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“In hindsight, I realize I may not have had enough information.”: Abortion due to Contraceptive Misunderstanding and Male Partners in Mongolia in 2025

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Abstract

Background

Many Mongolians can name contraceptive methods but do not have a comprehensive understanding of contraceptives. Contraceptive experience is common but current contraceptive use is just over half the population at risk of pregnancy. Inconsistent contraceptive use results from experience of side effects and beliefs about temporary or permanent infertility. Couple communication about family planning is common; however, male partners can be a barrier to contraceptive use.

Methods

This thematic content qualitative study included 24 in-depth interviews with 3 abortion clients, 3 male partners of abortion clients, and 2 abortion providers each at a public urban hospital, private urban hospital, and public rural hospital.

Results

Mongolians recognize they are lacking in knowledge about unwanted pregnancy prevention and are deeply interested in having more information on reproduction and contraception, for themselves and others. Currently the school-based sex ed curriculum is severely lacking, but study participants indicated school is the ideal location for comprehensive education on sex. Among the study participants, contraceptive experience was universal, often with multiple methods. Most couples communicate about contraceptive use, with the female partner taking the initiative to decide on the method and communicate that back to their male partner. Some male partners are barriers to contraception – through refusal to use male controlled methods, barrier to female partners using female controlled methods, and general dislike of contraception despite not wanting pregnancy. Unwanted pregnancies, and therefore abortions, result from nonuse of contraception, whether due to lack of awareness, male partner opposition, taking breaks from hormonal methods, or erroneously believing infertility in the postpartum period or otherwise.

Conclusions

Mongolians are eager for comprehensive information on reproduction and unwanted pregnancy prevention from reputable sources. Comprehensive sexuality education in schools, alongside ongoing education opportunities at the university level, and beyond, will help Mongolians better understand their own bodies, their roles in reproduction, and the tools they can use to prevent unwanted pregnancies.

Introduction

The family planning program began Mongolia in 1992 (Kipp et al., 2002). Only half of the population of in union adults have been exposed to mass media on family planning, les so among men (45% vs 52%) (National Statistical Office of Mongolia et al., 2014). Knowledge of at least one contraceptive method among in union persons is nearly universal – a bit higher among women than men (National Statistical Office of Mongolia et al., 2014). However, comprehensive knowledge about contraception is lacking in Mongolia (Enkhjargal et al., 2016; Valdur, 2020), and knowledge is even lower among men and adolescents (Monfemnet & Arrow, 2018). Mongolian adolescents primarily turn to friends for information regarding reproductive health as they fear their parents response and they do not trust providers at public health institutions and at their schools to maintain their privacy and confidentiality (Monfemnet & Arrow, 2018).

Family planning is not well funded by the Mongolian Government, nor is it widely promoted or easy to access. There is a history of limited contraceptive access in Mongolia that continues into present times (Neupert, 1992). There are 600 health institutions providing family planning services in Mongolia (Mongolian Family Welfare Association (MFWA), 2015). Not all health facilities offer the full range of contraception options. Nurses and midwives are the main providers of family planning, but there is a lack of training of health providers, particularly among those serving rural areas. Family planning is only free for women who are poor, have a chronic disease, or are mentally disadvantaged, otherwise, clients are told to purchase their contraceptives from pharmacies or others in the private sector (UNFPA Reproductive Health Team & Ministry of Health and Social Welfare, 2016); however, in one study 72% of women received their contraceptives for free (Amarbal, 2005).

There is a large gap between contraceptive use intentions and actual contraceptive use (Enkhjargal et al., 2016), although 92% of women have ever used contraception (Amarbal, 2005). Contraceptive use dropped from 69% to 55% between 2003 to 2013–48% is from modern methods while 6% is traditional – primarily periodic abstinence (National Statistical Office of Mongolia et al., 2014). IUD use makes up 24% of use while pills are 9%, condoms are 8%, injectables 4%, female sterilization 3%, and implants 1% (National Statistical Office of Mongolia et al., 2014). IUD is the most common method in nearby nations as well (Shekhar et al., 2010). Long term contraceptive methods are appreciated for the convenience of long term protection, and lack of daily or regular interval of resupply, and their effectiveness (Enkhjargal et al., 2016). Condoms are preferred for their ease of use, affordability, effectiveness, and lack of negative impact on women and men's bodies (Enkhjargal et al., 2016). Women who are 35 or older, whose husbands are 35 and older, with more education, those with jobs, those with sufficient income, who have electricity, are married, have 4 or fewer children, and live in rural areas are more likely to use contraception, and are more likely to use the IUD and traditional methods (Gereltuya et al., 2007; Phiri et al., 2022). Among sexually experience adolescents, 41% had contraceptive use experience (Bayaraa et al., 2023).

