they steer through the stigma attached to premarital pregnancy and how they respond to it.

Popular discourse and perceptions tend to paint unmarried men in premarital relations as oversexed, exploitative and irresponsible. However, study narratives reveal that increasing number of men are showing up with their partners for abortions. The common role played by male participants in a situation of premarital pregnancy is an all-in-one service provider of sorts for their

partners: they sought information about pregnancy kits, abortion pills, clinics and, wherever needed, purchased medication, reached the clinics, spoke to doctors, accompanied their partners to the clinics and paid for the abortion.

Men's experience of the sex-to-abortion and post-abortion journey is like a tightrope between gendered masculinities and vulnerabilities. It is influenced by several factors that act as enablers and/or barriers and are not always mutually exclusive. The traditional script of gender accords the role of the protector to men and that of the vulnerable dependent to a woman. Many participants of this study seemed to be enacting this script to varying degrees and in different situations. Many women recalled feeling helpless and fearful, barring a few from higher-income group (see pg.13, footnote 13 for details). Men (especially from middle-income groups) thought it was their responsibility to preserve and protect their partner's reputation and honor and so they felt duty bound to support her.

A key factor that shapes men's involvement is the shame and stigma associated with premarital sex. Accounts of the participants show that this factor can work in both ways – it could either propel them to stay with their partners and offer support or end the relationship and be untraceable. Male participants spoke about their share of anxieties if their partners' pregnancy or abortion news got to their families. For example, once the news reaches their families, even though they may not want to marry their sexual partner, they may be compelled or obligated to. The other common fear is that of being falsely accused by the girl and/or her family of rape. However, in some cases, this stigma motivates male involvement; when men know that their pregnant partners have no other support system except them, they may choose to stand by their partner either from a place of feeling like her 'protector' in a relationship or out of feeling equally responsible and wanting to be there for her.

The degree of personal freedom and mobility that young men and women enjoy also determines the extent of male involvement. Female participants from middle-income groups were more dependent on their male partners because of restrictions on their mobility and financial dependence on their natal families. In contrast, economically independent female participants did not depend as much on their

male partners. In instances where the couple lived away from home and were cohabiting, men were able to provide round-the-clock support to their partners. Where young men and women lived with their families, men struggled to extend support and spend time with their partners.

Although the situation is improving, the social aversion toward abortions is also propagated by medical providers. This acts as a barrier for young men and women in availing safe and non-judgmental abortion services and forces them to resort to pills. In health facilities, the male partner prefers to stay outside the medical premises to avoid direct communication with the staff (see the section on Interaction with Service Providers).

Narratives of young men and women reveal that they, especially men, rely on their peer networks and internet to gain knowledge and information about premarital abortions. Both these resources are easily accessible and safeguard their anonymity. However, this information is often incomplete and inaccurate, as a result young people find themselves in a situation of abortion related complications.

The findings of the study show that in the context of couples seeking a premarital abortion, men play an instrumental role. Their involvement aided women's access to safe and quality abortion care in a significant way. In some cases, they were more actively involved in the abortion process and in others, they chose to remain behind the scene while continuing to extend emotional support.

Pregnancy and abortion, as the findings reveal, present a window of opportunity to engage with men. Some specific recommendations include:

- **Capture the missing 'male voice':** Men's voices are often not prioritized in the discussions around sexual and reproductive health (SRH) and rights. During the research, men shared being silent, feeling anxious and vulnerable. Capturing these voices is crucial to altering male behavior as well as addressing their vulnerabilities.
- **Leverage men's role as 'quasi-service providers' (information seekers and providers):** Men with personal experience of premarital pregnancy and abortion were in unique and important positions to transmit more accurate information and knowledge about the issue and dispel related myths.
- **Leverage men's agency to facilitate gender equality within relationships:** Also, to encourage safe SRH practices.
- **Stimulate/encourage service providers' interactions with men:** Perceptions and attitudes of healthcare providers have a substantial impact on the access to and quality of abortion services. Since men are key players in a situation of premarital pregnancy and abortion, it is crucial that service providers interact with them.
- **Need to engage with a range of stakeholders:** There is a need to engage with various stakeholders such as schools, parents, community, medical personnel so they to talk to young people about their bodies, their sexuality and sex.

# Background

In 1994, the United Nations' International Conference on Population and Development in Cairo established that men's involvement in reproductive health was a global research priority.<sup>1</sup> Several studies thereon have examined male inclusion in the many domains of reproductive health. However, male involvement in relation to abortion services remains a largely understudied area, more so in instances of unintended premarital abortions.<sup>2</sup>

In India, unsafe abortion is the third leading cause of maternal death, contributing 8 percent to all such deaths annually.<sup>3</sup> Most Indian research studies on abortion focus on abortion rates and ratios, demographic profiles of women, contraceptive behavior, and rates of morbidity and mortality. Besides, these studies explore the abortion experiences of married women. Evidence on the vulnerability of young unmarried people (men and women) is sparse. Most existing studies provide insight only into how premarital abortion is perceived. These studies suggest that young, unmarried women are not only a significant minority of all abortion

seekers, but are also more vulnerable than their adult, married counterparts.<sup>4</sup> Even though unmarried women in India have the legal right to access abortion services,<sup>5</sup> they face challenges because of the secrecy, shame, and stigma associated with premarital sex and abortion.<sup>6</sup>

Existing research shows that young unmarried people in a situation of an unintended pregnancy, are penalized by their parents, lack a support system, do not have access to adequate medical and legal information, are subject to judgements by service providers', lack financial resources, and due to the fear of social repercussions may opt for clandestine and/or delayed abortions and increase the possibility of abortion-related complications. Although these studies highlight that men play a role in their partners' decision to terminate an undesired pregnancy, they do not provide insights on what men think and feel and why. Little is known about the socio-economic and gender dynamics – particularly from men's perspective – that underlie the process of a couple or woman's decision-making around safe abortion services.<sup>7</sup>

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1. Altshuler, Anna L., Nguyen, Brian T., Riley, Halley E.M., Tinsley, Marilyn L., Tuncalp, Özge. (2016). Male Partners' Involvement in Abortion Care: A Mixed-Methods Systematic Review. *Perspectives on Sexual and Reproductive Health*, 48(4):209–219. doi:10.1363/psrh.12000.

2. Ibid

3. IPAS Development Foundation (2017).

4. Jejeebhoy S., Kalyanwala S., Francis AJ., et al. (2010). Pathways to Induced Abortion among Unmarried Young Women: Are the Unmarried More Vulnerable than the Married?. *The Population Council*.

5. The Medical Termination of Pregnancy (MTP) Act of 1971, India decriminalized abortion, making it legally available. Under the MTP, abortion is a qualified right, it is not unconditional. An abortion can't be performed based solely on a woman's request. It can be performed only after an approval from a registered medical practitioner before 12 weeks of pregnancy. In case the woman has been pregnant for more than 12 weeks – but for less than 20 weeks – the opinions of two medical practitioners is required. Though the opinion of registered medical practitioners is required, no pregnancy can be terminated without the consent of the pregnant woman. For minors (girls under 18) and for women over 18, who may be a 'lunatic' (meaning assigned in Sec.3 of the Indian Lunacy Act, 1912), the pregnancy can only be terminated with the consent of their guardian.

6. Kalyanwala S., Francis Javier AJ., Jejeebhoy S., et al. (2010). Abortion Experiences of Unmarried Young Women in India: Evidence from a Facility-Based Study in Bihar and Jharkhand. *International Perspectives on Sexual and Reproductive Health*.

7. Ravindran, T.K.S. (2002). Gender Gaps in Research on Abortion in India: A Critical Review of Selected Studies. *The Gender and Reproductive Health Research Initiative*. CREA.

Abortion care is an important area for involvement of men. In addition to the potential benefit for individual women, male involvement may at a broader level improve women's access to safe abortion and quality care. Safe abortion with dignity is every woman's right and is, as noted in the recent Lancet-Guttmacher Commission report (Starrs, M.A., Ezeh, C.A., Barker, G., et. al., 2018), a key pillar of a comprehensive SRH and rights platform. Men can facilitate abortion access by gathering information, locating services, providing transportation, covering or sharing the cost of abortion, post-abortion care and by providing emotional support. Since men are partners, brothers, fathers and friends, their experiences with abortion services affects how women are treated and how abortion is perceived in society.<sup>8</sup>

In case of an unintended pregnancy before marriage the role played by men, becomes more crucial because social stigma associated with premarital sex, particularly in a context like India, heightens a woman's vulnerability, isolation and alienation. Men's supportive involvement in the case of an unintended pregnancy before marriage, can expand access to abortion services and improve them so that they are more youth-friendly and non-judgmental.<sup>9</sup> Since men play a key role in determining social norms and exercise greater decision-making power in a relationship,<sup>10</sup> this study posits that such a privileged position can be positively leveraged to challenge and reduce the stigma associated with premarital abortion. Men can be engaged to increase their role in supporting their partners during an unintended, premarital pregnancy and to promote right-based perspectives around premarital sex as well as equal relationships during and after pregnancy.

This exploratory qualitative study aims to fill a substantive gap – in terms of knowledge, applied research and advocacy – by investigating young men's attitudes, perceptions and experiences as partners, in relation to premarital abortion in

New Delhi. New research directions on men's roles in abortion-seeking may lead to greater understanding of men's own vulnerabilities, gender biases and motivations around unintended pregnancies. An understanding of these issues will help in designing policies and programs to capacitate men to support women and decrease the risks associated with unwanted pregnancies.<sup>11</sup> Besides providing some important programmatic clues, the study hopes to present its findings as various hypotheses to be explored further.

