International Seminar on decision making regarding abortion—determinants and consequences

Nanyuki, Kenya, 3-5 June 2014

Organized by the IUSSP Scientific Panel on Abortion Research

Chair: Susheela Singh; Panel members: Agnes Guillaume, Ndola Prata, Sabina Rashid and Harriet Birungi

SEMINAR REPORT

The IUSSP Scientific Panel on Abortion, in collaboration with the Population Council's Nairobi office, held a seminar on "Decision-making regarding abortion—determinants and consequences" in Nanyuki, Kenya, 3-5 June 2014. The seminar was supported by funds provided by the IUSSP, and with additional technical and financial support from STEP UP (Strengthening Evidence for Programming on Unintended Pregnancy) Research Consortium, funded by UK aid from the UK Government, as well as financial support from a number of organizations: Bixby Center for Population Health and Sustainability, University of California, Berkeley; Centre Population et Dévelopement (CEPED, France); Ipas; Venture Strategies for Health and Development (VSHD); and Venture Strategies Innovations (VSI).

This seminar provided a forum for discussing current research on the decision-making process regarding abortion and its determinants. The papers mainly focus on countries or contexts where access to abortion is restrictive due to legal conditions, high stigma, or poor quality of health systems. This group of papers presents results from new studies based on both qualitative and quantitative data, proposes new approaches and methodologies, and assesses the advantages and disadvantages of existing methodologies, with the goal of advancing and guiding future work in this area. The decision-making process regarding pregnancy resolution and abortion is insufficiently documented and poorly understood. The decision-making process related to pregnancy and abortion involves not only women but often other social actors such as male partners, family or community, medical institution and sometimes legal or religious institutions. In some societies women have little or no rights and autonomy regarding their own reproduction.

The 24 papers that were presented at the seminar addressed issues that included: abortion decision making – access and safety; social and economic factors and abortion; adolescents and abortion decision making; misoprostol and decision making; decision making and pregnancy outcomes; and there were three methodological papers.

Seminar participants came from diverse backgrounds and regions. They represented Latin America (5), Asia (4), Sub-Saharan Africa (8), North America (6), and other developed countries (6). Participants represented different career stages – several were junior scholars, a few at the pre-doctoral stage. Panel members are actively pursuing the possibility of having a large proportion of the papers published in a special issue of a journal and are discussing options with various journals.

Abortion Decision Making – Access and Safety

Five papers were presented during this session, four from Africa (one on South Africa, two on Zambia and one on Ghana) and one from Mexico. The paper on South Africa explored abortion decision making using the maternal health delay framework by focusing on the time interval between pregnancy recognition and abortion procedure. Qualitative in nature (15 in-depth interviews), the study interviewed women obtaining abortions in health facilities in Western Cape, South Africa. The health delay framework focused on four main sources of delays: i) recognizing pregnancy; ii) making a decision to abort; iii) reaching a health facility; and iv) receiving adequate care. The study showed that the largest contributor in the delay to obtaining abortion was the delay in recognizing pregnancy. All respondents reported that their pregnancies were unintended (so, for example, none of this small sample obtained the abortion to protect the woman's health) and their use of contraception was limited, in contrast to the relatively high contraceptive prevalence in Western Cape Province (60%). Women reported that the decision to terminate the pregnancy was theirs alone; they felt compelled to terminate the pregnancy despite their beliefs about abortion.

The paper on Ghana presented results on abortion decision making from 31 in-depth interviews of clients who presented to request an abortion at the Planned Parenthood Association of Ghana. The majority of clients were very young, unmarried and students. Contraceptive use among the study population was limited or inconsistent. Results show that parents, or what women perceived could be the reaction of their parents if the unintended pregnancy was found out, played an important role in the abortion decision making. Most women feared the negative reaction of their parents and that alone was a great motivation to arrive at the decision to interrupt the pregnancy.

The study on Zambia looked at factors that affect women's choices when seeking an abortion. Using a structured questionnaire, 906 women seeking legal therapeutic abortion were interviewed. Of those, 356 were interviewed a second time during the follow-up visits. The study used bivariate logistic regression to examine abortion decision making and predictors of delays in accessing care. Results show that a combination of personal factors and factors related to the health system can predict delay in seeking care. Factors associated with more than two weeks to get a pregnancy termination after pregnancy recognition included: being a teenager, not paying for the procedure, seeking care somewhere else first, not knowing where to go and believing it was too soon to have a child. The study concluded that the results can be used to target information to women most at risk.