Less than half, 42%, of in union women using contraception in the past 5 years have received counseling on side effects – more rural women than urban women have received this counseling (49% vs 38%). Counseling on how to address side effects is even lower, 30%, with higher percentages in rural areas

again. In terms of counseling on other methods, this is just 31%, 35% in rural areas compared to 30% in urban areas (National Statistical Office of Mongolia et al., 2014). Contraceptive users are quick to discontinue when side effects arise, to not switch methods immediately when discontinuing, and to delay initiation of method use in the postpartum period due to beliefs about protection from breastfeeding (Enkhjargal et al., 2016)

In one study on spousal communication about contraception, two thirds of women report communicating with their husbands about family planning (Kipp et al., 2002). When either partner disapproves of contraception, the couple is much less likely to contracept (Gereltuya et al., 2007). Male partners are less likely to approve of family planning than female partners (National Statistics Office of Mongolia & UNFPA, 1999).

Unwanted pregnancies result from non-use or misuse of contraception (Chatchawet et al., 2010), which can then result in an abortion. Given this backdrop of limited understanding of contraception in Mongolia, alongside barriers to contraceptive access, and inconsistent use this qualitative study aims to understand the role of contraceptive nonuse, mis use, and male partners on abortion in Mongolia.

Methods

The methodological orientation of this qualitative study utilizing in-depth interviews on abortion in Mongolia is thematic content analysis. The interviews were conducted by the research team members, both male and female whose first language is Mongolian. They are university professors with PhDs. Prior to conducting the interviews, they were trained by the first author, who has extensive qualitative research experience, on qualitative research methods, techniques, and research ethics.

On the day the team visited each hospital, help was sought from the hospital leadership in identifying abortion providers. Abortion providers then helped us identify abortion clients and male partners. Study participants were selected based on convenience. Every potential study participant was approached face-to-face.

The study participants did not know any research team members prior to recruitment. The researchers described the study to the potential study participant and asked them to read, or were read, the consent form.

There was a total of 24 study participants, there were a few male partners approached who did not meet the study criteria or refused to participate. There were 3 abortion clients, 3 male partners, and 2 abortion providers interviewed at each hospital: public urban hospital, private urban hospital, and public rural hospital. The interviews were all conducted at the hospitals in private rooms. No one was present for the interviews except for the interviewer and the interviewee. A semi-structured topic guide was used to guide the interviews. Each interviewee was only contacted and interviewed at one point in time; there were no repeat interviews. Each interview, with consent of the study participant, was audio recorded.

Field notes were also taken immediately before, during and after the interviews. Transcripts were not returned to study participants. The interviews lasted 33 minutes on average.

The audio recordings were transcribed in Mongolian, then the Mongolian transcripts were translated into English by the Mongolian authors. All authors coded the transcripts. The themes were identified from the data; no theme was defined in advance of data collection. Coding occurred in Atlas.ti 25. After all transcripts were coded, analysis continued within each code. Microsoft Excel was used to analyze within each code, with the quotes in the rows and the subthemes in the columns. This allowed for quantification of subthemes alongside triangulation of data between study populations around themes. Each code was then written up, summarizing the themes in the code and using illustrative quotes to demonstrate the themes.

Clients on average were 35 years old, male partners 30 years old, and providers 43 years old. Most abortion clients and male partners were university educated. The average number of abortions for both clients and male partners was one. Nearly half the sample of abortion clients and male partner were married, followed by cohabitating. Only one client each was single, divorced, or dating. All three study populations had on average 2 children. Half of abortion clients and male partners wanted more children; the other half wanted no more or were unsure. All abortion providers were female. Most abortion clients and male partners indicated past use of more than one family planning method, the most common method noted was the condom, followed by the pill, then the IUD, and the calendar method. The implant, injectable, and emergency contraception were also noted, albeit less frequently.

The study was approved by the ethics board at Western Washington University and at the National University of Mongolia. Each study participant consented prior to study participation.

Results

Family Planning Education and Understanding

Study participants were asked about their family planning knowledge, where they learn about contraception, as well as where they go to seek out more information about contraception.

Family Planning Information and Understanding

In terms of family planning information most study respondents indicated that they feel as though they, and most others, have incomplete information about how to prevent unwanted pregnancies. Abortion clients were the most likely to contribute to this theme, followed by male partners, primarily from the urban and rural public hospitals.

Honestly, being 38 and still figuring these things out just shows how much I’ve lacked information. I realize now that I should’ve been more informed and made more informed choices.

abortion client, 38, 3 children, wants no more children, rural public

On top of providing medical care, we also have to do health education and prevention. We carry a heavy workload, and many patients know nothing about reproductive health. When we talk to them, it becomes clear they're totally unaware.

OB/GYN, 34, rural public

People, especially those from urban and rural public hospitals, were eager for more information to complete their inadequate understanding.

