CHAPTER 2

LITERATURE REVIEW

In this chapter, previous research that highlights issues of importance in understanding how men participate in termination of unwanted pregnancy was reviewed. Topics include: gender role and sexual health, an overview of termination of unwanted pregnancy, male participation in termination of unwanted pregnancy, factors influencing male participation in termination of unwanted pregnancy, and health care services.

Gender Role and Sexual Health

Before discussing previous research with respect to men's participation when termination of unwanted pregnancy occurs, the effect of gender roles on women's health, especially sexual health will be discussed. The rationale is that men's participation is shaped by gender roles (World Health Organization, 2001).

"Sex" refers to the biological and physiological characteristics that define men and women. On the one hand, "gender" refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women (World Health Organization, n.d.b). Hence, a "gender role" is a set of behavioral norms associated with males and females in a given social group or system. Gender roles are not natural roles in those boys and girls are systematically taught to be different from each other (World Health Organization, 2001). Socialization into gender roles begins early in life. This includes learning to be

different to conform to one's gender role. For example appearance and dress, activities and pastimes, behavior, emotional responses, intellectual pursuits, and responsibilities are reflected in male or female gender roles. Gender roles are taught and reinforced by various social institutions including families, schools, religious institutions, workplaces, and peers. Women play as significant role as men in socializing girls and boys into their gender roles. Nevertheless, specific roles are prescribed for girls and boys, women and men, but they are valued differently. These values vary across cultures. In almost all societies girls and women are valued less than boys and men (World Health Organization, 2001).

The distinct roles and behaviors of men and women in a given culture, dictated by that culture's gender norms and values, give rise to "gender difference". Gender norms and values, however, also give rise to "gender inequity", that is, the process of not being equally fair to either women or men. Ideally both sexes would be treated fairly or justly in a societal distribution of benefits and responsibilities. Both gender difference and gender inequity can give rise to inequity between men and women in health status, especially sexual health.

The impact of socially constructed gender roles is felt significantly in the area of sexuality and sexual behavior. Men are often expected to be virile and have sexual desires that are uncontrollable once aroused, to take the initiative in sexual activity, and to be, by nature, incapable of being monogamous. Women are expected to make themselves attractive to men, but to be more passive especially by guarding their virginity, never initiating sexual activity, and taking care to protect themselves from the uncontrolled sexual desires of men (World Health Organization, n.d.b). Consequently, limited access to resources and control over their own sexuality make

women vulnerable to sexual exploitation, violence, sexually transmitted infection, and unwanted pregnancy, the later of which can lead to abortion.

An Overview of Termination of Unwanted Pregnancy

Globally, there are an estimated 200 million pregnancies annually. Approximately one-third of these (i.e., 75-80 million) are unwanted (Population Action International, 2001; World Health Organization, n.d.a). Unwanted pregnancy often leads to a decision to have an abortion rather than continuing with a pregnancy. From January 1995 through December 2000 nearly three-quarters of unwanted pregnancies worldwide were terminated, resulting in more than a quarter of a billion abortions (Daulaire et al., 2002).

Typical of countries where legal abortion services are rigidly restricted, an underground system operates in Thailand whereby women can procure illegal abortion (Simmons as cited in Lerdmaleewong & Francis, 1998). Exact numbers of women undergoing such procedures remain elusive; however, the number of illegal abortions appears to be on the increase (Worakamin, 1995). By way of illustration, a 1978 national survey (International Fertility Research Program, 1981) recorded over 26,000 induced abortions in rural Thailand. In 1993, the Ministry of Public Health estimated that as many as 80,000 unsafe abortions were performed in that year (Ratanakul, 1998). Recent information comes from a cross-sectional study funded by the World Health Organization, conducted in 1999 in 76 Thai provinces (787 government hospitals) (Boonthai & Warakamin, 2001; Warakamina et al., 2004). Differences in collecting data make any comparison of these two rates unreliable. Of a total of 45,990 cases of women accessing public hospital care because of symptoms

related to spontaneous miscarriage or abortion, 28.5 percent had induced abortions (19.54 per 1000 live births); 53 percent of women who had induced abortions were 25 years old or more. This survey indicates that induced abortion is more common among adult women than adolescents. Data from private hospitals and clinics were not included in this estimate. Therefore, this induced abortion rate is likely underestimated. In Songkhla province, there is a high rate of induced abortions among adult women. In the record of Gynecological Unit 340, Hatyai Hospital from January 2007 through December 2007, 230 women were admitted due to abortions, 69 percent were unsafe abortions; and 79.4 percent were found in women age 18 or older (Gynecological Unit 340, 2007). In the present study, the focus will be adult women who experience unwanted pregnancy and choose an abortion. Early adulthood is the age group of 18 to 40 years (Papalia, Sterns, Feldman, & Camp, 2002).

Rationale for Unwanted Pregnancies and Pregnancy Termination

The decision to undergo an abortion can be looked at in relation to the causes of the unwanted pregnancy. The factors relating to termination of unwanted pregnancy are dependant on the situations that women experience. Based on literature reviews, the most frequently cited causes of termination of unwanted pregnancy can be categorized as 1) conception resulting from unsafe sex and 2) not being ready to be a mother.

Conception resulting from unsafe sex

Women who are sexually active and do not want to get pregnant can prevent their pregnancies by using contraceptive methods. However according to literature reviews, some women cannot practice contraception because of improper use of contraceptives and unexpected sex.

Improper use of contraceptives. Unwanted pregnancies remain a common dilemma for women despite a high rate of contraceptive use in Thailand. According to the National Statistical Office (1997) the contraceptive prevalence rate for married women of reproductive age (15–44) was 75.2 percent, and in 2000, the rate was 72 percent (Warakamina et al., 2004). In a study of 80 women experiencing unwanted pregnancies, it was indicated that although all the married women had used contraception, they became pregnant either because they used the method incorrectly, discontinued its use due to side effects or experienced contraceptive failure (Tharawan, 2002). Tharawan (2002) further stated that unmarried women had limited access to and limited knowledge of contraception and tended to depend on methods that have a high failure rate, such as the rhythm method and withdrawal. Likewise, Warakamina and associates (2004) found that about half of the women who experienced unwanted pregnancy (52.1%) (n = 1,854) had not used contraception, 36.3 percent were irregular users and only 11.7 percent were regular users. The three most important reasons given for not using contraception were that they did not expect to become pregnant (61.6%) or to have sex (17.7%). Some reported that they were not permanently living with their partners (17.2%). Other reasons for contraceptive failure included experiencing unacceptable side effects from contraception (12.1%), having

inadequate knowledge of contraception (11.8%), being afraid to use contraception (7.7%), and feeling too shy to ask for contraceptive services (7.5%).