The second study on Zambia presented in this session was still in its implementation phase. Its objective is to examine the economic, physical and social costs of safe versus unsafe abortion on women and their households. This will be a longitudinal study with a total of 3 interviews over 6 months. The results are not yet available but seminar participants had the opportunity to discuss current challenges with study implementation.

The paper from Mexico focused on women's experiences of induced abortion in the state of Querétaro, where abortion laws are considered the most restrictive in the country. The study included women 18 years or older admitted for treatment of abortion complications. Qualitative in-depth interviews were also conducted to explore women's experiences with having an abortion in an illegal setting. Of the 122 postabortion care patients assessed in the study the majority were less than 30 years old; most had at least secondary education and reported being homemakers as occupation. The study reported that abortion decision making

is primarily done by the female partner. In some cases the male partner was not informed. Illegal terminations with misoprostol are common, but some women used surgical interventions such as Manual Vacuum Aspiration (MVA). Regardless of whether it was terminated medically or surgically, most women in the study had bad experiences with abortion. Their testimonies demonstrated the lack of awareness and knowledge among women and providers that results in poor health outcomes. Results from the study could stimulate policies and programs to prevent unwanted pregnancy.

Social and Economic Factors and Abortion

The findings from four papers on Bangladesh, Pakistan, Finland and Switzerland highlight the vulnerability of women when accessing abortion, irrespective of socio-economic and political contexts. Social, cultural and economic factors and larger political processes play a role in all of these contexts, from urban slum women in Bangladesh, to urban and rural women in Pakistan, to Turkish Kurdish immigrants in Switzerland to young women in Finland. It is clear that the poorer the woman, the more difficult her situation (or lack of choice and difficulty in decision making), thereby the need to cope with more adverse consequences. However, with marginalized populations (for example women in Dhaka slums) and ethnic minorities (Turkish immigrants in Switzerland) the situation is worsened due to language, social, class and economic barriers and little support from male partners or the mainstream community. Health providers particularly in low-income countries are critical to referring women to safe services but the influx of informal and private sector market, as well as brokers, impacts the kind of care women receive. The role of men is mentioned, particularly in the Pakistan and Switzerland paper, but an in-depth and nuanced understanding of men's role and attitudes towards their partners/wives regarding abortion would provide clarity on decision-making processes for abortion. One clear theme that emerged was the importance of recognizing unique data sets that may not have been designed to address these issues but which provide appropriate and valuable data to do so (e.g. the papers on Finland and Bangladesh) but also the need for careful analysis of rich qualitative data, which illustrates the complexity of individual lives, changing environments, fluidity of gender relations and a health market system which is diverse and populated by many different actors at all levels. While access to abortion services should be a right for many women, it is a difficult undertaking in most cases, given the social, economic and political barriers that women face all over the world.

The paper on Dhaka analyzed intimate partner violence and its association with adverse sexual and reproductive health outcomes among young women in urban slum areas of the city. Quantitative baseline data from a sample of 2,989 ever married women age 15-29 were analyzed. Multivariate analyses found that women ever experiencing physical violence or sexual violence are nearly two times more likely to have had a menstrual regulation (MR) procedure compared to those who had never experienced violence. The results of this study establishes that MR clients are at high risk and vulnerable to violence, and provides a strong impetus to exploit sexual and reproductive healthservice delivery channels to be used for screening and delivering intimate partner violence (IPV) services to urban poor women.

The second paper looked at abortion among immigrant women, focusing on Turkish Kurdish women in Basel, Switzerland. Quantitative data were collected on all women resorting to an induced abortion at the University Women's Hospital Basel (n=1,456). Focus group discussions and individual interviews were conducted with women and men of the Turkish-Kurdish communities (n=28). The induced abortion rate for the Turkish-Kurdish community

is twice as high as the national rate. The study addresses both immigrant men and women's perspectives in regard to obtaining abortions, and takes into consideration the local, social, cultural, political economic structures to ensure culturally sensitive care. The authors' goal was to better understand the conditions/reasons leading to unwanted pregnancy, and decisions to abort among women in this community. Decision-making on abortion among sexual partners is mainly taken as an issue within women's autonomy or men's dominance but less as joint decision among the two. Altogether, women originated from Turkey had a high proportion of conflicting intimate partner relationships and history of domestic and/or sexual violence which determined their decision-making.

The paper on Finland used register data on three female birth cohorts to explore linkages between socioeconomic status and abortion experience across cohorts. This study explores whether women have different socioeconomic position or likelihood of upwards intergenerational social mobility depending on the timing and outcome (abortion/birth) of their first pregnancy and whether the relationship has changed over time in Finland, where social mobility is relatively high and comprehensive support for families, family planning and sex education are available. Post-abortion socioeconomic position has not been widely studied before with reliable and comprehensive data. A unique longitudinal set of register data of women born in 1955-1959, 1965-1969 and 1975-1979 was analyzed using descriptive statistics and logistic regression. Women who experienced a pregnancy especially at young age had lower socioeconomic position later in life compared to women with no pregnancies. Births were associated with a lower socioeconomic position and smaller likelihood of upwards social mobility than abortions.