I've only used an IUD before—no other methods. I never really considered using others, partly because I didn't have much information about the available options at the time.

abortion client, 35, 2 children, wants more children, urban public

I haven't really received much information. But I do have the need and interest…please help women get proper, early information. Because the risk of making a bad decision is high without it.

abortion client, 43, 2 children, wants no more children, urban private

Some study participants even asked our study team for contraceptive information during the interview – they seemed anxious to increase their understanding of reproduction and contraception.

Sex Education in School

Abortion clients and male partners, primarily from urban public hospitals indicated they learned about contraception in secondary school. Unfortunately, everyone indicated that this curriculum was not comprehensive nor taught well.

When I was in school, we only had "health education" once a week, and it tried to cover everything in that one class. Because of that, students are missing out on really important things they need to know. Teachers themselves have even started asking students things like, "Have you ever had an IUD inserted?"—that's how bad it's gotten. Girls are getting pregnant during adolescence. That's why comprehensive health education needs to be included in the school curriculum—with more time, more depth, and better quality.

abortion client, 38, 3 children, wants no more children, rural public

Unfortunately, the "Health" class taught in school doesn't explain these topics in a clear, realistic way. Kids are making mistakes simply because they don't have accurate information.

OB/GYN, 60, urban private

Many study participants, across all participant types and geographic locations, indicated that children and adolescents need this information and they should learn everything they need to know at school.

In our country, reproductive health education is really lacking. Searching and reading online isn't easy for everyone either. I believe this kind of knowledge should be taught openly in schools, through teachers, especially for kids and teenagers.

abortion client, 35, 3 children, wants no more children, rural public

Sometimes even 16–17-year-old girls come in, which is something I personally find very concerning. It really makes me think that comprehensive, realistic sexual and reproductive health education must be taught more thoroughly in secondary schools. These young girls are becoming pregnant because they lack basic knowledge.

OB/GYN, 60, urban private

Some of the comments on this topic were specific about gender inclusive sexual education so that men can be equally informed about their role in reproduction and prevention of unwanted pregnancies.

I wish there were more education for young people and men, to understand that contraception isn't just a woman's issue.

male partner, 25, 0 children, wants children, urban private

I believe both men and women should receive this kind of information early—ideally starting in secondary school. That way, young people will have accurate information and develop a sense of responsibility. It's important to learn not just after becoming pregnant, but even before.

abortion client, 33, 0 children, wants children, urban private

Especially back in school, I think the health education curriculum needs to be updated. It's not just women who need information on contraception—men also really need proper guidance.

male partner, 20, 0 children, wants children, rural public

Parent Communication about Sex

Primarily male partners from urban public hospitals indicated that parental advice about sex and contraception is lacking. Parents are shy to talk with their children about sexual health related topics, and perhaps lack the understanding themselves, so often give warnings to their children without any teaching or explanation for these warnings.

I think most people from my parents' generation don't have enough knowledge about sexual education. Also, feelings of embarrassment and worry are dominant. In Mongolia, openly discussing these topics is

still relatively rare…here, it's mostly limited to warnings like "don't do that."

male partner, 18, 0 children, wants children, urban public

One young woman said her mom kept telling her, "Don't get pregnant, don't get pregnant," but never actually explained to her how to prevent pregnancy, what kind of person to be with, or when to have sex.

abortion client, 29, 3 children, wants no more children, urban public

This was given as evidence that the curriculum must come from the school to offset the shortcomings in teaching at home.

Seeking Family Planning Information

In terms of where people like to go to for information on contraception, most indicated seeking out health professionals at health centers. This arose more often among abortion clients and male partners from urban and rural public hospitals.

I would go to the family health center or a private gynecology clinic—they're trustworthy and provide clear information.

male partner, 25, 0 children, wants children, urban private

I'm thinking about going to the family health clinic. They should offer good support for women. I haven't gone yet, but I'm considering it. Family clinics might even be more effective than public hospitals because hospitals are overcrowded. I'd like to get more detailed advice and ask questions about contraception and preventing unwanted pregnancies.

abortion client, 35, 2 children, wants more children, urban public

I believe it's best to consult with professional and specialized doctors. They have the most knowledge and experience when it comes to contraceptive methods and tools. They can carefully consider my health condition and medical history to recommend the safest and most suitable option. Family doctors can provide some basic guidance at the initial stage, but I think gynecologists have deeper expertise and experience. That's why I prefer to consult with specialists in the field—it feels more reliable and reassuring to me.

abortion client, 35, 3 children, wants no more children, rural public

Even so, some indicated that health providers also gave inadequate information.

Sometimes the information was not complete or the choices were limited…

abortion client, 40, 3 children, wants no more children, urban public

…in general, there aren’t many places where you can get clear information directly.

abortion client, 38, 3 children, wants no more children, rural public

There were also examples of receiving incomplete support from health professionals.