If regular contraceptive methods fail or are not used, emergency contraceptive pills (ECPs) can be administered within 72 hours of sexual intercourse. These pills are recommended and approved by World Health Organization as safe and effective (World Health Organization, 2000). However, quality services and information about ECPs are not available in Thailand. ECPs are frequently dispensed by drugstore personnel who are not pharmacists. The survey in Hat Yai district of Songkhla province, southern Thailand, showed that approximately half of the drug stores were owned by pharmacists and that the drugstore personnel's knowledge and practice regarding ECPs were poor (Ratanajamit & Chongsuvivatwong, 2001). Moreover, most Thai women have access to little information on ECPs. They feel ashamed if they have to purchase ECPs themselves and further, they often use ECPs incorrectly (Naravage & Yongpanichkul, n.d.). Thus, unwanted pregnancy still occurs from misuse of ECPs.

Unexpected sex. In most societies, particularly in low income countries, women lack the power to decide when and under which circumstances and even with whom to have sex. In a qualitative study in Thailand (9 male and 6 female undergraduate students), it was reported that male undergraduate students were the ones who insisted that sexual relations should take place, determined the context in which they occurred and initiated the physical contact. Moreover, the first sexual intercourse of male undergraduate students was often premeditated, while that of female undergraduate students was unexpected (Pinyapong, 2003). Some women had

experienced “date rape” (Tharawan, 2002; Warakamina et al., 2004). Consequently, pregnancies were unwanted when they inevitably occurred.

Many women do not have the power to insist that their partners use condoms nor delay coitus until they are protected by another means. Social norms, including gender roles, dictate sexual behavior to a large extent and usually leave women in a passive role (Reproductive Health Outlook, n.d.a). Thai women reported that they did not have bargaining skill nor the power to ensure that their male partners would use condoms and engage in safe sexual practices (Chaichana, Ngunthammathat, Prateepkok, & Chutipatthana, 2003). Furthermore, Thai male respondents could not accept that unmarried females bought condoms and initiated their use. A similar study supported this finding and indicated that it was not acceptable for women to carry condoms or suggest their use. Women who take the initiative to have condoms on hand may risk appearing “too ready for sex” (Malhotra et al., 2005). Pinyapong (2003) found that Thai female undergraduate students were reluctant to select a contraceptive method for themselves or inform their partners to prepare themselves, since they feared accusations of being sexually experienced. Women, particularly those who are unmarried and engaged in a sexual relationship may not take responsibility for their contraceptive needs. They may choose to accept the risk of an unwanted pregnancy rather than ignore cultural barriers.

Not being ready to be a mother

Maternity norms are socially constructed for the sake of children. Women who want to become pregnant are ideally married since children need a father. Moreover, patriarchal societies cultivate the belief that women are the most

appropriate people to take care of their children (Feminist Perspectives on the Self, 2004; Jackson & Mannix, 2004). Readiness for motherhood, including biological, mental, and financial preparedness, is highly expected among pregnant women. When maternity norms are violated such as when pregnant women are not married, the male partner is not present which often leads to inadequate income to accommodate pregnancy, birth and childcare. In these situations, women often do not want the pregnancy and take steps to terminate it (Havanon, 1995; Ratchukul, 1998).

Not being married. Thai society stipulates a norm for controlling women's behavior in that women are expected to be married before they become sexually active (Yoddumnern-Attig, 1992). Sexual intercourse or being pregnant prior to marriage are social taboos. Unmarried women who get pregnant usually have negative feelings about their pregnancy because the pregnancy will disclose a behavior that is regarded as deviant (Ratchukul, 2003). Unmarried young adults who get pregnant are also faced with a difficult dilemma in that they are socially condemned and have to leave school or university if officials are aware of their pregnancy (Pinyapong, 2003; Ratchukul, 1998; Tharawan, 2002). Many will choose abortion as a route to put their life and social status in the best possible position before being blamed as a deviant person (Ratchukul, 1998). Moreover, most of them do not know of other options for resolving their unwanted pregnancy, so they often choose abortion (Nontapattamadul & Pandoungnet, 1995; Tharawan, 2002).

Pregnancy without a male partner. Some women do not want to be pregnant because of relationship problems with their partners or husbands. In some cases, the men leave and/or do not accept the pregnancy (Ratchukul, 1998; Tharawan, 2002). A common belief for Thai women is that a baby should have a father

(Ratchukul, 1998). Thus, if a woman gets pregnant and is not socially involved with sexual partner, she will likely be anxious and afraid that the society will blame her as "getting pregnant without a partner" (ท้องไม่มีพ่อ). Consequently, her pregnancy will be unwanted and she may choose to have an abortion.

Economic constraint. Most pregnant women are concerned about the financial support that is needed to raise a child (Alexander, LaRosa, & Bader, 2001; Havanon, 1995; Warakamin et al., 2004). Economic constraints are another important factor that causes women decide to have an abortion (Alex & Hammarstrom, 2004; Faundes & Hardy, 1997; Klima, 1998; Ratchukul, 1998; Tharawan, 2002; Warakamin et al., 2004). Pregnancy presents a grave problem for Thai women with low-paying jobs because employers often have little tolerance of absenteeism (Taywaditap, Coleman, & Dumronggittigule, n.d.). Having a child in urban environments is expensive. Few companies offer support for maternal and child care. A woman risks losing her employment, while anticipating the additional task of parenting. For rural women who migrate to work in the cities, losing their jobs means jeopardizing their only source of income which they need to support their family. All these factors influence the women's decision to seek an abortion.