## RESEARCH OBJECTIVES

The study seeks to explore answers to the following specific questions:

- I. How do young unmarried men perceive an unintended premarital pregnancy? What factors influence and shape these perceptions?
- II. How do these perceptions impact men's decision-making and their role in helping women cope with an unintended premarital pregnancy? What are the factors that promote supportive attitudes and practices and act as barriers to positive male involvement?
- III. How does male involvement impact women's access to and quality of abortion services and post-abortion care? Is there a difference in access to and quality of abortion services between cases where men are supportive and unsupportive?
- IV. What do women think of men's perceptions and roles in facilitating care during an unintended pregnancy?

The following section will present the methodology, conceptual framework and limitations of the study. The rest of the report presents findings of the research in relation to the above questions. The report ends with a set of recommendations to strengthen male involvement during premarital abortion.

8. Kalyanwala S., Francis Xavier AJ., Jejeebhoy S., et al. (2010). Abortion Experiences of Unmarried Young Women in India: Evidence from a Facility-Based Study in Bihar and Jharkhand. *International Perspectives on Sexual and Reproductive Health*.

9. Ibid

10. Altshuler, Anna L., Nguyen, Brian T., Riley, Halley E.M., Tinsley, Marilyn L., Tuncalp, Özge. (2016). Male Partners' Involvement in Abortion Care: A Mixed-Methods Systematic Review. *Perspectives on Sexual and Reproductive Health*, 48(4):209–219. doi:10.1363/psrh.12000.

11. Ibid



## METHODOLOGY

Given that the study raises questions that are exploratory in nature and there exists very little evidence to guide structured questioning, qualitative research methods were adopted for the study. IDIs, FGDs and KIIs were conducted with the selected participants using semi-structured questionnaires.

## STUDY PARTICIPANTS

Participants for IDIs, FGDs and KIIs were selected using purposive sampling techniques. IDIs and FGDs were held with young men and women in the age-group of 18 to 35 years.<sup>12</sup> For IDIs,

young married and unmarried women and men who had/whose partners had a premarital abortion were selected. For FGDs, young unmarried men and women from communities and colleges; and for KIIs, experts working on SRH issues and providers of abortion services – doctors and clinic in charges – were interviewed. To unpack the socio-economic factors that influence the perceptions, attitudes and experiences of young people, participants were selected from lower, middle and higher-income backgrounds.<sup>13</sup>

In total, 17 IDIs, six FGDs and 15 KIIs were conducted for this study. The profile of selected participants is presented in the table below:

**Table 1:** Sample size and participants profile

Research Activity	Sample Size	Participants' Profile
IDIs <sup>14</sup>	17	<ul style="list-style-type: none"> <li>• Ten male respondents (aged 24-35 years) – Six came from middle-income backgrounds and four came from higher-income backgrounds.</li> <li>• Seven female respondents (aged 20-33 years) – Four represent middle-income backgrounds and three belong to higher-income backgrounds.</li> <li>• The respondents were young and unmarried/married women and men who/whose partners had a premarital abortion.</li> </ul>
FGDs <sup>15</sup>	Six FGDs	<ul style="list-style-type: none"> <li>• Six FGDs were held with unmarried men and women (aged 18-32 years). Each FGD had around eight to ten participants.</li> <li>• Three FGDs were conducted with groups of women. Two of these comprised participants from middle-income groups and were held in the areas of Azadpur and ITO, Delhi; one FGD was conducted with women from higher-income groups in the Jamia Millia Islamia University, Delhi.</li> <li>• Three FGDs were conducted with groups of men. Two of these comprised participants from middle-income groups in the areas of Samaypur Badli and Azadpur, Delhi; one FGD was conducted with men from higher-income groups in Rithala, Delhi</li> <li>• More FGDs were conducted with participants from middle-income groups because identification of participants was relatively easier given the study partners' presence in these communities.</li> </ul>

12. The study does not seek to explore the experiences of minors, given the ethical considerations around conducting research with minors. Hence the minimum age limit for the study was 18 years. For the upper age limit, initially the mean age of marriage in India (19 years for women and 24 years for men) was identified based on the Census of India, 2011. However, difficulties in identifying young men and women who would be willing to speak on a taboo issue like premarital sex led to the modification of the upper age limit to 35 years. This helped in reaching out to more participants.

13. These categories were developed for the purpose of the study. Anyone earning up to INR 10,000-15,000 per month and in temporary or daily-wage jobs (considering that the minimum wage for daily labor could vary between INR 150-300 per day) depending upon skills were considered belonging to low-income groups. Anyone with a somewhat stable job or business and earning between INR 15,000-30,000 were considered from middle-income groups and those earning above this limit were considered from higher-income groups.

14. A detailed profile of IDI respondents is presented in the findings section of the report.

15. FGD participants are also referred to as discussants.

Research Activity	Sample Size	Participants' Profile
KIIs <sup>16</sup>	15	<ul style="list-style-type: none"> <li>Abortion service providers – doctors and clinic in charges – affiliated to clinics run by community-based organizations in Delhi – National Capital Region</li> <li>Gynecologists in private practice</li> <li>Experts in the field of SRH and rights</li> <li>Independent Journalist(s)</li> <li>Social Marketing Representatives affiliated to the study partner</li> <li>Private 'Dai' (midwives)</li> </ul>

## PARTICIPANT RECRUITMENT

Participants were largely recruited in partnership with Tyagi Foundation, an NGO in New Delhi that provides sexual-reproductive health services. Tyagi Foundation works with various other NGOs<sup>17</sup> that implement community-based programs and run clinics to provide SRH services. They also work with private sector providers of maternal health services. Tyagi Foundations partners work across the city – in urban, peri-urban and rural areas – and cater mostly to lower and middle-income individuals across different age groups. The Foundation's decades-old work has included workshops for youth that emphasize human rights and informed choice, principles that put them in line with ICRW's work.

For the study, Tyagi Foundation used its ongoing workshops in communities and university spaces, its network of community-based health workers and its relationships with clinics run by other NGOs to spread word about the research, identify participants and seek their consent for participation. All members of the Foundation who participated in the recruitment and screening process for potential participants had to undergo training on ethics of research, including principles of confidentiality, respect for persons, beneficence and justice. Since the participant's consent was primary in their selection for the study, a thorough and ethically sound consent form was prepared.

## DATA COLLECTION AND ANALYSIS

Safe, private and convenient venues as well as suitable date and time for IDIs, FGDs and KIIs were identified in consultation with Tyagi

Foundation and the participants. Interviews lasted for about 60-90 minutes each and were completed in one session. Conversations were audio-recorded in cases where participants consented to the recording. FGD and IDI participants were provided with a travel allowance for participating in this research.

FGDs and KIIs focused on young people's relationship dynamics, their perceptions of gender norms, premarital sex and abortion-related knowledge and beliefs, the role of men as partners and suggestions for strengthening the support system available to young unmarried men and women while dealing with an unwanted pregnancy. In IDIs, besides the above-mentioned aspects, the focus was on young men and women's experiences of dealing with an unintended pregnancy before marriage and the role that the male partner played in the process.

All the interviews were transcribed and translated by the research team. Simultaneously, the team developed a coding frame around themes and sub-themes to facilitate content analysis with the use of research questions, interview guides and transcripts.

The data was manually coded and analyzed as per the following themes:

- Young women's perceptions on premarital sex and abortion;
- Young men's perceptions on premarital sex and abortion;
- Decision-making processes around abortion;
- Access to abortion services;
- Male involvement in abortion-related care;
- Factors influencing the abortion decision pathway;

16. KII respondents are referred to as service providers, unless otherwise specified.

17. One such organization is Parivar Seva Sanstha (PSS) that runs Parivar Seva Clinics, which provide a range of reproductive health services, including legal, safe and affordable abortion services.

- Barriers to positive male involvement;
- Enablers for positive male involvement;
- Impact of male involvement on abortion care/experience;
- Areas for further enquiry.

During the analysis, efforts were made to capture the difference in premarital abortion related perceptions and experiences of participants belonging to varied socio-economic contexts. These differences are highlighted throughout the report. Methodologically, during analysis efforts were made to triangulate responses from FGDs, KIs and IDIs and examine where they overlap, where they do not and why.

All field work (and subsequent coding, analyses and writing) was done by experienced qualitative researchers between February and June 2018. The study received ethical approval from the IRBs of ICRW, Washington, D.C., and Sigma Research and Consulting in New Delhi.