I used an IUD for six years until 2019. One day, a relative advised me to see a gynecologist because long-term IUD use could affect the uterus. So I went to the hospital, and the doctor said I should remove the IUD and give my uterus some rest. After I had it removed, my period returned away. I didn’t get another IUD after that—and that’s when I started having unintended pregnancies and getting abortions again.

abortion client, 35, 2 children, wants more children, urban public

In terms of where people actually go for information about sexual health, abortion clients and male partners, mostly from public hospitals, noted going to social media or the internet for information.

Mostly from the internet. Doctors are too busy to explain in detail.

abortion client, 34, 3 children, wants no more children, rural public

I mainly learned about contraception through health education classes. In high school, the information was limited but gave a basic understanding. At university, I received no information about it. Recently, I’ve started looking for information on social media. Overall, I haven't received detailed or comprehensive information that fully meets my needs.

male partner, 27, 0 children, wants children, urban public

Finally, friends were noted as an information source for abortion clients and male partners in private and rural public hospitals.

There’s a big gap between the information we get and reality. We mostly rely on friends and social media for information.

male partner, 20, 0 children, wants children, rural public

In rural areas, abortion and contraception info is limited. I got info from doctors, the internet, and friends, but it was sometimes unclear or questionable.

male partner, 27, 0 children, wants children, rural public

Friends were noted as a resource due to the dearth of information and education from schools and parents.

Mostly from people around me—cousins, girlfriends, relatives—just word-of-mouth, really. I didn’t receive much formal education on the topic from parents or school.

abortion client, 35, 3 children, wants no more children, rural public

I didn't get info from formal sources. Mostly from friends and word-of-mouth… In hindsight, I realize I may not have had enough information.

abortion client, 33, 0 children, wants more children, urban private

We had a health class in 10th grade, but it didn't give us practical, useful knowledge. In university, we didn't learn anything about it. I learned mostly from friends. Back then, I thought condoms were the only method. I didn't know about other options.

abortion client, 33, 0 children, wants more children, urban private

Abortion providers and clients noted the power in increasing knowledge, awareness, and action for young girls and women to protect themselves, their bodies, and their futures.

I would advise girls and women to love and protect themselves. A woman's body is something only she truly understands—not her husband or her partner. A husband doesn't carry the burden of his wife's pain in his own body, so it's essential for a woman to know and take responsibility for her own body. I hope women understand that protecting and loving themselves should always come first.

Contraception is not just about protecting your body—it's a way to prevent future risks as well. That's why, to avoid unwanted pregnancies and health complications, I would encourage all girls to take care of their health, and if needed, to have the knowledge and courage to consult professional doctors in person.

abortion client, 35, 3 children, wants no more children, rural public

Increasing awareness and accurate knowledge of contraceptive methods is crucial to empowering women to make informed, proactive reproductive choices.

OB/GYN, 43, rural public

Family Planning Method Experience Among Clients and Male Partners

The most common mentioned method used by male partners was the male condom, nearly equally among clinic types. Abortion clients noted IUD use and male condom at the same frequency, and equally among rural and public clients, but no private clients indicated past use of the IUD.

I feel that the IUD is more suitable, safer, and more convenient for me. In my view, the IUD is much more effective and comfortable than pills.

abortion client, 40, 3 children, wants no more children, urban public

Most IUD comments were negative – about failure or unmanageable side effects leading to early termination.

I tried an IUD after my second child, but it caused inflammation and was removed. Then I used condoms, but due to irregular cycles, I miscalculated the timing and got pregnant. Some methods just aren't suitable for me.

abortion client, 34, 3 children, wants no more children, rural public

I had an IUD inserted before. But it started causing pain because it got embedded inside, so I had it removed. Since then, I haven't really used any consistent method. I've taken pills occasionally.

abortion client, 38, 3 children, wants no more children, rural public

I've used several types of contraception. When I first needed to prevent pregnancy, I got an IUD. After consulting with my doctor, we decided that was the most suitable method for me. But it didn't work well for me — it shifted and came out within a few days. I went back to the doctor and had it removed.

abortion client, 35, 3 children, wants no more children, rural public

Contraceptive oral pills were another common method used, noted more often by male partners than abortion clients and more often among rural participants. The traditional method of the calendar method was noted next often, primarily by clients from the private clinic. The implant was the next mentioned method – more often by rural clients. Emergency contraception, injectables, and abstinence were each mentioned by one or two study participants.

On average, study participants used 2 methods, with rural participants using on average 3 methods. Sometimes the methods were used sequentially and others mentioned utilizing dual method use.

we use various methods—such as tracking the calendar, pills, and we also used to use condoms during sexual intercourse.

male partner, 38, 3 children, wants more children, urban private

Study participants discussed side effects, more among abortion clients and only those from public and rural clinics. Many respondents noted frustration with the available methods, side effects, and their understanding of the available options and knowing the best methods for themselves and their partners.

Male Partner Family Planning Discussions and Support

Study participants were asked about how they communicate about contraception with their partners, and how male partners support contraceptive use.