Decision Making from the Maternal Perspective Regarding Termination of Unwanted Pregnancy

Thailand's abortion law was proclaimed in 1956. Sections 301-305 of the Thai legal code address abortion. Section 301 states that induced abortion, whether self-induced or induced by another person, is a crime leading to punishment with imprisonment not exceeding three years or a fine not exceeding 6,000 baht or both

(National Committee, 1985). Under this legislation, there are two situations where Thai women are legally permitted to have an abortion. The first is when the pregnancy is dangerous to the mother's health and the second is when the pregnancy is the result of rape or incest (Warakamin et al., 2004). Women will be denied an abortion for other reasons. In addition to violating the law, induced abortions are also against moral and social norms. Most members of Thai society blame or label women who decide to have an abortion as bad or evil-minded. They rarely consider the rationale behind these decisions (Havanon, 1995; Isarabhadi, 1999; Kanato, 1998; Vasikasin, 1984). Society members who have no direct experience with abortion bring their own attitudes, biases, and perspectives to judge those women who have had direct experience. In many studies, it is reported that women had several reasons for their decisions (Havanon, 1995; Ratchukul, 1998; Tharawan, 2002; Whittaker, 2002c). Ratchukul (1998) reported that the process of women's decision to have an abortion included self-interaction, strategies to resolve problem of unwanted pregnancy, negotiation, and action. Each of the steps in this process will be discussed separately.

Self-interaction

After women find out that they are pregnant, they reflect or start to talk or have interaction with themselves to understand why they are pregnant. They consider the causes of and meaning attached to the pregnancy. They decide whether or not they want to continue their pregnancy. Finally, they evaluate the consequences of continuing.

Strategies

The strategies for making decision to continue or terminate a pregnancy are the step that makes the most trouble for women. Women are reluctant because the chosen options are out of necessity rather than their real needs. Women weight between advantage and disadvantage of the options. Women will make the choice that is least likely to disrupt their lives; most will choose an abortion rather than continue their unwanted pregnancies.

Negotiation

In addition to the loss, most Thai women view induced abortion as a sin or demerit; it kills a potential human who could be her child. Even when women decide to follow through with the abortion, they often do not decide immediately but weigh positive and negative consequences of choosing an abortion. They need time to think about these consequences and consider the reasons that they have to choose abortion as a method of resolving her problem. It can help women to be calmer and reduce their stress and guilt. After that, they go through the process of having an abortion.

Action

The act of induced abortion is the last step in the decision process for obtaining an abortion. Although women are usually afraid of the procedure, they are concerned with the necessity of abortion, especially during the early pregnancy. Early abortion can help the women conceal their unwanted pregnancies. Thus, the induced abortion may make some women frustrated, confused, and stressed.

Impact of Abortion on Women's Health

Many women cannot access safe abortion services because of inadequate or no information about the existence of safe services, or because social taboos, legal restrictions, and high costs prevent them from continuing with their pregnancies (Ratchukul, 1998). Therefore, many pregnancies are terminated using unsafe procedures. Consequently, women bear the physical, psychological, and social impact of unsafe abortion.

Physical impact

The most common complications of induced abortions are incomplete abortion, tears in the cervix, perforation of the uterus, sepsis including septic shock, and severe hemorrhaging (World Health Organization, 1998). It is estimated that complications from unsafe abortion account 13 percent of all maternal deaths worldwide (World Health Organization, 2004). There is evidence that unsafe abortion continues to be a significant cause of maternal mortality in Thailand (Sopchokchai, 1995; Worakamin, 1995; Warakamina et al., 2004). However, the actual number of deaths may be underestimated because women who die outside hospitals or in emergency wards may not be identified as victims of unsafe abortion (Planned Parenthood, 2000). Unsafe abortion also has serious long-term consequences, including chronic pelvic pain, future spontaneous abortions, infertility, and ectopic pregnancy (Meir & Belsey, 1980; Sundstriim as cited in Faundes & Hardy, 1997; Wasserheit, 1989; World Health Organization, 1998). Consequently, women who turn to unsafe abortion services have to face with terrible complications, if not death.

Psychological impact

Women are confronted with the psychological impact at the time they decide to procure an abortion and this impact may continue long after the abortion actually takes place. When a pregnancy is unwanted, a woman feels ambivalent. In a Swedish quantitative study of pregnant women, about half of the women thought it was rather difficult or very difficult to make a decision regarding abortion. Ambivalence was found among a third of those who decided to have an abortion, compared with a quarter of those who decided to continue their pregnancies (Tornbom, Ingelhammar, Lilja, Svanberg, & Moller, 1999).

Women often feel mixed positive and negative emotions following an abortion. Some women may experience sensations of regret, sadness (Holmegren as cited in Alex & Hammarstrom, 2004), guilt, or shame (Holmgren as cited in Alex & Hammarstrom, 2004; Mundingo & Indriso, 1999). Thai women who have an abortion also feel ashamed and/or guilty because they are cultivated that induced abortion is being an un-Buddhist and sinful act of prostitutes and promiscuous women/students as well as violating the law (Havanon, 1995; Narumon, 1998; Ratchukul, 1998; Tharawan, 2002; Vasikasin, 1984; Whittaker, 2002c). Abortion is a stressful experience (Russo & Zierk, 1992). However, it may also reduce stress resulting from an unwanted pregnancy (Russo & Zierk, 1992). In many studies, it is reported that the overwhelming initial post abortion response is relief (Broen et al., 2004; Frye, 1993; Ratchukul, 1998) and happiness (Adler, 1992).

Social impact

The social impact of choosing abortion is less well studied but not less important. This includes family disruption and different forms of ostracism for affected women. Pregnant students face social consequences including the early termination of their education as they tend to be expelled from school (Ratchukul, 1998). However in some studies, it is found that students who resolved unwanted pregnancy through abortion had a greater ability to think about and envision their future, greater motivation, and higher educational aspiration than those who chose to continue with their pregnancy (Brazzell & Acock, 1988; Resnick, 1992). Infertility and pelvic pain caused by unsafe abortion also result in a failure to function as society assigns, which in practice means that a woman's role in society may be reduced (Faundes & Hardy, 1997).