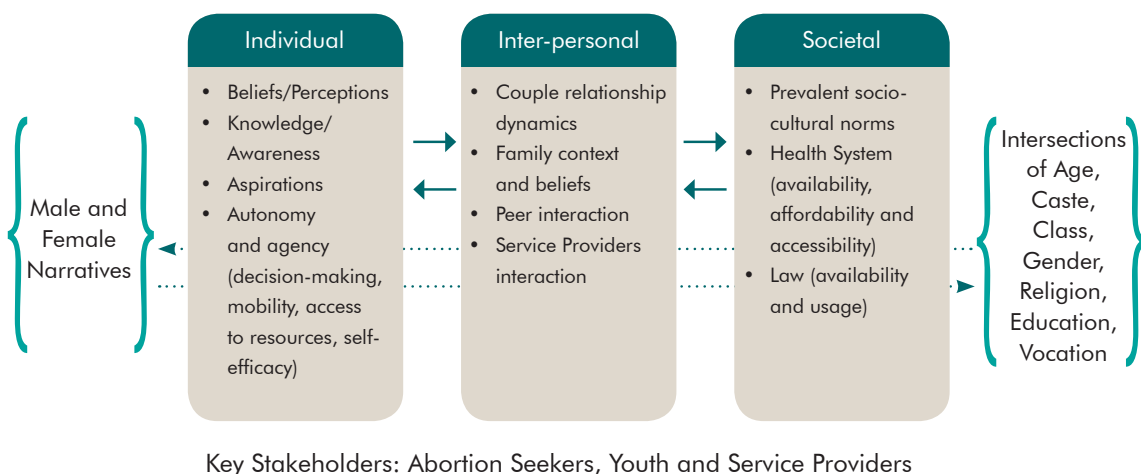
### CONCEPTUAL FRAMEWORK

Gender forms the crucial backdrop against which young men and women’s perceptual, decision-making and caregiving trajectories in relation to unwed abortions are explored in this research. It reveals men and women’s understanding of their assigned and chosen private/public

roles, of the binaries of good/bad conduct, the power, privileges and vulnerabilities that affect them, their negotiations with and navigation around norms and their actual experience within their respective family/community settings and premarital relations and abortion.

However, since gender is one among the many axes of identity and social discrimination (such as caste, class, education, etc.) that define and influence individuals, the use and analysis of gender is intersectional. The research explored these interlocked identities and how they influence participants respective experiences. As depicted in the diagram below, a Socio-Ecological Model – popularized by Lori Heise in 1998 to study gender-based violence – helps build a comprehensive and dynamic argument from multiple but inter-related levels of the landscape of premarital abortions – individual, inter-personal and societal or structural. Narratives of all participants speak to and from all these distinct levels, thereby highlighting the complex mix of individual, socio-cultural, legal and financial determinants and results of premarital relations and abortions. Such a framework brings into view the interrelatedness of various aspects that shape the premarital abortion process for men and women and avoids the pitfalls of a reductive understanding of each level and actor.

**Figure 1:** Framework to examine factors that affect male involvement in premarital abortions



## CHALLENGES AND LIMITATIONS OF THE STUDY

A key limitation of the study is that purposive and voluntary selection might overrepresent men's positive engagement in abortion behavior. The study could not speak to men who did not participate in the abortion process. As a result, study narratives are primarily of men who were involved during abortion. Further, since most participants were recruited from clinics, experiences and narratives of those seeking abortion services from non-clinical settings could not be captured.

Given the highly sensitive and taboo nature of the issue of premarital sex and abortion, there were some challenges during the study. It was difficult to locate those who had experienced premarital abortion and then equally hard to find out those who may be willing to participate in the research. The research team hoped to recruit 25 respondents for IDIs, but only 17 participants could be found. It was difficult to access male partners of abortion seekers.

Further, accounts of participants could not be triangulated with his/her partner because either the participant had experienced the abortion with an ex-partner who they were no longer in contact with or the partner was unwilling to speak about the incident.

Due to the heavy association of premarital sex with morality, these accounts could be particularly influenced by the desire to project or hide a certain behavior or belief. Trained qualitative researchers conducted these interviews and tried to navigate through this challenge, however, it remained difficult to speak about these sensitive issues with young men and women. In fact, many of them did not agree for an audio recording of their interviews and expressed reluctance in talking about their sexual behavior and relationship. Moreover, the relationship between the study partner and the participants is that of a service provider and workshop participant/client/patient respectively. This carries its own dynamics of power and may have impacted both recruitment of participants and their articulation of their abortion-related encounters and journeys.

## STUDY FINDINGS

Table 2 presents a detailed profile of the 17 IDI participants. These details help explain the contexts of the participants and the variances therein – age, caste, class, religion and education. It is important to note these variances while understanding the participants' premarital abortion experiences.



**Table 2:** Profile of IDI Participants

Participant code	Age	Gender	Religion	Caste <sup>18</sup>	Economic Status	Education	Vocation	Marital Status	Age during abortion	Medical (MA) or Surgical Abortion (SA)	Living arrangement at the time of abortion	Primary provider of support at the time of abortion
P1	20	F	Hindu	Valmiki (SC)	Lower class	Till Class 7	Housewife	Married	16-17	MA	With Parents	Mother
P2	24	F	Hindu	Jatav (SC)	Middle class	Postgraduate in Political Science	Former teacher	Unmarried	24	MA	With Parents	Parents
P3	26	F	Hindu	Kashyap (Upper caste)	Lower class	Illiterate	Housewife	Married	18	MA	With Parents	Male Partner and Friends
P4	27	F	Sikh	Sikh	Middle class	Class 12	Data Entry Operator	Married	23-24	SA	With Parents	Male Partner and a Female Friend
P5	27	M	Hindu	Jatav (SC)	Middle class	Not Available	Unemployed	Unmarried	27	SA	With Parents	Male Partner
P6	27	M	Hindu	Jatav (SC)	Middle class	Postgraduate	Tenant Verification Officer	Married	23-24	MA	With Parents	Male Partner
P7	27	M	Jain	Jain	Upper class	Computer Engineer	Technology Consultant in the United States	Unmarried	23-24	SA	With Partner	Male Partner
P8	28	M	Hindu	Jat	Middle class	Lawyer	Lawyer	Unmarried	24	MA	With Parents	Male Partner
P9	29	M	Hindu	Dalit (SC)	Middle class	Graduate in Commerce	Tuition Teacher	Unmarried	24-25	SA	With Parents	Male Partner

18. Caste, even though considered officially abandoned in India, remains one of the strongest social determinants of health. Caste has been shown to be the most appropriate household characteristic for identifying poor and disadvantaged households. Socially disadvantaged groups including the Scheduled Castes (SC) and Scheduled Tribes (ST) and Other Backward Classes (OBC), are not only distinguished by economic poverty but also by their marginalization and seclusion from the rest of the society, having different traditions and living in the most economically disadvantaged areas. (Nayar K.R. (2007). Social Exclusion, Caste and Health: A Review based on the Social Determinants of Health Framework. Indian J Med Res. With reference to this report, the caste group Kashyap, Brahmin and Kayasth have been considered as 'upper caste' and Kumhar (OBC), Valmiki, Jatav and Dalit (SC) have been considered 'lower caste'.

Participant code	Age	Gender	Religion	Caste <sup>18</sup>	Economic Status	Education	Vocation	Marital Status	Age during abortion	Medical (MA) or Surgical Abortion (SA)	Living arrangement at the time of abortion	Primary provider of support at the time of abortion
P10	29	M	Hindu	Baniya								
P11	29	M	Agnostic	Kayasth (Upper caste)	Upper class	Engineer, currently preparing for Ph.D.	Micro-chip Designer	Unmarried	25-26	MA	With Partner	Male Partner
P12	30	M	Hindu	-	Upper class	Master of Business Administration (MBA)	Professional	Unmarried	26-27	Information Unavailable	With Parents	Independent
P13	31	M	Hindu	Brahmin	Upper class	Diploma in Merchandising	Senior Merchandiser	Married to the same partner through an abortion	23	SA	With Parents, but frequently stayed over at Partner's place	Independent agency and male partner support
P14	32	F	--	--	Upper class	Postgraduate	Journalist	Married to the partner she had an abortion with	27	SA	With Partner	Independent agency and male partner support
P15	33	F	Hindu	Kayasth (Upper caste)	Upper class	Two Master's Degrees	Former NGO professional, currently a Postgraduate (Master's) Student	Married to the partner she had an abortion with	22	MA	At Hostel	Independent
P16	33	F	Sikh	Sikh	Upper class	Graduate	Manager, Treasury and Trade Finance	Married	26	MA	At Hostel	Male Partner
P17	35	M	Hindu	Kumhar (OBC)	Middle class	Dropped out of graduation	Auto-Mechanic and Salesman	Married to the same partner through an abortion	20-22	Respondent does not have accurate information	With Parents	Female Partner's sister (Male Partner was present, but behind the scenes)

# I.

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# Premarital Sex and Abortions: Norms and Perceptions

## COMMON, RISING, 'CLANDESTINE'

Conversations with service providers revealed that premarital sex is a widely prevalent, open secret. During these discussions, service providers in clinics shared that easy access to the internet, contraceptives and emergency contraceptive pills as well as financial independence are important factors behind the prevalence and growth of premarital sex among the 'liberated youth'. A middle-aged female clinic in-charge of an NGO-run clinic shared:



*"There are few restrictions on youth nowadays. They have more mobility. They are also more 'westernized'. Now they are free. They have more facilities and contraceptive pills are also easily available. Young people say that premarital sex is not right, but not everyone follows these values."*

This impression was corroborated during all FGDs with young men and women who shared that premarital sex is common among their peer group. This was also endorsed during individual interviews with young male and female abortion-seekers. A young IDI participant belonging to a higher-income group shared:



*"Premarital sex is common and highly prevalent. It is purely sexual in nature. However, the acknowledgement of this across classes does not exist."*

## 'IMMORAL' AND STIGMATIZED

Discussants and most key informants viewed premarital sex as immoral and therefore inappropriate. In the words of a female clinic in-charge at an NGO-run clinic:

“We live in a society that does not give permission for premarital sex...this (sensitivity) is our honor.”

Service providers across class echoed this view, except for one young female gynecologist who acknowledged that young people should have sexual agency.