The last paper from this session focused on unsafe abortion in Pakistan, where abortion is highly restricted. Despite this and the considerable social taboo associated with abortion, it is estimated that one in seven pregnancies ends in abortion (Sathar et al., 2007). Because of the illegality of the act, procedures are often carried out under unsafe conditions. This paper focused on the qualitative component of a larger study on abortion and postabortion care. The study found that poverty and gender-related issues play a significant role in the decision-making process, especially for women living in rural areas: financial dependence on husbands, limited mobility heightened by distantly located services, and inability to afford a skilled provider make abortions riskier for poor rural women.

Adolescents and Abortion decision making

Three papers documented the abortion decision making among adolescents and youth, a population exposed to increasing risks of unplanned pregnancies and abortion because of changes in patterns of sexual debut, in a context where premarital pregnancy remains stigmatized. The papers covered this topic in African cities (in Burkina Faso, Cameroon and Nigeria), all countries where access to abortion is restricted, but widely practiced. Based on qualitative studies to describe the abortion process, they showed important similarities: Adolescents' decision to abort is rarely an individual woman's decision, and could involve the male partner, her or his family, social networks such as friends and doctors, and the influence of religious or social norms.

In Ouagadougou, in-depth interviews were conducted with women who ever had abortion or were seeking abortion and men whose partners had an abortion. The abortion decision process was analyzed according to the theory on *uncertain humanity* showing that it involved different actors at different stages of the decision process, and inserted in a social space to negotiate the

decision, each with its own social logic. The study found that abortion decisions mobilised different people and were influenced by social norms; also, that the practice of abortion is a long process in terms of temporality (up to 12 weeks of negotiation), in terms of actors implied in the decision (as many as ten people) and different stages of negotiation in the decision-making process. Social networks are mobilized but at the end, the role of the male partner is preponderant.

The paper on Lagos analyzed qualitative data on male and female undergraduate and post-graduate students, and documented the abortion decision-making process through a complex framework. Three groups of factors were considered: structural factors related to social and legal determinants; personal factors, which correspond to women's characteristics and the type of relationship; and operational factors, which are related to the condition of abortion practice. The weight of social norms remains a very important determinant, and family environment and religious factors have a strong influence on abortion behavior. The conclusion was that the abortion decision process is strongly guided by structural and personal factors but operational factors have little to no influence, confirming that the conditions of abortion and associated risks do not limit the practice.

In Yaoundé, using in-depth interviews with both young men and women, a typology of attitudes related to abortion is proposed and results show, as in Burkina Faso, that abortion can be a controversial decision between men and women. Pregnancy can be used by a woman as a strategy to oblige her male partner to marry her while the man does not want the pregnancy, or vice versa. Parents could be involved or concerned by the decision by obliging their daughter to abort, or the young woman could decide to abort to avoid family shame or rejection. The young men and women interviewed managed the issue of pregnancy according to their social and economic situation but also to social norms. They underlined the high risk of unwanted pregnancies because of the difficulties that adolescents have in accessing contraception including lack of information, lack of access to sources, shame of purchasing contraception, and young women's difficulties in negotiating condom use with their partner.

To conclude, these papers illustrate the lack of autonomy of young women regarding their reproduction. The final abortion decision is a complex process that involves different actors. The adolescents' difficulties in preventing unintended pregnancy are an important public health problem.

Misoprostol and Decision Making

The four papers in this session documented the decision-making process and the use of misoprostol in two countries of Latin America, Uruguay and Argentina. The information presented, along with the discussion from the first session on the decision-making process in Mexico, gives a general picture of the experience of women seeking an abortion in Latin America. Three of the four papers focus on understanding the decision-making process leading to abortion, while the fourth paper explores the impact of an intervention, the Safer Abortion Hotline in Argentina.

The processes of seeking an abortion and the use of misoprostol are quite similar across countries in the region of Latin America. Countries in this region are characterized by high contraceptive prevalence, desire of a family size of two children, relatively high education, and a certain degree of female autonomy. Most of the women seeking an abortion had been contraceptive users but did not use a contraceptive method at the time they got pregnant.

Another common characteristic in the various countries examined was that women who will opt for a pregnancy termination will very likely inform the partner and others (mother, relatives and friends) about the unintended pregnancy, but most of the women will make the decision independently of their partner or family members. Women seek out emotional support from their partners during the whole process of abortion.