In summary, women who turn to unsafe abortion services have to face with terrible complications, if not death. When women manage termination of an unwanted pregnancy and cope with its impact, they often need to confront and solve their problems alone (Havanon, 1995; Ratuchukul, 1998; Tharawan, 2002; Whittaker, 2002c). In a fair way, men who participated in the sexual encounter leading to unwanted pregnancy should participate in the process that leads from unwanted pregnancy to abortion.

Male Participation in Termination of Unwanted Pregnancy

For many years male participation has been an issue on the international agenda, mainly in relation to reproductive health. In the 1994 International Conference on Population and Development in Cairo, it was reported in the Program of Action that special efforts should be made to emphasize men's shared responsibility for reproductive health and promote their active participation in responsible parenthood including responsible sexual and reproductive behaviors (UNFPA, 1994). Greater male participation is needed in order to improve and protect the sexual and reproductive well being of both men and women. Unwanted pregnancy and abortion are topics in reproductive health in that men need to seek not only physical pleasure from sexual intercourse but accept responsibility for or participate in the consequences of their actions.

Rationale for Male Participation in Termination of Unwanted Pregnancy

Male participation in termination of unwanted pregnancy can build the possibility of achieving equitable relationships between men and women. Since sex is usually mutual, both a woman and a man who have engaged in sexual relationships are equally responsible for the consequences. Sharing responsibility for or participating in care and decisions with respect to unwanted pregnancy provides benefits to everyone: women and men individually and as couples, children, and society.

Benefits to women

Men are seen both as a potential support and an obstacle for women to achieve better health. Men can be a health risk for women if they are denying them proper care and services, forcing them into abortion or not participating in decision and care during and after abortion (Sundstrom & Nordemark, 2001). Nevertheless, many men reveal great concern for the need to protect women's health.

In the 1995 World Conference on Women in Beijing, it was indicated that shared responsibility or participation between men and women in matters related to reproductive and sexual behavior is essential to improve women's health (The United Nations, 1995). Male participation in providing support before, during, and after an abortion may have an important role in promoting maternal health and reducing maternal deaths. In an Egyptian study about a husband's involvement in post-abortion care, it was concluded that support by husbands is critical for women's recovery and future use of contraception. Emotional support by her husband is particularly important for a woman's physical and emotional recovery (Tawab, 1997). It also reduces the burden when solving problems related to termination of unwanted pregnancy. Women can achieve consensual and more pleasurable sexual relations if their partners are accountable and participate in the consequences of their sexual behaviors (Cohen & Burger, 2000).

The process of educating and supporting men, regarding reproductive health issues will help them to be more sensitive to women's needs and therefore more supportive of participating in efforts to enhance women's status (EngenderHealth, 2001; UNFPA, 1994). In addition, involving men increases masculine awareness as

well as acceptance and support of their partner's needs, choices, and rights. These qualities can increase a sense of entitlement and empowerment in reproductive health and rights of women.

Benefits to men

Besides benefits to women, men also receive the advantages if they participate in decisions and care related in termination of unwanted pregnancy. In sexual and reproductive health, including termination of unwanted pregnancy, men are concerned, not only because they have important roles as fathers and sexual partners but also because it is important in their own right (The Alan Guttmacher Institute as cited in Armstrong, 2003). Men have the right to be involved in pre and post abortion counseling, to receive information about unwanted pregnancy and to share in the decision about how to deal with the unwanted pregnancy (Armstrong, 2003; Coleman & Nelson, 1999). Therefore, men's right will be improved.

Benefits to couples

In addition to benefits to the individual women and men, male participation in unwanted pregnancy and abortion is beneficial to couples as well. The benefits include the ability to negotiate sexual safety and to participate in joint decision-making with respect to sexuality, procreation and parenthood (Cohen & Burger, 2000). Sharing suffering and support of male partner can enhance the couples' bonding and intimacy (Cohen & Burger, 2000). More intimate and sexually satisfying sexual relationships are another benefit for couples.

Benefits to children

When men take responsibility in unwanted pregnancy, some of them do not want their partners or wives to procure an abortion; they prefer instead to adopt a paternal role (Ratchukul, 1998). Thus, the children can achieve care and nurturing from both parents and benefit from a positive paternal role model.

Benefits to society

Social benefits include a reduction in unwanted pregnancies and abortions. This will automatically lead to a reduction in health care costs associated with unsafe abortion (Thaneepanichsakul, 2000). The cost for treating one who has had an unsafe abortion is approximately 21,024 baht (Warakamin et al., 2004) or $ 612 US. Men can appreciate the impact of unwanted pregnancy if they are involved in post-abortion family planning. Successful contraception requires consensus and an effective dialogue between the two partners (Bianchi-Demicheli, Eliane, Bianchi, Dumont, Ludicke, & Campana, 2003). The inclusion of male partners in family planning education and services has been shown to increase utilization of family-planning methods in a variety of settings (Becker, 1996; Terefe & Larson, 1993; Soliman, 1999; Piotrow, Kincaid, & Hindin, 1992). Specifically related to abortion, a randomized trial (n=1,800) in China was conducted to compare three modes of family planning education on pregnancy and abortion rates (Wang, Vittinghoff, Hua, Yun, & Rong, 1998). Groups were a) women who received family planning education by themselves, b) women who received education with their husbands and, c) women who received no such education. Among non-IUD users, the odds of having an

abortion within approximately 2 years of the intervention was approximately 75 percent lower for couples than for women who received family-planning education alone.

Components of Male Participation in Termination of Unwanted Pregnancy

If men participate in care of women who terminate an unwanted pregnancy, it is possible that an improvement would be seen in both women and men's health. Men do not bear the physical burden of carrying an unwanted pregnancy or undergoing an abortion, but they can be active partners when a woman has to go through this process. Most women expressed the hope that their partner would care for and marry them and that they could keep and care for their child if they had an unplanned pregnancy (Ford & Kittisuksathit, 1994). If the men openly accept that they are mutually responsible for the pregnancy, the abortion might not occur. However, if they cannot openly accept the women as a wife and themselves as a birth father because of extenuating circumstances, womens believed that they should provide emotional and/or financial support to the mother so that she is able to take care of their baby (Ratchukul, 1998; Tharawan, 2002).