There was a clear difference regarding perceptions about premarital sex between young men and women from different socio-economic contexts as revealed during FGDs and IDIs. More men and women from middle-income backgrounds believed that a couple should engage in sex only if they are ready to marry each other. Casual sex with a non-marital partner was unacceptable. Therefore, the promise of a premarital relation turning into a marriage justified its supposed immorality, at least to some degree. A male discussant from a middle-income background went a step further and said:

“If the boy feels he would want to share a life-long relationship with a girl, he would choose not to engage in premarital sex. If it’s only for time-pass, then he will surely have sex with her.”

Men also acknowledged the social harm their female partners may face by engaging in premarital sex and therefore, they felt bound to protect the woman’s reputation and perceived honor through marriage.

Although male and female participants from higher-income backgrounds did not think that premarital sex was necessarily wrong, they hid such practices from friends and family. For instance, a female IDI participant noted:

“We like to lay the blame (of stigmatizing women who engage in premarital sex) on lower classes, but it is difficult even in upper classes.” (P15)

A female IDI participant explained why she chose to not tell her friends about her experience of sex:

“Premarital sex is pervasive, it has been happening since my college days...but you can’t share it (the experience of having sex) with anyone...because people in your surroundings are not doing it, but you are doing it, so you do not share because you are afraid of people’s judgment.” (P16)

Given the social taboo around premarital sex, an unwed pregnancy is seen as a matter of great shame and disrepute for a woman as well as the family. As a result, couples with unwed pregnancies are left with no option but abortion. Their experience therefore is secretive and mostly without support from friends and family.

Most service providers believed that premarital abortions are immoral and so premarital sex should be avoided as much as possible.<sup>19</sup> A majority of young men and women and abortion seekers had somewhat accepted and internalized the discourse around the ‘Indian sensibility’ of the immorality of premarital abortion.

In popular thought, abortion is equated ‘to killing an unborn child’. An unquestioning acceptance of this idea or religious notions of children as ‘god’s gifts’ made it difficult for men and women to come to the decision to end their pregnancy. Yet, the stigma around premarital pregnancies leaves young people with no choice but to abort.

## SEXUAL DESIRE: DIFFERENT STANDARDS FOR MEN AND WOMEN

Conversations with study participants across IDIs, FGDs and KIs revealed that although dominant social norms prohibit premarital sex for men and women, men’s defiance of such a norm is tolerated or even accepted while women’s defiance is unacceptable. Service providers and young men and women pointed out that men were seen as much more ‘naturally sexual’ in comparison to young women. There was very little mention of female sexual desire in these conversations. During an FGD with young men from middle-income backgrounds, one of the participants shared:

19. Interestingly, most service providers said that they did not disapprove of all abortions per se, only premarital abortions. To them, abortion within a marriage is acceptable and a mark of a responsible citizen, who wants to help control the country’s population.



●● —————  
*“Boys are interested only in sex. Their character is like that. Most men use the girl for sex and then leave her.”*

This was echoed by an older gynecologist in private practice, who shared:

●● —————  
*“Men use girls for their time-pass and pleasure.”*

In contrast, women are expected to be repositories of sexual abstinence and social morality. Female focus group discussants from different backgrounds evoked emotional attachment and companionship when speaking of the dynamics of their relationships. They too believed that while men are keen to become physically intimate, young women are often coerced by their partners to have sex. Discussants shared that men sometimes threaten to end the relationship if their partner refuses to have sex and so women consent out of the fear of losing their male partners. That being said, a few women university students did share that women too have sexual desire, but no one acknowledges that.

Virginity is a key characteristic of a ‘good’ or ‘respectable’ woman, while sexual experience is often seen as a characteristic of a ‘real man’. Talking about the need to preserve a woman’s virginity (or honor), a male discussant from a higher-income background said:

●● —————  
*“All boys want their wives to be a virgin because who wants to drink dirty sewage water, they want mineral water.”*

Other male discussants in the same group added that unlike men, women accept non-virgin men as their husbands. Such is the societal privilege that men have vis-à-vis premarital sex that during discussions, service providers and young men and women shared that men usually feel a sense of pride about their sexual encounters

and feel encouraged to share it with their peer groups. However, they shared that young women experience more fear and stigma in relation to sex. During a FGD with men from middle-income backgrounds, a discussant highlighted this cultural contradiction as:

●● —————  
*“If a girl is seen roaming around with more than one boy then her character is questioned whereas if a boy is seen with one or more girls, people would say he has some talent.”*

This patriarchal imperative that women be virgins before marriage is a main source of stigma for women with premarital pregnancies. A young male discussant during an FGD with participants from middle-income backgrounds remarked:

●● —————  
*“The boy gets saved. But the girl gets stuck. Girls often have no choice, but to commit suicide if the man does not provide support.”*

Some discussants knew of cases where parents had abetted their young daughters’ suicide when they found out about their pregnancy. It is important to note that in these perceptions, men are viewed as the perpetrators and women as victims, but women are still judged harshly. Further, in India, parents can be rigid about caste and class affiliations of the partner,<sup>20</sup> hence making a situation of premarital abortion more challenging for young men and women.

## QUESTIONING NORMS GRADUALLY

Interestingly, most focus group discussants – both male and female – more or less agreed with the social norm against premarital sex and thought that it is wrong, yet they were flexible about their opinion and choices. This is so because they viewed sex as a legitimate and natural need. However, if they themselves are in a situation

20. FGD and IDI participants shared that their parents do not accept inter-caste relations as it defies their communities’ norms around endogamy and can lead to ostracization of the family. Since marriage with parental consent is an impossibility for these inter-caste couples, they finally have to end the relationship. Among our IDI participants, there were several couples who wanted to marry, but could not because they belong to different castes. A couple of male IDI respondents from lower-income groups shared that their partners broke up with them – post abortion – due to their low caste status.

of premarital pregnancy, the societal notion of premarital sex as wrong works its pressure on them and causes emotional and moral burden. This internalization of the stigma associated with premarital sex was evident during an FGD with young men from a higher-income background, when a participant shared:



*“Sex is natural and it’s a need, but society is a barrier.”*

The openness to embrace new attitudes toward premarital sex, despite being socially conditioned to reject such values, was attributed to the exposure to new value systems at school/college and/or work as was evident during IDIs. The primary sources of this exposure were generally friends, followed by the internet.<sup>21</sup>

Young men and women constantly navigate between accepting themselves as sexual beings and conforming to social norms that restrict sexual expression. The extent to which young people break away and question these norms

impacts how they steer through the stigma attached to a premarital pregnancy and how they respond to it. The degree of fear experienced and the internalization of this stigma varies across class, caste, religion and other factors such as living independently, outside the ambit of the familial home. Young people who are financially independent, do not live with their parents and therefore have more exposure to perspectives that their family may not endorse are the ones who seem to have more control over their sexual behavior and choices.

The following section presents narratives of men who had been supportive of their premarital partners’ abortion and examines how these men and their partners navigate the prevalent norms around premarital sex and abortion. This is because it was difficult to gain access to men who have not supported their partners. Contrary to the popular discourse about the recklessly sexual male, the male participants of the study emerged as supportive, if not always sensitive. It is interesting to compare narratives of supportive men with the general discourse.

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21. Male participants spoke about pornography as a popular source that normalized sex and sexuality; for women, their ‘boyfriends’ were mostly the source of information regarding sex. Participants from middle to higher-income groups recalled attending anatomy/reproductive health sessions at school, but these were devoid of the sex education component.

## II.

# Premarital Abortions: Experiences and Male Involvement

This section presents the premarital abortion experiences of the 17 IDI participants and highlights the role played by the male partner in these experiences.

### FINDING OUT ABOUT PREGNANCY

Conversations with all IDI respondents revealed that women usually check for pregnancy only when they missed their periods. This was confirmed by service providers in clinics. All IDI participants<sup>22</sup> were aware that missing a period could signal a pregnancy. Therefore, there was no delay in identifying a pregnancy in most cases. However, for women with irregular periods (P2, P3), the pregnancy was discovered only when they missed their period for a second consecutive month. Certain male IDI respondents (P5, P7, P13) confirmed that their partner suspected a pregnancy only after missing the period the second consecutive month. As a result, these women were around 7-8 weeks along when they discovered their pregnancy.

#### Enablers:

- Awareness about detection of pregnancy
- Access to information about pregnancy kits through peer networks and television ads
- Accessibility and availability of pregnancy kits
- Male freedom and mobility
- Less parental control on men

\*Please see the Annexure for detailed comment on Enablers and Barriers to Male Involvement

The most commonly used method to determine a pregnancy – across all socio-economic backgrounds – is the pregnancy kit. IDI participants shared that it was usually the male partners who purchased the pregnancy kits and brought them to their partners. Although both partners knew about pregnancy kits, women avoided buying these themselves due to the stigma associated with premarital abortions and in some cases due to restrictive mobility. As expressed by a male IDI respondent:

● ● *“She did not want to get weird looks from the chemist shop owners. She was hesitant, so I offered to go and buy it.” (P7)*

22. IDI participants refer to both male and female, unless otherwise specified.

However, a couple of female participants (P14, P15) did mention that they purchased the pregnancy kits on their own:

●● *“Though my partner offered to help, I told him that I will take care of it, so he could just relax.” (P15)*

IDI respondents learnt about the kit from their peers and in some cases through television advertisements. A couple of female IDI respondents shared that they had seen their female relatives use the kit before and hence knew about it.