The first paper on Argentina explored the chain of events and decisions that a woman faces in the process of terminating a pregnancy. The study collected quantitative data and interviewed women in public hospitals in different regions. One of the innovations of this study was that data were collected on topics such as desires and feelings regarding the pregnancy, intentions to abort, and causes of admission to the hospital, topics usually addressed in qualitative interviews. Findings show that during the decision-making process leading to abortion, women go through several stages of thought and action. In the abortion situation, the relational dimensions with "significant others " (partner, mother, relatives, friends) play an important role. Women sought help and shared their situation with significant others, principally their partner, but the decision was ultimately autonomous and the abortion was mostly done using a method that does not require the involvement of another person. Although economic reasons are often cited as a reason for abortion, for a significant number of women, the reason was that the pregnancy came too early or at the wrong time.

The second paper on Argentina in this session described the process of decision-making in using misoprostol to induce abortion in a restrictive legal context. Twenty in-depth interviews were obtained among women who used misoprostol to terminate a pregnancy in Cordoba, Argentina. This data was complemented with additional qualitative data from local feminist activists and "friendly" doctors from the public health system. Findings indicate that women with a previous dilation and curettage (D&C) abortion had negative experiences: traumatic surgical abortion, curettage without anesthesia, in precarious hygiene conditions and at high cost. For women using misoprostol one of the values of the procedure, in addition to the low cost, was that misoprostol allowed them to carry out their abortions *autonomously*. The use of misoprostol let them decide how, when, and where to abort, fundamentally because it allows for self-administering. The women reacted positively to having the support of feminist activists who provided them with information and described in detail the symptoms that would be present and warning signs to be aware of.

The first paper on Uruguay explored women's decision to abort an unwanted pregnancy, as well as when they decided and how long it took to decide. It also explored the nature of partners' involvement in the decision-making process and the role of misoprostol availability in the decision to abort their pregnancy. The context in which this study occurs is quite different to the other countries, since in 2012 Uruguay decriminalized abortion services (and conditions were moderately liberal from 2004 onwards, health providers have been permitted to provide information about abortion safety when using misoprostol). This paper presented results from in-depth interviews of 28 women who had an abortion: 21 women had accessed legal abortions while seven women were recruited and interviewed in October 2012 before abortion was decriminalized. Women came from varied socioeconomic backgrounds, yet had similar reasons for the abortion, with financial concerns being the most common. For some the decision-making process was not simple or linear, yet in all cases but one the participants' decision to abort was independent from the contact with and opinion of health professionals. When asked how soon after confirming the pregnancy they decided to terminate, many women reported immediately knowing they wanted to terminate the pregnancy. Despite having reached a decision before seeking health services, many women experienced doubt,

guilt and mixed emotions. Partner involvement varied among interviewed women. The partner more or less gave support, but the decision of abortion was independent of the involvement of the partner. Most women were worried about aborting using medication, mostly because they would not be under direct medical supervision.

The second paper on Uruguay used decision analysis to elucidate pathways by which a hotline may impact health outcomes for women seeking abortion, and the cost of savings associated to the hotline. Little research has been done to estimate the impact of hotlines that deal with sexual and reproductive health services, and even less so on one that provides information on accessing misoprostol for abortion. The paper considered different possible scenarios in estimating the benefits of the hotline in terms of health outcomes and cost savings. To account for imperfect data, several sensitivity analyses were performed to create best and worst-case scenarios for the hotline's potential impact. Results showed that the hotline increases the number of complete abortions and reduced serious complications from incomplete abortions among its callers. The results suggest that programs of this kind are very likely to reduce harm and be cost-saving, making them a powerful tool for improving women's health.

Decision Making and Pregnancy Outcomes

The papers presented in this session dealt with different aspects of decision-making in Africa and one country in Asia (Bangladesh): whether to seek out an abortion, whether to seek a safe vs. an unsafe abortion and whether to have premarital sex—which can lead to an abortion (Dakar and Rabat). One paper dealt with the issue from the providers' perspective examining providers' decision-making whether to perform abortions.

The paper examining pregnancy termination in Zanzibar, based on qualitative data gathered through Respondent-Driven Sampling (RDS), reported the results according to the order of the pregnancy that was aborted and respondents' demographic characteristics at the time of their abortion. In this analysis, the author distinguishes between women's moral concerns and health concerns. The authors stated, "Many women believe that even if abortion is the best option, it is morally wrong." The data found that greater education is needed to educate women about the efficacy of using post-partum amenorrhea to prevent pregnancy since many women cited this as the contraceptive method they were using at the time they became pregnant. Other misleading information that the respondents held was that one of the reasons women said they were choosing to have an abortion was because of the cultural belief that if a breastfeeding woman becomes pregnant, this would spoil her breast milk. They concluded that participants feared the consequences of unwanted pregnancy more than they feared abortion.