If both men and women decide to procure an abortion, men should also participate with women. In a pilot study, eleven women who experienced terminating an unwanted pregnancy, were interviewed in-depth (Chatchawet & Sripichyakan, 2005). The women reported that they wanted their sexual partner to be involved or share in the responsibility at all stages of unwanted pregnancy and abortion. This includes pre-abortion, during induced abortion, and post-abortion stages.

Pre-abortion stage

The pre-abortion stage is described as when women decide that their pregnancies are unwanted. Women wanted their partners or husbands to participate in decision making about whether their pregnancies should be continued or terminated (Chatchawet & Sripichyakan, 2005). However, Tharawan (2002) found that although the women needed men involved in the decision making process, the women wanted to make the final decision. Furthermore, the women also needed men not to leave them alone but to offer emotional support (Chatchawet & Sripichyakan, 2005). Similarly, Coleman and Nelson (1999) indicated that both male and female American students wanted male involvement in the decision process of what action they should take if an unwanted pregnancy occurred and in the provision of emotional support. Not only women need men to participate in the pre-abortion stage, but also in several studies most of male partners wished to involve or to be included in the decision-making process on abortion (Holmberg & Wahlberg, 2000; Johansson et. al., 1998; Rasch & Lyaruu, 2005).

In the case of deciding to procure an abortion, women reported that men should participate in finding out about abortion methods and services. In addition, men can provide or make necessary arrangements for transportation to an abortion clinic (any abortion clinic performed by either a skilled health professional or an unskilled person) and accompany their partner to the clinic (Chatchawet & Sripichyakan, 2005).

During induced abortion stage

This stage refers to the time when women decide to undergo the abortion and any of a variety of methods may be used to induce the abortion such as curettage, insertion of substances into the vagina, injection, and so on. The women in a pilot study reported that they wanted men to take physical, emotional, and financial supporting roles throughout the abortion process (Chatchawet & Sripichyakan, 2005). If women induced the abortion by themselves, they suggested that their partners should help them with activities of daily living including going to the rest room, eating or cooking, and so on. When women go to abortion clinics (any abortion clinic performed by either a skilled health professional or an unskilled person), they wanted their partners to provide emotional support or share the stress with them by accompanying and being with them. Ratchukul (1998) also found that women needed men to provide emotional support while they went to an abortion clinic. In the United States, male participation on the day of the procedure was perceived by the women as providing emotional support (Beenhakker et al., 2004).

Post-abortion stage

This stage refers to the time after the induced abortion. Women wanted their partners or husbands to stay with them for emotional support (Chatchawet & Sripichyakan, 2005). Emotional support by their husbands is important for women's physical and emotional recovery (Tawab, 1997). Helping with their physical care is another that women needed their male partners to participate, such as helping them with activities of daily living or helping with household tasks. Moreover, the women

also needed the men to feel guilty for their part in creating the need for an abortion or to feel that abortion is a sin. The women also wanted men to participate by "making merit" or atoning for their part in the procreation of their babies because it could reduce their feelings of sin (Chatchawet & Sripichyakan, 2005; Ratchukul, 1998).

Another important topic during the post-abortion stage is preventing further unplanned pregnancies. Women who experience abortion-related complications noted that they wanted their partners or husbands to participate in post-abortion family planning (Chatchawet & Sripichyakan, 2005). Likewise, Tharawan (2002) found that women needed the men to participate in preventing further unplanned pregnancy by using contraceptive methods because some women had side effects from using female contraceptive methods. Similarly in Senegal, 65 percent of the post-abortion women who were interviewed wanted their husband or partner present during counseling for family planning (Population Council, 2000). Male involvement in post-abortion family planning can reduce unwanted pregnancy and abortion rates more than involvement by women alone (Population Council, 2000).

Strategies that men can use to support post-abortion family planning use are presented (EngenderHealth, 2001). Men can provide their partners with financial support. Emotional support can also be offered by accompanying partners/wives to the clinic, discussing reasons for choosing one method over another, and/or supporting her choice of method. Men can help by reminding and supporting women in using the family planning method. Finally, men can support women by using an alternative contraceptive method such as withdrawal or condoms, in case their partners forget to use or have an unexpected problem with their chosen method.

Factors Influencing Male Participation in Termination of Unwanted Pregnancy

According to literature reviews, factors that prevent men from participation in termination of unwanted pregnancy can be socio-cultural, individual, and systemic.

Socio-Cultural Factors

Socio-cultural factors that influence the willingness of men to participate in termination of unwanted pregnancy are presented in relation to religion and gender norms.

Religion

Almost 95 percent of the Thai population is Buddhists with an almost equal proportion between males and females (Thomson & Bhongsvej, 1995). In Songkhla province, approximately 65 percent of the population is Buddhists, 32 percent Muslim, and 3 percent Christian and other religions (Songkhla Culture Office, 2008). Abortion is a complex issue attached to religious beliefs. Each religion provides different doctrines in relation to abortion. Understanding perspectives on abortion is, in part, achieved by understanding people of different religious backgrounds. The values and beliefs of Buddhism and Islam, the predominant religions in southern Thailand, will be described in relation to abortion.

Buddhism. Some scholars have identified Buddhism as a source of and justification for gender inequity in Thailand (Kuhlthau, 1992). Theravada Buddhism is an integral part of Thai society. The ultimate goal of Buddhism is to achieve nirvana, the elimination of suffering which ends the cycle of rebirth. Nirvana is rarely

achieved and is a result of one's past merits (past here refers to past lives as well). Karma determines one's social position at birth but it can be changed through meritorious acts. It is not fatalistic since one can earn merit in a variety of ways; for instance by doing a good deed, contributing to the monastery, or becoming a monk. The Buddhist concepts of merit and rebirth are intimately related to the concepts of individualism and hierarchy found in Thai society (Pongsaphich & Podhisita, 1985).