## REACTION TO A PREMARITAL PREGNANCY AND IMPLICATIONS

The internalization of the social stigma around premarital pregnancy makes fear the initial reaction of young persons with premarital pregnancies. All IDI participants said they feared their parents and family members finding out. This fear caused them intense stress and panic. A female IDI participant said:

●● *“I could not understand what was happening. I got very, very stressed. The first thing that came to my mind was about what my parents would say or do if they were to find out. It felt like the ground had slipped from beneath my feet.” (P2)*

### Barriers:

- Stigma of premarital pregnancy,
- Fear of parents' violence in inter-caste relationships. Men felt vulnerable because of the threat of harm and violence from parents or community. This made them hide the premarital pregnancy and manage the situation with as little assistance as possible.

### Enablers:

- Physical distance from family and community reduces fear enabled men to support their partners more confidently.

A male participant said:

●● *“It was a nightmare. My mind just went blank.” (P6)*

IDI participants expressed the fear of extreme restrictions being imposed on women in terms of mobility, education and interaction with friends and peers. A female participant mentioned:

●● *“My mother found out about my pregnancy. She stopped me from talking to my male friends. I felt scared for my life.” (P1)*

Although she tried to hide her pregnancy from her parents, her mother got suspicious when she did not ask her for sanitary napkins. Later, her mother found a pregnancy kit in the bathroom and discovered the pregnancy. The participant was beaten and locked up in the house for days, after which she was taken for an abortion.

In certain situations, women face a threat to their lives if their parents find out about their premarital pregnancy. A male participant shared the fear he experienced on finding out about his partner's pregnancy:

●● *“Her family could have done anything to her. Premarital pregnancy can be very dangerous. We are from Haryana and I know what happens there. I know of a case where a brother and a sister had relations with each other in the hostel they lived in. The parents got them killed and their bodies were chopped and buried. No one came to know. In cities such as Delhi, abortions can be done, but in states like Haryana, there are murders and no one can stop these.” (P9)*

He and his partner made sure that no one came to know about the pregnancy.

In cases of inter-caste relationships, threat to life often extends to the male partners as well. A few male participants (P5, P6, P10) mentioned that they were in relationships with women who belonged to higher castes. Once they found out about the pregnancy, they felt at risk because upper-caste families are intolerant and would not hesitate to harm their daughters' lower-caste partner. One such young man said:





*“She comes from an upper-caste family. They are rigid and conservative. They could have killed her, or it could have reached my family. There are cases of lower-caste men being killed by upper-castes.” (P5)*

However, participants who lived away from their family shared that the distance from their parents and community somewhat reduced their guilt and fear. For the woman, the fear of her parents finding out makes the man the fulcrum of her support. Hence, his role becomes crucial in such situations of premarital pregnancy.

## ABORTION DECISION-MAKING

Given the stigma around premarital sex and pregnancy, unmarried youth do not have the choice to continue with a pregnancy in India. Therefore, the decision to undergo an abortion becomes essential. Young men and women do not deliberate about whether to have an abortion or not – in fact, the decision to make is how soon and where to get it done with utmost secrecy.

*The ideal male response was seen to be his promise of marriage – the best way to give sanctity to a ‘not-so-sanctimonious’ act and save reputations from being tainted.*

However, they do discuss if marriage is possible. Conversations with several IDI participants revealed that the decision to get an abortion done is closely knit to the idea of marriage. If they cannot marry each other, abortion is their only option.

More than half the number of total IDI participants, (P1, P2, P3, P4, P5, P17, P10, P12, P16) shared that upon discovering the pregnancy, they preferred marriage over abortion. Most of these participants belonged to a lower socio-economic background in terms of caste, class and education. A female participant shared:



*“I opted for the abortion since my partner was not ready to marry me. If he had been prepared to marry me, I would have kept the child and continued with the pregnancy.” (P2)*

A male participant from a similar background stated:



*“I would have liked to think about marriage, but she was from a higher caste and hence she refused. If marriage was possible I would have preferred that.” (P5)*

In fact, while talking about male involvement in a premarital abortion experience, these respondents defined supportive male involvement as synonymous with marriage.

The perceived inability to marry did not come up as strongly a reason to get an abortion for some male and female participants (P6, P7, P8, P9, P11, P13, P14, P15). Most of them belonged to a higher socio-economic background in terms of caste, class and education. Their reason for abortion was their financial and emotional unpreparedness to parent a child. A female participant said:



*“I was very clear I did not want a child. I was 27. I did not have any maternal feelings or any emotions of that sort. I felt that I had just started dating this person so I did not want that. Also, I had struggled for such a long time with Polycystic Ovary Syndrome (PCOS) that I did not want to do this to my body.” (P14)*

On similar lines, a male participant shared that:



*“I did not want a child because I was not financially or emotionally ready. My priority was my PhD. Even my partner did not want a child. She was not in a position to take responsibility of one. Both of us thought it would be irresponsible on our part to bring someone to life at this stage.” (P11)*

IDI participants who were economically well off and more educated were not ready for marriage; it threatened or at least challenged some of their personal ambitions related to education and career. For them, love, sex and/or pregnancy did not necessarily lead to marriage. In contrast, young men and women from lower socio-economic backgrounds did not speak about the vulnerabilities that could emerge because

of early marriage and parenthood. Their correlation between love, sex and marriage was pronounced.

### INFORMATION SEEKING: HOW AND WHERE TO GET A PREMARITAL ABORTION?

All male and female IDI participants mentioned that their knowledge and information about abortion came from peers/friends and/or the internet.

#### Enablers:

- Access to information through a 'whisper network' of peers.
- Access to the internet

#### Barriers:

*Sense of stigma and related shame prevented men from reaching out for help and further pressurized them to collect information on their own.*

IDI participants shared that their information on which method to use (medical or surgical), availability of medicines, location of clinics and so on was sourced from friends/peers (some of whom were working at clinics or drug stores). Or, they had prior knowledge through other sources such as television advertisements. In fact, during some group discussions most young men and women (those who had not undergone abortions) confirmed that knowledge about abortion methods and clinics is usually sourced through friends/peers. This is their 'whisper network' where such secret information is shared with each other.

Even though friends and peers are an important channel of information, stigma around premarital sex and fear of judgment can prevent young people from sharing their premarital pregnancy with their peers. Such secrets are usually shared with one or two close friends and mostly to acquire information about abortion. They feared that the news may spread, and many other people may come to know. As a result, a few IDI participants used the internet to access information about abortion – options available, access to these options as well as the impact of these options on the health of women. Along with the internet, young men and women

reached out to a 'close friend' who would not judge them and keep their secret intact.

The seeker, carrier and transmitter of abortion-related information is usually the male partner. He reaches out to his peers and uses the internet to get and verify information about next steps, medicines, clinics and so on. For instance, a male participant said:



*"I learnt about a few clinics where they do abortions from my friends. I then went and checked the clinics, informed my partner and took her to one clinic that was best suited. My friend's friend knew about this place; his girlfriend had an abortion there." (P5)*

Men also shared about their use of the internet for information:



*"I was able to access all information from Google and through its use, was able to take decisions. On the internet, I found information about medicines that could be consumed for abortion. It was mentioned that if a woman consumes those medicines within a certain period of time, an abortion can take place. I purchased it and gave it to her. My research on abortion methods on the internet was very extensive and detailed and hence I was confident about the medicine I was purchasing." (P8)*

This role of men as information seekers and providers was reiterated during IDIs with female participants. A young female IDI participant shared that:



*"My boyfriend knew about the pills from his friends. When I refused to buy them, he went and bought it for me." (P1)*

The practice of the male partner being a primary channel of information gathering and service provision was more pronounced among the narratives of IDI participants from lower socio-economic backgrounds. Most IDI participants from these backgrounds said that the male partner sourced information as they had easier access to friends, internet and more mobility. In one such conversation with a male participant, he said:



*“My girlfriend did not know anything about abortion. She did not know about medicines, doctors, clinics. All she had heard that was abortion causes weakness because one of her female relatives had experienced this. I found out everything and gave the information to her.” (P5)*

A female participant said that she had no knowledge about sex, contraceptives, pregnancy and abortions. This lack of knowledge made her feel tense and made her depend on her partner.

Conversations with male and female IDI participants from higher socio-economic groups pointed out that both the partners collectively sought out information from peers and, importantly, from the female partner’s gynecologists. Gynecologists did not feature in accounts of IDI participants from lower socio-economic backgrounds.

## UNDERGOING THE ABORTION

### MEDICAL ABORTION

Service providers find that women mostly consume medicines for abortions,<sup>23</sup> given their easy accessibility, lower costs as well as the privacy they provide. A female IDI participant who had undergone an abortion substantiated this:



*“I was in a space where I had my friend’s non-judgmental support and easy access to pills over the counter. I was in Delhi, away from my family and that made it easy. I was in a hostel and could get it done easily without my family knowing about it. We took a print out of the name of the pill. The chemist thought it was a prescription. So, it became easy.” (P 15)*

#### Enablers:

- Accessibility to chemists due to men’s mobility and the less likelihood of men being judged at chemist shops
- Access to the internet for information on medical abortion pills

#### Barriers:

- Incomplete information provision by chemists regarding medical abortion pills

Usually, it is the male partner who goes to chemist stores to purchase medicines. In cases where women had medical abortions, it was their male partner who purchased the pills. There was only one exception: a female IDI participant who lived away from her family and so could buy the abortion pills on her own (P15).