Family Planning Communication with Male Partners

In terms of partner communication about family planning, the most common scenario provided was that the couple communicates about family planning. The way in which most couples communicated ensued the following sequence: the woman decides the method she wants to use, communicates this plan to the male partner, he agrees with her decision, and thus they have jointly agreed to their contraceptive plan. Male partners were twice more likely to contribute to the she decides, he agrees with her, so they agree jointly scenario than abortion clients.

We usually decided together, but she often took the initiative.

male partner, 27, 0 children, wants children, rural public

We usually decide together. I mostly respect and follow my wife's decisions.

male partner, 38, 3 children, wants more children, urban private

My husband generally supports and understands my decision to use contraception in the future. He respects and agrees with my choices.

abortion client, 40, 3 children, wants no more children, urban public

From the comments men often initially present the process as joint, but upon further explanation it becomes clear how they play a more behind the scenes supportive role. Women often carry the burden to select, use, and continue contraceptive use.

My girlfriend is always very active and responsible regarding contraception. She regularly talks about contraceptive use and health and reminds me when it's necessary to use condoms. I see contraception as a shared responsibility in our relationship.

male partner, 18, 0 children, wants children, urban public

We would discuss the different methods and decide together. But he never tried to take over the decision-making entirely—he played more of a supportive role. Ultimately, I've felt that it's my responsibility to protect myself. As a woman, that responsibility weighs heavily. A man doesn't always know whether or not he wants a child at a given moment. That's why I always tried to discuss and make joint decisions with him.

abortion client, 35, 3 children, wants no more children, rural public

Similarly, a few male partners and providers from public hospitals noted how women can be left to navigate contraception completely on their own.

I believe that women themselves should take care of this. Honestly, I don't know much more. I just think my wife will handle it on her own.

male partner, 33, 1 child, undecided on more children, urban public

Another big issue is male responsibility. Women keeping a menstrual calendar is good for health — men should share responsibility by using condoms too. But men often don't see themselves as responsible for preventing pregnancy — that must change.

OB/GYN, 50, urban public

Male Partners as Barriers to Family Planning Use

Less commonly noted, but noted by some study participants, nonetheless, were male partners objection to contraceptive use. These subthemes were only contributed to by abortion clients and abortion providers, primarily from the urban public clinic and rarely from the rural public clinic.

…many clients follow their contraceptive plans, but not all. It depends greatly on their understanding, attitudes, and circumstances. The partner's attitude and open communication between both partners are also crucial.

OB/GYN, 47, urban private

Male partners could oppose contraceptive use via refusing to use condoms due to not liking how they negatively impact sensation during sex.

We usually talk and make decisions together. My husband doesn't complain or refuse, but he says, "I don't want to use condoms, they're uncomfortable." Since we're in a monogamous, stable relationship, it hasn't really caused any issues.

abortion client, 38, 3 children, wants no more children, rural public

We always discuss these things. My husband is supportive. He has concerns about condoms—he says they feel uncomfortable or might be used incorrectly. So we jointly decided the implant was the better option.

abortion client, 34, 3 children, wants no more children, rural public

Male partners could also oppose long term method use, particularly the IUD, due to feelings of jealousy and mistrust of their female partner's fidelity.

He will likely influence the decision. We'll need to talk about it. He tends to be jealous, so we'll have to discuss it together.

abortion client, 35, 2 children, wants more children, urban public

…sometimes their husband objects — there can be mistrust and domestic conflict.

OB/GYN, 50, urban public

Some have partners who refuse to use condoms or do not allow them to use other methods.

OB/GYN, 43, rural public

These feelings of mistrust seemed to be correlate with male partners having jobs that required short term migration from their domestic spaces.

My husband's opinion significantly affects my decisions about contraception. I sometimes think I'll just go and get the IUD again, but my husband isn't always around. He drops in unexpectedly sometimes, and that causes tension or worry. I think he might not agree with me getting the IUD—he could say, "Why would you need that now?" So I end up hesitating and can't make a firm decision. But now I realize that I don't really have a choice.

abortion client, 35, 2 children, wants more children, urban public

One abortion provided shared that male partners might remove the IUD.

. Sometimes their husbands remove the device forcibly.

OB/GYN, 47, urban private

Vasectomy was rarely noted as an option for contraception due to male partner's refusal to use that method.

If I decide not to have more children, I'm considering suggesting a vasectomy for my husband. I've researched it and found it to be highly effective and safe. Although he's not fully on board yet, I try to help him understand my health risks. Every pregnancy has been difficult for me. I've had severe hip and back pain, and in the later months, I couldn't even walk or sleep properly. I barely managed to deliver my third child. I honestly don't want to go through that again. I think male contraception is the best solution.

abortion client, 34, 3 children, wants no more children, rural public

Male sterilization is rare because many men are reluctant. But occasionally, a supportive husband will agree, saying: "I've put my wife through enough; I'll take responsibility and get sterilized myself." Such men do exist, and they are commendable.