Women and men earn merit in different ways. In the Thai interpretation, women are commonly seen as lower on the hierarchy of merit because they cannot be ordained. According to the Theravada view, a being is born as a woman because of bad karma or lack of sufficient meritorious acts (Khin Thitsa as cited in Taywaditap et al., n.d.). Men's main way of obtaining merit is by becoming a monk. Women's most important means of earning merit is by giving a son to the monkhood. A secondary but more frequent means of gaining merit is by giving food to the monks as they make their daily rounds accepting offerings of food. Women can become nuns, but female nuns have a secondary position to male monks (Boonsue, n.d.). This difference in how men and women obtain merit is critical because it means that women must rely on bearing children, especially male children for merit.

According to the principles of Buddhism, anyone who kills or destroys an animal or human life is stigmatized and frequently censured by religious teaching. He/she will receive bad outcomes from a bad action. This is called the "*law of karma*". An abortion, especially unsafe abortion is also considered to be a life-destroying act that constitutes a serious Buddhist sin/demerit (บาป) although abortions conducted after quickening at four to five months are considered by women to involve greater demerit than earlier abortions (Whittaker, 2002b). Therefore, women who

intend to undertake abortion are taking responsibility for having the abortion, which in the Buddhist religion is deemed to be bad and receive bad outcomes as well. The outcomes that the women receive may be blame, health consequences, or punishment by law. On the other hand, men who are their partners or part of the sexual encounter do not have to assume responsibility or receive minor the law of karma from being involved in undergoing an abortion because they do not directly kill or destroy their baby's life. Nonetheless, although abortion runs contrary to the principles of Buddhism, there is evidence that many Thais view abortion as supplementary means of fertility control if they do an abortion under the legislation (Knodel, Chanaratrithirong, & Debavalya as cited in Lerdmaleewong & Francis, 1998).

Islam. Most of Muslim Thais are Sunni Muslims. The doctrines of Islam are the Qur'an and sunnah. The doctrines are influenced on Muslims' views and actions (Marddent, 2003). Although the Qur'an views women and men to be equal in human dignity, this spiritual or ethical equality has not been reflected in most Muslim laws. For example, women do not have equal rights to make independent decisions in relation to choice of (marriage) partner, obtaining a divorce and custody of their children (Ahmed, 1992).

To control human sexual desire in order to keep it righteous, Islam requires both knowledge of the faith acceptable behavior. Followers of Islam are encouraged with the focal concerns of the Qur'an and Sunnah. Every path to and kind of sex without marriage, sexual promiscuity, sexual orientation, adultery, fornication, and prostitution are prohibited in Islam (Ahmed, 1992). Still, Islam is encountering modernization of ethical issues toward sex as a result of globalization. Contraception is permitted when necessary as a component of reproductive health but Islam does not

support the policies of family planning and abortion (Marddent, 2003). The focus of Islamic principle is to protect the rights of the fetus and infant. Some prominent ethical issues toward sexual behaviors and reproductive health such as prohibiting family planning or abortion show that life for followers of Islam is a sacred gift. Muslims believe that abortion at any stage of pregnancy is a crime against humanity, which then becomes part of the problem rather than the solution. They also believe that encouraging the practice of abortion will lead to unwant pregnancies in that promiscuity will be encouraged (Kasule, 2003). However, sources of this theistic ethics also provide outlets for cases where it is necessary to have abortion or family planning to promote the physical and psychological security of mother and baby (Marddent, 2003).

Gender norms

Thailand is noted for being a male-dominated patriarchal society and the gender roles and expectations for Thai men and women differ accordingly (Taywaditap et al., n.d.). The ideal Thai woman, the ideal Thai man, and a sexual double standard will be described next.

The ideal Thai woman. Women in Thailand assume the role of motherhood as an ideal. The preparation for the title of mother takes place informally much earlier as young girls or unmarried women are often given the title of mother with an endearing or humorous tone. The society stipulates whether or not they have a child have to take maternal roles and adopt feminine characteristics such as being unselfish, nurturing others, sacrificing, and so on. The role for women in religion is also characterized by the mother-nurturer image in that women support and provide for

Buddhism by way of giving young men to the Sangha (monk), and nurturing the religion through alms giving (Keyes, 1984). Moreover, the mother-nurturer role is idealized in the female code of social and sexual conduct. Historically in the Thai tradition, a "virtuous woman" (kulasatrii,กุลสตรี) is defined as proficient and sophisticated in household duties; graceful, pleasant, yet unassuming in her appearance and social manners; and conservative in her sexuality. Girls are taught that a good woman remains a virgin until marriage. These features bear striking similarities to the traditional "feminine mystique" in other cultures, which has come under criticism from the Western feminist movement (Taywaditap et al., n.d.).

The ideal Thai man. There are two ideal male images available for Thai men. Corresponding to the Buddha's biography, Thai men face a recluse/householder or monastic/secular dichotomy (Van Esterik as cited in Taywaditap et al., n.d.). The monastic-recluse image personified by the Buddha's life is the Sangha. Through monastic discipline and practice of the dharma, monks not only eschew worldly attachments, but also their sexuality and male gender characteristics. On the other hand, the secular male image is represented by the notion of "chaai chaatrii" (ชายชาตรี), which is an embodiment of the typical masculine features also found in other cultures such as authority, courage, self-assurance, physical and emotional strengths, and sexual prowess. The masculine attributes in the *chaai chaatrii* image have found behavioral expression in an image midway between a playboy and a gangster. The term portrays a powerful man of action who works hard and plays equally hard, is supportive of his friends, fierce to his foes, and a great womanizer (Thorbek as cited in Taywaditap et al., n.d.).

Double standard for sexuality. The Thai culture exhibits a double standard, which gives men greater latitude to express their sexuality. Thai young men eagerly look forward to their first intercourse and, as its slang term, *khuen khruu (ขึ้นครู),* roughly implies, a learning process with someone sexually experienced. For many young Thai men this practice continues beyond their first sexual experience and commercial sex becomes a bachelor's recreation. On the other hand, young women are supposed to be virgins until they are married (Havanon, 1995; Isarabhadi, 1999; Kanato, 1998). Sex is thus not a recreational option for unmarried women, as it is for men. Violation of this rule occurs in the cases of prostitutes and carefree women. A carefree or an unmarried woman who seeks sexual pleasure from a casual partner is stereotyped as shallow, emotionally disturbed, and self-destructive. She presumably has lost her virginity because she was amoral, careless, gullible, or blindly following the western code of sexual behavior (Havanon, 1995; Narumon, 1998; Vasikasin, 1984). Needless to say, sex before marriage is the key criterion that distinguishes a "bad woman" from a "good woman."