IDI participants were afraid of being judged and asked intrusive questions by chemist shop owners. As a result, they preferred that the male partner purchased abortion/contraceptive pills. This was more so among IDI participants from lower socio-economic groups where women face greater restrictions on mobility. One male IDI participant shared:



*“It is easier to interact with the chemist to buy the pill. But a woman cannot go and buy the medicine because people will taunt and spread the word.” (P6)*

Service providers verified that couples often get to know the name of abortion pills on the internet or from friends, and then the male partner purchases the pills from a pharmacy. This route to abortion provides abortion seekers the much-needed privacy – they avoid meeting doctors. Quite often they do not have complete information about how to use the pills. As a result, many women end up consuming the wrong dosage of abortion pills, leading to unsuccessful abortions. According to doctors, many women come to clinics for surgical abortions after an unsuccessful medical abortion. This was the case for a couple of IDI participants who had surgical abortions. Many participants did not know that medicines only work if a pregnancy is less than or up to 8 weeks old. Many women consume these pills at much later stages of their pregnancy, leading to incomplete abortions. A few doctors added that many women are not aware about the gestation period for abortion pills, hence they consume the pills before time and end up going to clinics to seek surgical abortions.

23. Despite being a prescription product, medical abortion pills are easily available without prescriptions at chemist shops.



Risk taking behavior was higher among participants from lower socio-economic backgrounds (P1, P2, P3, P6). Most male participants purchased pills from the chemist and gave it to their partners without consulting any doctor. They used pregnancy kits to determine if the abortion was successful. This was not the case with IDI participants belonging to higher socio-economic backgrounds (with one exception, P13) who consulted doctors before deciding on the method of abortion and even sought post-abortion check-ups.

### SURGICAL ABORTION

Among the participants, the decision for surgical abortions was taken because of one or more of the following reasons – lack of knowledge about availability of pills, access to a friend/acquaintance at an abortion clinic who knows about the surgery, delayed discovery of pregnancy and/or incorrect consumption of medical abortion pills and mistrust of abortion pills. Participants were fearful about surgical abortion and concerned about the expense it caused. They found it more difficult because of the physical consequences such as weakness, as well as its demands on their time in terms of bed rest and day-long stay at the clinic. Due to these reasons, chances of family members finding out about the pregnancy increases.

#### Enablers:

- Accessibility to information about abortion clinics
- Resourcefulness in terms of transport, money and information networks

#### Barriers:

- Judgements and fear of being reprimanded by service providers

Unlike medical abortions, access to and cost for surgical abortions is a concern for the young. Conversations during IDIs as well as KIs revealed that the choice of doctor and clinic depends on several factors. For example, the need for confidentiality and secrecy made young couples choose clinics that were located far away from their homes. A gynecologist in private practice commented: *“I used to receive patients from lower economic backgrounds in my private*

*clinic located in the higher-income group areas of Delhi. They opt for clinics that are away from their homes.”*

A male IDI respondent also made a similar remark:

● ● *“I took my girlfriend to a clinic that was half an hour away from her place. We chose this place because this was far from her house.” (P5)*

In most cases from lower socio-economic backgrounds, men selected the clinic because their partners faced restrictions with respect to mobility. Abortion seekers from higher socio-economic backgrounds chose clinics based on the advice of the female partner’s gynecologist, besides feedback and reviews from friends. Many participants who had undergone an abortion said that they consulted their friends who either worked at these clinics or had made use of their services at some point. For instance, a male participant said:

● ● *“I was lucky to have those two people who gave me some information and directed me to the right places. Otherwise, it would have been more difficult. For me it was not easy to get to know about this place. It is also not very close to our house. But the place felt safe.” (P10)*

Among all IDI participants, the male partner accompanied the woman for the surgical abortion. In many cases they took care of the transport, accompanied them to the clinic, interacted with service providers, paid for the service and dropped their partner back home. Service providers at clinics confirmed the higher presence of men over the years. They found that men who accompany their partners ask about the procedure in detail and its impact on women’s health. Male IDI participants shared feeling anxious and responsible. This involvement is perceived to be greater among cases of abortion in higher-income groups. Among participants from lower socio-economic groups, some men preferred waiting outside the clinic for fear of being seen in the clinic. However, they accompanied their partner to the clinic and waited outside to take her back home in the



evening. Therefore, sometimes men are involved behind-the-scenes during surgical abortions given their fear of being judged and accused by service providers.

It is usually the male who pays for the abortion pills and the surgical procedure. Most men see it as their responsibility to take care of the expenses; some men from different class strata thought that a couple should share the expenses. A couple of female participants from higher-income groups paid for their abortion.

### INTERACTION WITH SERVICE PROVIDERS

Attitude of health providers emerged as a major concern in shaping the overall abortion experience of young men and women and their perception of the quality of care they received.

#### Barriers:

- *Judgmental attitude of service providers, wherein they hold men responsible for putting their female partner in such a situation of pregnancy and reprimand young people who engage in premarital sex*
- *Limited interaction between men and service providers*

IDI participants and policy experts shared that medical facility providers often divert abortion into an area of legal sanctity. When unmarried women come to clinics, to seek abortion services, health providers often ask deeply intrusive questions to determine the marital status of these women. Given the many legal rules that clinics have to follow in providing abortion services, particularly to determine if the abortion seeker is a minor or has been subjected to non-consensual sex, they feel apprehensive and often tell women to register police complaints. In fact, the deep scrutiny and judgment that women are subjected to in clinics is one of the main reasons why the recourse to pills has become so common.

According to service providers and policy experts, the scrutiny about marital status is much higher in government clinics than in private ones. As a result, abortion seekers prefer private clinics at a higher cost and/or clinics run by NGOs and avoid the free abortions at government clinics/hospitals. However, there is evidence to

suggest that private clinics can also be risky for the young. For example, a male IDI participant said that after his partner consumed an abortion pill, they saw a private doctor to determine if the abortion had been successful. The doctor asked them for all their personal details such as name, address, and contact details; this caused them tremendous stress. The doctor refused to provide them with the service; her stated reason was that she does not perform abortions for unmarried couples. They left feeling scared.

The male partner said:

“The attitude of the doctor was very disappointing. People have a fundamental right to privacy and doctors cannot impinge upon that. Despite being educated and aware, doctors scare patients away. If they don’t understand, who will?” ( P8)

Even when service providers attempt to be open-minded and non-intrusive, personal opinions and judgments get in the way. For instance, IDI participants said that doctors and service providers at clinics would often advise couples to not abort their first pregnancy and suggested they get married instead.

The study found a few instances of non-judgmental service providers and doctors. One such female IDI participant said that her doctor was understanding and comforted her with advice. She instructed the male partner to not indulge in any sexual activity for four weeks; the woman appreciated this because she was apprehensive and concerned that male partners could get abusive in these situations. Further, some service providers were appreciative of seeing more men accompany their female partners to clinics. They felt these men owned up to their responsibility.

It is important to note that even though men played the lead role in the background for gathering information about abortion procedures, doing a recce of clinics, selecting the abortion facility, handling logistics of travel to/from the clinic, paying/sharing the bills, buying medicines and even be physically present during the (medical/surgical) procedure, communication

between them and the medical or other staff at the abortion clinic/hospital was often limited. The exchange with the male partner was mostly around filling up of forms, fact-checking and quite often, a quick reprimand on morality or use of contraception by the doctor. As a result, the non-medical/medical staff interviewed for the study did not seem to have much familiarity or rapport with the male. This has important consequences on male engagement in the process.

In the few cases where service providers had interacted with men, the latter were made to feel guilty. They were reprimanded by the staff for placing their partner in a difficult situation and felt judged. A service provider shared that:

●● *“Men should feel responsible. Because they are harming someone. They are harming the woman, the girl. The man is using a lady for his desire. How can such a person be good? So, how can such a thing be good? No? A man should be mature enough to resist. Maturity is the question here. It is immature behavior. Just indulgence I would say.”*

### POST-ABORTION CARE AND FEELINGS

The post-abortion experience of participants was conditioned to a large extent by their gender, relationship dynamics, level of support received from partner or family and their socio-economic status. Clinic staff said that women experience psychological trauma due to an abortion and require counseling to recover fully from guilt and fear. This trauma is enhanced if women do not receive the support of their male partners or are abandoned. Women who are not economically independent and are neglected by male partners often are compelled to disclose their pregnancies to their families.

#### Enablers:

- Men’s sense of feeling responsible
- Cohabitation of partners, hence men were able to provide post-abortion support

#### Barriers:

- Perceptions that men feel no sense of responsibility
- Physical distance from partner
- Judgements and stigma prevent post-abortion checkups.