OB/GYN, 43, urban public

Abortion providers noted how without male partner participation and support with contraceptive use, prevention of additional unwanted pregnancies is unlikely.

… if the partner doesn't support or share in contraceptive responsibility, the issue won't be solved.

OB/GYN, 60, urban private

They should be involved, but usually they're not. Men don't take responsibility for protection, and they're also not present when women come for abortions.

OB/GYN, 34, rural public

In some cases, the husband or partner does not want another child but refuses to share responsibility for contraception. Some men simply insist on terminating any unintended pregnancy, so the woman secretly comes for an abortion because she feels she has no choice.

OB/GYN, 43, urban public

Family Planning Misuse Leads to Abortion

A common reason given for abortion was a lack of understanding, misunderstanding, or a misuse of family planning methods. Providers from the urban public facilities were more likely to contribute to this subtheme.

We used a condom during intercourse, but it slipped off mid-act and we didn't notice. We only realized afterward. I took the emergency pill within 72 hours, but I still got pregnant.

abortion client, 33, 0 children, wants more children, urban private

…many lack proper reproductive education or fail to use contraception effectively. Some used contraception inconsistently or incorrectly, and others are pregnant for the first time and have no knowledge of any methods.

OB/GYN, 60, urban private

Relatedly, abortion providers and clients noted people can opt to take a gap or break in contraceptive use to rest from the hormones and then they can find themselves pregnant during that short break period.

Some become pregnant while temporarily stopping contraceptive pills for a "break" before restarting, which is generally acceptable.

OB/GYN, 47, urban private

After giving birth to my two children, I had an IUD inserted. But shortly after having it removed, I became pregnant very quickly. I never thought I'd get pregnant that fast.

abortion client, 35, 2 children, wants more children, urban public

Some abortion clients and a male partner indicated they experienced contraceptive failure – they were using a long term method and yet still faced an unwanted pregnancy while using that contraception. This theme came from only public facilities – both urban and rural.

They say that only 2% of women get pregnant with an IUD, and I ended up being one of them. I think of it as a lesson.

abortion client, 29, 3 children, wants no more children, urban public

I then had a contraceptive implant inserted. It's been almost two years now; the implant is supposed to last for five years…Even the doctors were surprised. I was told the implant is highly effective.

abortion client, 34, 3 children, wants no more children, rural public

My wife and I talked and decided on an implant because it was said to be the most reliable for five years. But she got pregnant in the third year. Now I've lost trust in contraception. They said it was the best method.

male partner, 34, 3 children, wants more children, rural public

A provider and male partner from the public clinics indicated experience with a pregnancy in the postpartum period due to not contracepting.

The abortion was due to a mistake on our part, maybe from a lack of knowledge. Since the baby was still breastfeeding, we thought she couldn't get pregnant yet. We hadn't gotten around to reinserting the IUD, and then she got pregnant.

male partner, 33, 1 child, undecided on more children, urban public

An abortion client and an abortion provider from public clinics indicated that sometimes clients think they are infertile so do not using any contraceptive protection – so the pregnancy was a total surprise.

I have ovarian cysts and had one ovary removed. The doctor said since I only have one ovary, it is quite small. So I thought the chance of getting pregnant was low.

abortion client, 40, 3 children, wants no more children, urban public

For most participants in this study, an abortion occurred due to an unwanted or mistimed pregnancy, which occurred due to misuse of contraception.

Ideally, if a family has a clear plan — when to have children and how many — abortion can be completely avoided. But sometimes women fail to use contraception properly or assume they cannot get pregnant but then do.

OB/GYN, 43, urban public

Discussion

Abortion clients and male partners indicated a need for more information about contraception, in some ways frantically so, even asking the study team for guidance. Others have also found that knowledge about reproduction and contraception is very low in this setting and others, and even lower among men (Olsson & Wijewardena, 2010; Rak & Janes, 2004). In one study, among women not using periodic

abstinence, 9% gave a wrong answer about their fertile period and 37% indicated they did not know their fertile period during a menstrual cycle (National Statistics Office of Mongolia & UNFPA, 1999).