Some slang terms used by the young men for sexual intercourse can be roughly translated to "taking," "earning," "playing," "grinding," "gobbling," and "poking the yolk." On the contrary, sexual intercourse was seen by young women as a loss of their body/self (*sia tua*, เสียตัว), and women who have lost their virginity were seen as "impure," "soiled," or "tarnished." In addition, there is a belief that a forbidden sexual experience can predispose a young woman to becoming sexually out of control, (*jai taek*, ใจแตก) especially if the liaison ends with the man deserting her (Ford & Kittisuksathit, 1994). Blame for unwanted pregnancy, as expressed by both

the young men and women, was placed on a woman for "allowing" intercourse to occur. In this sense in addition to concerns about pregnancy and health, women face the risk of stigmatization form losing their virginity outside of marriage.

When unwanted pregnancy occurs, women are expected to bear the brunt of unwanted childbearing (Russo & Zierk, 1992). Frequently a woman has no one to turn to for moral support and sympathy before, during, or after an abortion (Kabir, 1989). Once a woman decides to abort her pregnancy and this decision becomes irreversible, she will carry out the abortion independently of the legal, moral or religious sanctions attached to voluntary interruption of pregnancy. Abortion remains associated in the popular imagination as being an un-Buddhist and sinful act of prostitutes and promiscuous women (Havanon, 1995; Narumon, 1998; Ratchukul, 1998; Tharawan, 2002; Vasikasin, 1984). This perception is supported by a continued unsympathetic portrayal in the press of women who abort being characterized as heartless, bad or morally corrupt, fun-loving students (Whittaker, 2002c). Moreover as with ideal Thai women, they aspire to the role of motherhood and nurturer that they are expected to assume for the well-being of their husbands, parents, and children (Taywaditap et al., n.d.). As a result, they are usually blamed and considered to be evil-minded when they have an abortion. Women may even be arrested for violating the law. In fact, if society did provide options for resolving unwanted pregnancy, it would need to go beyond labeling or punishing them.

In conclusion, a gender bias or gender inequity is reflected when considering unwanted pregnancy ending in abortion in Thailand. Since antiquity, in Thai traditional cultural values, gender norms including beliefs and attitudes regarding gender inequity have been cultivated. This is especially true for sexual norms where a

man can freely pursue and enjoy his sexual desires whereas a woman is restricted (Ford & Koetsawang, 1991; Isarabhadi, 1999; Kanato, 1998). If a woman violates rules by having sexual intercourse or becoming pregnant before marriage, she is blamed or labeled (Havanon, 1995; Isarabhadi, 1999; Kanato, 1998; Vasikasin, 1984). If she chooses to terminate her pregnancy for socio-economic or any reasons, she is stigmatized by society or/and punished by the law (Ratchukul, 1998). On the other hand, it is not addressed how men who are part of the sexual encounter participate in or accept responsibility with respect to abortion (Tharawan, 2002). Members of Thai society stipulate that women are responsible for their actions, whereas choices are provided for men about whether they want to take responsibility or not.

Individual Factors

According to traditional cultural values regarding termination of unwanted pregnancy, the population is greatly influenced by beliefs about sexual behavior inferred by the norms of a patriarchal society. Attitude regarding termination of unwanted pregnancy of men and women is also influenced by those beliefs and norms. That is, men can satisfy their sexual desires but are not expected to take responsibility for the consequences of their actions such unplanned pregnancy. On the other hand, women are expected to take responsibility for their sexual behavior and the consequences of their behavior.

In a qualitative Thai study, Tharawan (2002) indicated that some women reported that their partners pushed the burden of taking responsibility for unwanted pregnancy onto them because they did not prevent the unplanned pregnancy by using effective contraceptive methods. Moreover in a qualitative study where focus groups

of young factory workers were interviewed (ages 15 to 24), young women were well aware of the dilemma of premarital pregnancy in the lives of their friends or siblings (Ford & Kittisuksathit, 1994). In discussing the consequences of sex, women mostly feared premarital pregnancy with references to baby dumping, infanticide, and abortion. Young men focused on issues of STD and HIV. The men did not concern themselves with premarital pregnancy because the pregnancy did not affect them as much as the possibility of STD or HIV.

Economic constraint of men may be another factor that influences men to participate in termination of unwanted pregnancy. A man who has high income may give a support such finances to their partner/wife more than a man who has low income. A woman in a pilot study reported that her partner who had high income could not accept the pregnancy openly, but he still had an opportunity to involve in all stages of unwanted pregnancy and abortion by providing financial support (Chatchawet & Sripichyakan, 2005).

Besides male factors, female attitude factors are also important in understanding why men do not participate in taking responsibility for the consequences of their sexual behavior. Some women accept the societal norm that they are the main person to assume responsibility in unwanted pregnancy, especially situations leading to abortion. Women accept this condition because they feel their main role in the sexual act is to prevent conception (Chaichana et al., 2003).

Health Care System Factors

Even though Thailand has a *Reproductive Health Policy* that allows both men and women to access gender sensitive reproductive health care services, the services, especially for unwanted pregnancy where abortion is being considered or procured are not gender sensitive (Kraisuraphong, 2003). Thus, both men and women still experience gender biased services. For instance, men do not have to be involved in family planning services or unwanted pregnancy counseling.

Health care providers are also members of the society and culture and from this perspective accept the belief that only women have to take responsibility for the consequences of unwanted pregnancy and abortion. Therefore, they bring their own attitudes, biases, and perceptions to their interactions with clients and exclude men from those services. This exclusion may also violate male rights for those who wish to obtain health care services for unwanted pregnancy and abortion (Armstrong, 2003; Coleman & Nelson, 1999).