IDI participants also shared that women experience greater trauma and guilt for they are the ones who experience the physical and emotional pain acutely. Speaking about the impact of the episode on his female partner, one male participant said:

●● *“She would keep crying. She felt that I was not providing her with support. That caused her greater pain. She was depressed. It took her a long time to come out of it. She kept saying that she killed her baby.” (P 11)*

Interactions with men and women during IDIs reflected that while they believe women experience more trauma and guilt, men also carried guilt for having put their partner in such a situation. One male participant said:

●● *“We both felt a sense of shame after the episode. We felt that we had committed some wrong.” (P11)*

The general perception about the impact of an abortion of men, as evident from FGDs and KIs, is that men experience little grief and psychological trauma due to an abortion because they do not have to face societal stigma and the physical experience. However, conversations with men revealed their sense of responsibility, sometimes out of a sense of obligation or the precept of ‘male responsibility’ and/or attachment and affection. Men also stated that they did not tell anyone else about these feelings of guilt and responsibility. In fact, some of the male IDI respondents, were speaking about these feelings for the first time. One male IDI participant shared that:

●● *“It is strange for me to speak about all this. I have never spoken about this to anyone. This is the first time I am opening up about that experience. I was reluctant initially.” (P9)*

Conversations revealed that women also faced the additional fear of their male partners leaving them as a result of the abortion. Many IDI participants, particularly from lower socio-economic backgrounds, expressed and felt

grateful that their male partners decided to stand by them during the process. One such male participant said:

●● \_\_\_\_\_  
*"She was also scared that I would step away from the relationship due to the abortion. She was relieved that I stood by her." (P6)*

However, in direct contrast to these narratives, one female participant from a higher-income background while describing her experience said that:

●● \_\_\_\_\_  
*"I was okay, even though my partner was not around, I was able to manage on my own." (P15)*

In fact, a couple of women from higher-income groups said that they were glad that their male partner was around, though they could have managed without them.

Beyond the immediate relief and guilt, participants also spoke about the changes and negotiations that took place in the relationships with their partners. In almost all post-abortion cases, couples experienced a degree of fear toward sexual intimacy and this caused a lull in sexual activity. This was reiterated in both male and female IDI narratives. In a number of narratives, the abortion also accelerated the end of the relationship. This was particularly the case with participants who were involved in inter-caste relationships where marriage was not an option. One such male participant said:

●● \_\_\_\_\_  
*"We have not met ever since the abortion. She took off for 3 days after the abortion and then resumed her coaching classes. If we weren't from different castes, it may have been different. But then they are Brahmins. They practice casteism."*

Narrating a similar experience, another male participant said:

●● \_\_\_\_\_  
*"The biggest impact was that we almost stopped meeting after the abortion. We were in touch till sometime after that. Then her family got her married." (P5)*

Having said that, there were also instances of couples continuing the relationship and marrying each other. Some participants spoke about how the abortion episode brought them closer emotionally.

Interestingly, there are variations in the communication between different sets of participants post abortion. In the case of cohabiting couples (P7, P11, P13), men were physically present through the entire process and were also available to attend to the needs of their female partners. Communication between such partners was better; women expressed their pain more openly and their partners engaged more. In contrast, couples that were not cohabiting found it more difficult to communicate and interact with each other post abortion. Due to the fear and guilt of the abortion and inability to communicate effectively, the emotional upheaval led to a complete breakdown of the relationship.

However, more positively, several male participants said that they became more careful about using condoms post the abortion and would not get sexually intimate without any contraception.

Few participants mentioned getting post-abortion check-ups. In fact, two male participants (P5, P10) said that they did not refer to a doctor at all because of the fear that their secret might get revealed. Service providers too observed that young couples just want to get done with the abortion and most never show up for post-abortion advice or checks.



# III.

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# Discussion

This study reveals a backdrop of premarital sex and abortions in Delhi that is fraught with entrenched patriarchal norms as well as shifting attitudes that weaken those norms. Most prominent is the norm of marriage that continues to hold the place of an ideal institution for the expression of sexuality and maintenance of caste/faith endogamy. This glorified ideal approves reproductive sexuality and 'family planning' related abortion but censures these in other contexts especially in relation to premarital sex and abortion. It compels the young and unmarried to grapple simultaneously with their strong socialization against premarital sex and their budding sexual desires. As a result, most young people respond to premarital relations with ambivalence, resistance and/or conformity, depending upon individual agency and socio-economic circumstances.

A notable dimension of young sexuality is norms and ethics around sex, especially male privilege. Narratives show that men persuade or even coerce their female partners to have

sex who submit out of fear of displeasing the men. Besides this, there is more evidence of the stereotypical sex roles of the passive female and active male. Men enjoy a certain privilege and power in relationships, whereas young women have a limited degree of sexual agency, and therefore there is little acknowledgement and articulation of female sexuality as well as desires, if at all.

The larger discourse and stigma around premarital sexuality is driven by notions of women's sexual 'chastity' and 'honor', among others. Unlike men who talk about – sometimes flaunt – their sexual encounters among their peers and see premarital sex as their 'coming-of-age' milestone, unwed pregnant women hide their sexuality even from friends for fear of negative judgement. Women's biggest fear though is their secret being outed to their parents who could take a range of violent actions against them – from deschooling them to marrying them early/forcibly, to physically harming or killing them. Men also expressed fear of their families



finding out, some of them from the lower to middle classes especially felt threatened, by their partners' families.

It is clear from this study that across class, premarital sex and abortion have grown, even as both are seen as wrong and against 'Indian culture' by the youth, their parents and even doctors. Only a minority of middle-to-upper class young men and women – the educated, economically independent and mobile – asserted and claimed their sexuality. This minority is distinct from the lower-income group youth in another marked way – it does not view premarital sex as a precursor or condition to marriage and is thereby less traditional with respect to attitudes toward premarital relations.

At the abortion stage, access to non-judgmental medical advice and psycho-social help/counseling is not available for young people. Thus, anxiety and guilt-ridden youth, due to the stigma associated with premarital sex, get caught in a ripple of complications – little/no sex education implies little/no knowledge about pregnancy related issues. Lack of open communication and support systems cause abortion seekers to rely upon their peers' ill-informed/incomplete/dated information, which leads to health risks and then greater trauma.

In such a situation, the male partner operates from a position of privilege and thus plays a crucial role as reflected through study findings:

- Popular discourse and perceptions tend to paint unmarried men in premarital relations as oversexed, exploitative and irresponsible. However, service providers reported seeing a steady increase in the number of men who show up with their partners for abortions (men from across the class spectrum, especially those from the higher-income groups). Besides, educated and privileged women are taking equal responsibility for the pregnancy. Discussions and interviews with young men and women also suggest that men feel responsible for the pregnancy and choose to be a part of the abortion journey of their partners, openly or covertly.
- The common role played by all male participants was that of an all-in-one service provider of sorts for their partners; they sought information about pregnancy kits, abortion pills, clinics and, wherever needed, purchased medication, recced the clinics, spoke to doctors, accompanied their partners to the clinics and paid for the abortion. In a male participant's words:
  - *“When you experience an abortion, you are emotionally involved with your partner... involving a third person is avoided because you feel he/she would not understand and will judge you. My partner was sharing her home with a girl at the time. They were close, but her roommate never got to know.”*
- Men rely the most on their male peers for information and even monetary support at times (if required). They have more avenues to seek information from and communicate about premarital sex and abortion than their partners.
- Male support is driven by gender stereotypes around men being the provider and caretaker in relationships along with an emotional attachment to their partners.
- Fear of violence from the woman's family/community or being accused of rape is also an important factor that drives men toward abortion-seeking behavior.
- In cases where men are cohabiting with their partners, they were able to provide greater emotional support due to physical proximity.
- The easy availability of abortion pills over the counter has also increased the ability of men to help their partner in a situation of premarital pregnancy.
- Medical systems/personnel seem to exclude men in the encounter with premarital abortion seekers and do not make any conscious effort to engage with them. Notably, medical personnel appear to be reprimanding of men. As a result, men tend to stay away from or outside the abortion facility to avoid feeling judged or embarrassed. This limits male engagement at the time of abortion.



## IV.

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# Recommendations

The findings of the study show men playing an instrumental role in the premarital abortion process. Their involvement aided women's access to safe and quality abortion care in a significant way. In some cases, they were more actively involved in the abortion process and in others, they chose to remain present in the background while continuing to extend emotional support. Pregnancy and abortion, as the findings reveal, present a window of opportunity for engaging with men.

### **CRUCIAL TO CAPTURE 'MALE VOICES' AND TO INVOLVE MEN**

Men's roles are often not prioritized in the discussions around SRH and rights. This is a result of and a contributor to the dominant belief that SRH is a women-only domain. Conversations revealed that men appear willing to share the premarital pregnancy and abortion burden with their partners and want to play a supportive role. Therefore, it is important to engage them more rather than solely viewing them as the

cause of the problem. Men can and should be a part of the solution. They need to be involved as much as their female counterparts and as early as possible – at the school and/or college level. During the research, men shared being silent, feeling anxious and vulnerable, and this highlights an important gap in health research and policy; that of the missing the 'male voice'. Capturing these voices is crucial to altering male behavior and for strengthening women's healthcare and men's well-being.

### **LEVERAGE MEN'S ROLE AS 'QUASI-SERVICE PROVIDERS' (INFORMATION SEEKERS AND PROVIDERS)**

The study shows that men played a proactive role as seekers and transmitters of knowledge and information about contraception, pregnancy and the abortion process not only as male partners, but also as friends/peers and close confidants within the 'whisper networks' of the young. It was found that men with personal experience

of premarital pregnancy and abortion were in unique and important positions to transmit more accurate information and knowledge about the issue and dispel related myths. Engaging men as seekers, carriers and disseminators of information would therefore be an effective strategy to encourage communication on these issues, especially among young couples, promote contraceptive use and positively influence safe abortion practices. However, for this to happen it is important that correct information reaches men. For instance, chemists need to pass on accurate information about abortion pills to young men, so that they can share it with their pregnant partners.