When asked where people learn about family planning many indicated lessons in secondary school but quickly followed with comments about the inadequacy of the curriculum and teaching methods. The abortion providers also critiqued the current sex education efforts, as have other medical providers in other research (Monfemnet & Arrow, 2018). Inadequate comprehensive sexuality education has been noted by other research and in other settings as well (Amindavaa et al., 2005; Monfemnet & Arrow, 2018; Olsson & Wijewardena, 2010). In this study, as well as others, participants noted a desire for sex education to be improved for future generations, and for continuing opportunities to learn about reproductive health after exiting school (Bayaraa et al., 2023; Corey et al., 2022; Monfemnet, 2017; Monfemnet & Arrow, 2018; UNFPA, 2022). There was a special mention for men to receive the education as well, aligning with calls from others (Arrow et al., 2021; Kriel et al., 2019; Monfemnet & Arrow, 2018; Valdur, 2020). The literacy levels in Mongolia are nearly 100% (Hill et al., 2006) for both men and women, and 99% transition from primary to secondary school (National Statistical Office of Mongolia et al., 2014). This indicates that many Mongolians interact with the education system, so efforts to educate the public on reproductive health via primary and secondary school would reach many in the population, particularly with a strengthened curriculum, more time to offer a comprehensive curriculum, and trained teachers to deliver the curriculum (Monfemnet & Arrow, 2018). The WHO shows how governments must provide comprehensive sexuality education to their people to meet their population's human rights (*Abortion Care Guideline, Second Edition*, 2024).

Parents were noted as inadequate sources of information on sexual health as well – due to a combination of embarrassment about the topics and perhaps also a lack of knowledge and understanding. Others have noted how families and older generations are not open to discussions concerning sex (Arrow et al., 2021; Roberts et al., 2005; Valdur, 2020). For youth faced with an unwanted pregnancy, they do not go to their parents as they fear their strong, potentially violent or forced isolating, reactions (Monfemnet & Arrow, 2018). During Socialism, there was no sex education, sex only occurred between marital partners so the state decided education on the topic was not necessary (Terbish, 2013). Therefore, it is possible that older generations of Mongolia truly do not know about sex and reproduction as any lessons on this topic were not offered when they were in school. However, researchers have noted that it is vital for parents to engage in conversations and support of their children around reproductive health topics and issues (Monfemnet & Arrow, 2018), and research has shown the positive impact parents can have on adolescents when they are supported to talk with them about sex (Schwandt & Underwood, 2013).

People noted a desire to obtain information on sexual health from providers, particularly those with the most training in this area, a finding found in other research as well (Kipp et al., 2002; Roberts et al., 2005; Schwandt et al., 2016). However, there are also complaints about not being able to obtain the information that they desired from health providers, particularly in rural areas, which aligns with prior research findings (Gereltuya et al., 2007; Kipp et al., 2002). In addition, past research shows that many

contraceptive users in Mongolia purchase their contraceptives from pharmacies (16%) compared to public hospitals (76%), and even higher if examining short term method use (43%) and condoms (54%) (National Statistics Office of Mongolia & UNFPA, 1999). Mongolians have a history of wanting to obtain information and services from highly qualified doctors, as opposed to utilizing the services closer to them, which results in costs to the individual as well as the system (Kipp et al., 2002).

Mongolians go to the internet and social media, for information on contraception, as noted by other research as well (Enkhjargal et al., 2016; Monfemnet & Arrow, 2018; Valdur, 2020). Mass media use is very low in Mongolia, 10% of women and 13% of men read a newspaper or magazine, listen to the radio, or watch television at least once a week. Comparatively, 74% of women and 72% of men used the internet in the last year, higher among urban residents as compared to rural residents (National Statistical Office of Mongolia et al., 2014). Friends were also a noted source for information here and among other research (Monfemnet & Arrow, 2018; Valdur, 2020), and for pregnancy as well (Valdur, 2020). In this study, and others respondents recognized the limitation of friends as sources of information (Roberts et al., 2005).

Study participants indicated experience with contraception – mostly male condoms and the IUD, but other methods as well. Most participants in this study had used at least two different contraceptive methods in their reproductive lives, and at times concurrently. Similar to findings in other settings (Cooper et al., 2005). These results, however, differ from survey data in Mongolia indicating that women with abortion history are less likely to have contraceptive use experience (Phiri et al., 2022). Women often discontinue hormonal methods due to side effects or health concerns (Rak & Janes, 2004), which could be supported differently by the health system (Schwandt, Boulware, Corey, Herrera, Hudler, Imbabazi, King, Linus, Manzi, Merritt, Mezier, Miller, Morris, Musemakweli, Musekura, Mutuyimana, Ntakarutimana, Patel, Scanteianu, Shemeza, Sterling-Donaldson, et al., 2021). Research shows that male condoms can be difficult to obtain for herder populations and that adolescent girls discontinue hormonal contraception as soon as any issues arise (Monfemnet & Arrow, 2018). Reliance on traditional methods, combined with incorrect or inappropriate use of short term methods contribute to abortions (Amarbal, 2005). Despite the experience with contraceptive methods – there was a common sentiment for more contraceptive options as well as more information about the available methods.