Traditional attitudes and sexual behavior in Thai society are supported by culture, norms, and beliefs that involve gender specific relationships between males and females. Males are regarded as superior to females and have control over sexual behaviors. Thus, it is difficult to achieve mutual participation for reproductive health concerns, especially unwanted pregnancy or the negotiation for safe sex, if both men and women as well as health care providers do not cooperate with encouraging men to participate in taking responsibility for the consequences.

Health Care Services

Reproductive health services in a Thai government setting are provided for women, particularly married women (Kraisuraphong, 2003). Although there is no specific written policy regarding the provision of services according to the mutual needs of both men and women, the Thai Ministry of Public Health announced the Reproductive Health Policy in July 1997. In the policy statement, both men and women have the rights to be informed, make decisions, and have access to reproductive health services. Interdisciplinary teams have been cooperating to develop a set of consensus-based policy recommendations for drafting a new amended reproductive health law in Thailand (Women's Health Advocacy Foundation, 2004). However, services are not sensitive to the needs of men nor do they facilitate male participation in reproductive health activities (Kraisuraphong, 2003). In a public hospital, an internal mechanism does not exist to ensure gender-based equity in reproductive health care. Since the focus of reproductive health services is mainly women, promotion of male participation in the process of unwanted pregnancy (pre-abortion) counseling, post-abortion counseling, and treatment are hindered. Therefore, women have to solve or be responsible for their problems alone.

Service providers and other health care workers bring their own attitudes, biases, and perceptions to their interactions with clients; some health care providers humiliate and disrespect women (Whittaker, 2002a; World Health Organization, n.d.a). These attitudes can negatively affect their ability to provide adequate health care services. Indeed, women with unwanted pregnancies need access to reliable information and compassionate counseling (UNFPA, 1994). Men should be

encouraged to become involved in that service especially as it is related to assuming some responsibility for termination of unwanted pregnancy. The right of women to gender sensitive health care services is a basic reproductive health right. It should include pre-abortion and post-abortion care services.

Pre-Abortion Care Services

The service that is important for pre-abortion period is pre-abortion counseling. The World Health Organization (2003) reports that counseling can be very important in helping women consider their options and ensuring that they can make decisions free from pressure. The World Health Organization (2003) further suggests that counseling should be voluntary, confidential and provided by a skilled or trained person. If the woman opts for an abortion, her health care provider should explain any legal requirements for obtaining it. She should be given as much time as she needs to make a decision, even if it means returning to the clinic later. The safety and effectiveness of an earlier abortion should be explained. The health care provider should also provide information to women who decide to continue with their pregnancies. Information about adoption, including referrals as appropriate, should be available. If a man attends counseling with a woman, the counselor should encourage the man to participate in the process of providing emotional support and sharing in the decision about choosing alternatives. However, he should be encouraged to accept and support the woman's final decision.

If health care providers suspect that a woman experiencing an unwanted pregnancy is being coerced by her male partner, they should talk with the woman alone or refer her for additional counseling. If staff know or suspect that a woman has

been subjected to sexual violence or abuse, they should refer her for other counseling and treatment services as appropriate (World Health Organization, 2003).

In Thailand most of the women who have unwanted pregnancies find pre-abortion counseling inaccessible. Most women also, especially if they are unmarried, are ashamed to ask for information about unwanted pregnancy services because of social taboos about pregnancy in unmarried women (Ratchukul, 1998). The focus of reproductive health services is mainly women; men are usually excluded from counseling services. This reflects a gender bias or inequity so that women are denied for reproductive rights that all couple should share. In addition to violating women's rights, men's rights are also violated in that they are not involved in such services and may not be promptly informed about an unwanted pregnancy (Armstrong, 2003; Coleman & Nelson, 1999).

Post-Abortion Care Services

Post-abortion care is one important way to reduce maternal mortality and address the high unmet need for contraceptive methods; facilitating this important aspect of care could reduce the incidence of women seeking unsafe abortion services (UNFPA, 1994). In Paragraph 8.25, which was adopted in the *ICPD Program of Action,* the following is noted. …"In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education, and family planning services should be offered promptly, which will also help to avoid repeat abortions" (UNFPA, 1994).

Post-abortion care services have been used successfully throughout the world to improve women's access to and the quality of life saving care. It consists of

three components, including (1) emergency treatment services for complications of spontaneous or unsafely induced abortion, (2) post-abortion family planning or contraceptive services, and (3) linkages between emergency treatment and other reproductive health services (Greenslade, McKay, Wolf, & McLaurin, 2002; Langer et al., 1997; Solo, 2000). Men can also participate by providing financial support and emotional support; being physically present and involving themselves in contraceptive use to prevent repeated unwanted pregnancies. Post-abortion care offers health care providers the opportunity to inform men about their partner's condition, postoperative care and family planning methods that might ultimately prevent further unplanned pregnancies.

In Thailand, women who procure unsafe abortion will receive post-abortion care services when they have complications from the abortion and are admitted to a hospital. Therefore, women who procure an abortion and are not admitted to a hospital do not have access to this service. According to Ratchukul (1998), women did not receive any information before and after having unsafe abortion, especially in regard to the topic of post-abortion family planning. Although men have access to the service, health care providers will often include only women in the counseling they provide (Chatchawet & Sripichyakan, 2005). Health care providers have their own attitudes and share similar culture beliefs to others in their society, and may decide women are responsible for using contraceptives (Reproductive Health Outlook, n.d.b; Varkevisser, 1995). They may not be prepared to accept men as client.

In summary, changes in policy and practice for the termination of unwanted pregnancy by encouraging men to take responsibility or participate in the all process of abortion are needed in Thailand. Women need access to high quality and

compassionate health care services regardless of where they live. Ensuring that health care providers, especially nurses, are able to provide such services will help to reduce gender bias in health care services provided for those who are experiencing termination of unwanted pregnancy. Consequently, the purpose of this study is to deeply explore how men and women who choose termination of an unwanted pregnancy perceive male participation throughout the experience. The understanding of how males and females experience termination of unwanted pregnancy is an initial step in organizing services that are sensitive to their needs, as required by the ICPD, and cultural sensitivity.