### STIMULATE/ENCOURAGE SERVICE PROVIDERS' INTERACTIONS WITH MEN

In the study, perceptions and attitudes of healthcare providers have a substantial impact on the access to and quality of abortion services. It also found that service providers have very limited interaction with men while most of it remains restricted to women. Since men are key players in a situation of premarital pregnancy and abortion, it is crucial that service providers interact with them. This interaction can positively alter a woman's abortion journey. It can also help address men's specific vulnerabilities and concerns with safe sexual behavior.

### ENGAGE MEN TO ADDRESS NORMS OF GENDER

The narratives establish that men yield significant decision-making power and gender norms have a strong bearing on the decisions made around premarital sex and abortion. Men, as the findings show, have the tendency to coerce their partners to engage in sex. They threaten to end the relationship to make her consent to sex. It was also found that men refuse to use condoms as it inhibits their pleasure. Given socio-cultural norms, women experiencing unwanted pregnancy and abortion are more susceptible to shame and stigma as compared to their male partners. Leveraging men's agency may facilitate gender equality within relationships and encourage safe SRH practices. This includes respecting women and recognizing their choice and agency, promoting equal decision-making, challenging attitudes that cause sexual and gender-based violence and inequality.

Conversations with young men and women and service providers highlighted the need to engage with a range of stakeholders, like schools, parents, community, medical personnel and the health and legal system. These actors influence the premarital abortion pathways of young men and women. Some specific recommendations for them are highlighted below:

	Recommendations for Potential Action and Change
Outreach Programs	<ul style="list-style-type: none"> <li>• Regular outreach programs for young men and women, particularly through Comprehensive Sexuality Education in schools, with information on safe sex and contraception, including emergency contraceptives.</li> <li>• Awareness about the need to seek help as early as possible in a situation of an unintended pregnancy.</li> <li>• Involvement of parents in programs on gender and patriarchy so they to talk to young adolescents about their bodies, sexuality and sex.</li> <li>• Behavior change campaigns that help normalize the discourse of desire and reduce the widespread anti-sex rhetoric that young adults have internalized.</li> <li>• Outreach among health service providers for non-judgmental and sensitive support to young abortion seekers (female and male).</li> <li>• Public campaigns that address the lack of awareness around legal rights of men and women seeking premarital abortions.</li> <li>• Dissemination of feminist ideas of women's dignity and honor as against patriarchal notions of embodied honor to counter shame, stigma and violence.</li> </ul>
Skill/Training	<ul style="list-style-type: none"> <li>• Life-skills workshops for youth to navigate their choices. For example, young women need to be more assertive of their sexuality and young men need to respect their partners' desires.</li> </ul>

	Recommendations for Potential Action and Change
Knowledge dissemination	<ul style="list-style-type: none"> <li>• Make sex education and decriminalization of adolescent sexuality mandatory for safe and healthy sexual practices among the youth</li> <li>• Leverage real-life accounts of men who have acted as responsible partners and social agents of change to encourage their accountability and discourage the patronization of gendered behavior.</li> <li>• Research on premarital sex and health and some specific issues like the rising consumption of emergency contraceptive and abortion pills by young people and the common confusion between the two.</li> </ul>
Institutional reform	<ul style="list-style-type: none"> <li>• Provision of non-judgmental and confidential medical information at the school and college level.</li> <li>• Institutionalization of male role: include male engagement in Standard Operating Procedures at abortion clinics to leverage men's role and inculcate in them the idea of sensitive responsibility toward their female partners.</li> <li>• Lobby for an amendment in abortion law for second trimester abortions: relax the upper limit of legal abortion from 20 to 24 weeks so that girls and women in vulnerable situations can seek safe abortions.</li> </ul>





# Annexure

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# Enablers and Barriers to Male Involvement

Men's experience of the sex-to-abortion and post-abortion journey is like a tightrope between gendered masculinities and vulnerabilities. It is influenced by several factors, which act as enablers and/or barriers and are not always mutually exclusive. Some such factors – personal, inter-personal and institutional – that were evident in the narratives of the participants are elaborated below:

## **IDEALIZED ROLES: 'VULNERABLE WOMAN' AND 'PROTECTIVE AND RESPONSIBLE MAN'**

The traditional script of gender accords the role of the protector to men and that of the vulnerable dependent to a woman. Many participants of this study seem to be enacting this script to varying degrees and in different situations. Many women recalled feeling helpless and fearful, barring a few from the upper income group. Men (especially from middle-

income groups) thought it was their responsibility to preserve and protect their partner's reputation and honor and so they felt duty bound to support her. A male IDI participant, while sharing the need to ensure that his partner's honor remains intact said:

● ● —————  
*"I do not want her (his partner) to be dishonored and certainly not because of me. This was my main concern." (P5)*

## **SHAME AND STIGMA OF PREMARITAL SEX**

A key factor that hampers men's involvement is the shame and stigma associated with premarital sex. Male participants spoke about their share of anxieties if their partners' pregnancy or abortion news got to their families. For example, even though they may not want to marry their sexual partner, they may be compelled or obligated to. The other common fear is that of being

falsely accused by the girl and/or her family of rape. A male participant shared his reasons for supporting his partner during abortion:

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*“If something happens to her, I will get caught. Legal issues, police, society are not even a concern. The most important fear is if the family comes to know, they will kill you. Legal cases are a concern now. That time it was only family.” (P13)*

However, in some cases, this stigma motivates male involvement; when men know that their pregnant partners have no other support system except them, they may choose to stand by her their partner, either from a place of feeling like her the ‘protector’ in a relationship or out of feeling equally responsible and wanting to be there for their partner.

Accounts of the participants show that these fears can work in both ways – either propel them to stay with their partners and offer support or end the relationship and be untraceable.

### CONCERN FOR PARTNERS’ WELL-BEING

Sentiments for and attachment with their partner also makes men to be a part of the abortion process and provide her their partner with the support she needs. A male IDI participant shared:

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*“I did not think of leaving her. I loved her. We were in a two-year-old relationship.” (P11)*

During conversations, some male participants also shared feeling a sense of guilt and pain for the trouble that their partner was going through. Since they did not experience the physical discomfort and pain of the pregnancy, the least they felt they could do was provide emotional support and companionship.

### AUTONOMY AND ACCESS TO RESOURCES

The degree of personal freedom and mobility that young men and women enjoy also

determines the extent of male involvement required in abortion. Female participants from middle-income groups were more dependent on their male partners because of restrictions on their mobility and financial dependence on their natal families. In contrast, economically independent female participants did not depend as much on their male partners. In instances where the couple lived away from home and were cohabiting, men were able to provide round the clock support to their partners. Where young men and women lived with their families, men struggled to extend support and spend time with their partners. In such cases, men could only remain in touch with their partners on the phone or wait outside their house. For example, a male participant said:

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*“I waited outside her house for three days while she was taking pills. I was afraid. I used to fear what if she faints in the house, what will we do?” (P13)*

### INTERACTION WITH SERVICE PROVIDERS

Although the situation is improving, the social aversion toward abortions is also propagated by medical providers. This acts as a barrier for young men and women in availing safe and non-judgmental abortion services and forces them to resort to pills. In health facilities, the male partner prefers to stay outside the medical premises to avoid direct communication with the staff. A male participant recalled his experience of visiting a clinic with his partner for abortion as follows:

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*“I asked her to go see the doctor and I decided to sit in the waiting area. If you ask me why I did that, I won’t be able to answer because I do not know. The doctor’s cabin was open and she pointed at me and asked my girlfriend if I was the same guy. She said yes. The doctor asked her if we were married. My girlfriend said no. Then she asked why we did it. I got scared. Then she shared her views that we should not have done it. I was scared that she would ask our numbers next and inform our parents.” (P7)*

## LACK OF AWARENESS AND KNOWLEDGE

●● *A major difficulty was getting the right advice or information on what should be the next steps, who to talk to, should more doctors have been consulted. We did not get the proper guidance.” (P7).*

Narratives of young men and women reveal that they, especially men, rely on their peer networks and internet to gain knowledge and information about premarital abortions. Both these resources are easily accessible and safeguard their anonymity. Seeking information through internet and peer groups has facilitated and widened access to safe medical abortions for unwanted pregnancies. However, this information is often incomplete and inaccurate; as a result young people find themselves in a situation of abortion related complications.

According to a key participant, many Indians believe that abortion is illegal in India. This is also why people are apprehensive about seeking abortion-related services. There is limited awareness about the MTP Act, 1971. A gynecologist in private practice said the lack of correct information about sex, contraceptives, pregnancy and abortion is because:

●● *“We (society) are always denying a person is sexually active. There is stigma. Anything related to sex is a problem”*

## EASY AND WIDE ACCESS TO ABORTION PILLS

According to a SRH expert, male involvement in premarital abortion has improved over the last decade, thanks to greater and easy access to abortion pills. Men are also far more comfortable purchasing the pills from medical stores than seeking abortion services at clinics and hospitals. He (the expert) said, “In India about 15.6 million abortions occur every year...around 73 percent of those happen outside the health sector, that is, they go to the pharmacy for the pills.” Both men and women are more articulate about abortion, which helps build knowledge and awareness around the issue and facilitates improved decision-making.

Key informants also pointed out, for instance, the quick growth in the consumption of emergency contraceptive pills among women. This can be attributed to the awareness built by media. However, it also carries risks of incomplete and unreliable information which limits the scope of informed decision-making. A key challenge is the confusion between emergency contraceptive pills and abortions pills, and the excessive consumption of the former and the resultant complications. Inadequate knowledge about the pills and its easy availability off the counter is a major concern.

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# Notes

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