Couples do often communicate about contraceptive use – but the most common scenario is that the female partner does the research and makes a decision, brings that information to the male partner, who then agrees with the decision. Women noted the burden involved in navigating the information and contraceptives options on their own with limited support, as is seen in other nations as well (UNFPA, 2022). Researchers have noted how couple communication about family planning occurs among some couples, but not all (Valdur, 2020). Among adolescents and those in unstable partnerships, the female often makes the decision and uses contraception without disclosing her use to her male partner (Monfemnet & Arrow, 2018). In successful interventions to enhance male partner involvement in family planning, spousal communication was the main predictor of contraceptive initiation (Lundgren et al., 2005; Schwandt, Boulware, Corey, Herrera, Hudler, Imbabazi, King, Linus, Manzi, Merritt, Mezier, Miller,

Morris, Musemakweli, Musekura, Mutuyimana, Ntakarutimana, Patel, Scanteianu, Shemeza, Stapleton, et al., 2021; Shattuck et al., 2011).

Some male partners are barriers to contraceptive use – particularly through refusal to use male controlled methods – the condom and vasectomy (Kriel et al., 2019; Valdur, 2020). Male partners could also refuse to allow their female partners to use female controlled methods – and this was often due to relationship instability and jealousy, particularly from male partners who migrate regularly from the domestic sphere for work purposes (Enkhjargal et al., 2016; Kriel et al., 2019). Male partners could also decline to support their partner's transportation needs to access contraceptive services for initiation or resupply of methods (Enkhjargal et al., 2016). Research has shown higher intention to use contraception among women (57%) than men (46%) as well as higher approval of contraception among women (92%) than men (79%) (National Statistics Office of Mongolia & UNFPA, 1999). Additionally, male partners can be against abortion but also against contraceptive use (Monfemnet & Arrow, 2018). Historically and currently, family planning as seen as in the woman's domain as she is in the one who gets pregnant (Valdur, 2020).

Findings from this study suggest that while women often appear to independently seek out information, select, and use contraceptive methods, male partners' "silent power" plays an important role in shaping reproductive decision-making in practice. Although men may not express overt opposition, participants' narratives indicate that women's choices are constrained through men's lack of support for contraceptive use, refusal to use condoms, skepticism toward long-acting methods, or disengagement from decision-making altogether. Such forms of subtle resistance and limited involvement further concentrate contraceptive responsibility on women, increasing their burden of acquiring information, assuming risk, and managing the consequences of contraceptive failure. Previous studies similarly highlight how this dynamic reinforces gendered inequalities in reproductive responsibility (Kriel et al., 2019; Monfemnet & Arrow, 2018; Valdur, 2020).

This study has a number of strengths – the qualitative nature of the study allowed for in depth study on this subject, particularly the inclusion of three study populations – abortion clients, male partners of abortion clients, and abortion providers, allowed for triangulation of the data.

This study also has several limitations. First, due to its qualitative design and use of purposive sampling, the findings are not generalizable to the broader population. Participants were recruited from selected public and private health facilities, which may exclude the experiences of individuals who lack access to formal health services or who obtain abortions through informal means. Information collected relied on self-reported accounts and may therefore be subject to recall bias and social desirability bias.

Abortion often occurred to misuse of contraception – from a lack of awareness or understanding about contraceptive methods generally, or from taking a break from contraception while not taking a break from sexual intercourse, not contracepting in the postpartum period, failure, incorrectly assuming infertility, and male partner opposition to use. Contraceptive misuse is a main reason for abortion in other research as well (Cooper et al., 2005; Kipp et al., 2002). Supposed infertility, as well as infrequent

sex were all reasons given for not intending to use contraception in the future by Mongolian women of reproductive age (National Statistics Office of Mongolia & UNFPA, 1999; Rak & Janes, 2004). When modern contraceptives are used as they should be and consistently, unintended pregnancy will decrease, and the need for abortion will also decrease (Cohen, 2012). In one study, 95% of the abortions would have been averted if contraceptives had been used (Pandey, 2002). In order to reduce the need for abortion, Mongolia will need to ensure an informed public (Cohen, 2012) – particularly among men to understand their role in reproduction and unwanted pregnancy prevention.

Many participants reported experiences of incorrect use, discontinuation, or failure of contraceptive methods, underscoring the need to understand abortion not as an individual failure but as the outcome of intersecting systemic shortcomings. Interpreting abortion solely as a result of poor personal decision-making risks misdirecting policy responses. Instead, international research and guidelines emphasize the importance of integrated, system-level interventions that strengthen sexual and reproductive health education, improve the quality and continuity of contraceptive counseling, and promote meaningful male engagement in reproductive health (Cohen, 2012; UNFPA, 2022).

Strengthening male engagement, improving comprehensive sexuality education across the life course, and addressing structural barriers to contraceptive access are critical areas for further investigation to reduce unintended pregnancy and the need for abortion in Mongolia.

Declarations

Ethics approval and Consent to Participate

Ethics approval was obtained from Western Washington University and the National University of Mongolia IRBs. Consent to participate in the study was obtained from all study participants. The research study was conducted in accordance with the Declaration of Helsinki.

Consent to Publish

Not applicable.

Competing Interest declaration

The authors declare that they have no competing interests.

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