The paper based on data from Lusaka, Zambia attempted to understand why unsafe abortion still happens in a context where abortion is legal under broad criteria. Using facility-based recruiting and record audit, two interviewers co-interviewed one respondent and filled out both a quantitative survey at the same time as the in-depth interview was occurring. The authors capture women's abortion experiences through trajectories and determined that the primary difference between women seeking out a safe procedure from a government facility versus women seeking out unsafe methods was knowing someone who either knew that the services were available or were able to procure the direct phone number of a doctor who would provide the service. Male involvement was instrumental in both reaching the decision to terminate as well as in procuring appointments and paying for treatment. Those women without someone to confide in, and who did not know that safe abortion was an option or

where to procure one, were more likely to try multiple (often escalating and unsafe) methods. In this context, abortion is highly stigmatized and the false perception that it is prohibited contributes to steering women towards clandestine methods.

The paper which reported on results from Matlab, Bangladesh, a Demographic Surveillance Survey (DSS) site, was able to identify a matched sample of women with unintended pregnancies: half had a termination and half carried the pregnancy to term. The authors found that those who terminated and those who did not were similar on contraceptive use and reasons for contraceptive nonuse. The author's findings point to a high level of incorrect use of pills and condoms. Women who terminated their unintended pregnancies were more knowledgeable about modern methods of termination and reported lower costs to treat complications and lower health risks compared to those who did not terminate their unintended pregnancies. Just as was found in the paper from Lusaka, Zambia, the importance of social networks also emerged in Matlab as a decisive predictor of whether women obtained an abortion: Women who terminated unintended pregnancies received more support from husbands, family members, and health workers as well as faced less familial/social consequences for termination compared to women who did not terminate their unintended pregnancies.

A paper on Ghana examined midwives' motivation to provide abortion for women with pregnancies of gestation 12 weeks or less in three regions of Ghana: Ashanti, Eastern and Greater Accra. Using Ipas-gathered records of service provision, they found that in spite of the program's rigorous selection procedure, support from Ghana Health Service and Ipas-Ghana, a number of trained midwives, especially in Ashanti and Eastern regions, take a long time to decide to provide comprehensive abortion care services. After 10 months, 88% of providers were providing abortion services. The authors found that religious affiliation, experience in the health profession and attendance at any workshop prior to Ipas training were positively related to provision of abortion services; however, monitoring support that providers receive after training is most important.

The paper summarizing qualitative results from Rabat and Dakar draws attention to the low status of women in both countries where women's value is still determined by their sexual purity and the social constraints that this imposes on women related to sexual behavior and unintended pregnancy. Rabat appeared to be more conservative than Dakar in terms of the social stigma directed at women for violating social expectations where families sometimes fiercely required or forbid abortion. In these contexts, sexual debut is called rape. Choosing abortion when faced with unplanned pregnancy depended on the woman's life cycle and on the stage of her relationship. These data highlighted the strong involvement of families in managing couple relationships and their fertility.

Both the Zanzibar, and the Dakar and Rabat papers grappled with whether the social problem is the unwanted pregnancy, and whether abortion is just a way to manage a social problem, meaning that the social problem is not the abortion per se. The Zanzibar paper found that "stigma against mistimed pregnancies can be worse than stigma against abortion" because abortion can be kept a secret but pregnancy cannot. The paper summarizing data from Dakar and Rabat found that the real issue is stigma related to the unintended pregnancy and that abortion resolves the issue of unintended pregnancy. The role of social networks in facilitating access to (safer) abortion was supported by results from Lusaka as well as Matlab.

Methodological Papers

The three papers in this session explored new approaches to data collection related to decision making. The first paper reported on a pilot test of a tool that explored whether providers can collect data to document abortion practices in countries with restrictive abortion laws. A 24-question survey was administered to 505 women requesting abortion or post-abortion care services at ten private sexual health clinics in two abortion restrictive settings. The survey was successfully carried out and providers were able to collect data relating to clients' own abortion attempts as well as the abortion attempts of their confidants. The data gives insights into the types of unsafe providers and methods that women are using to attempt to end a pregnancy. Even with a relatively small sample, our data reveal that in abortion-restricted settings women are still attempting to end their pregnancies, often through unsafe means. Authors concluded that in countries where abortion is restricted, private providers can be used to capture data on unsafe abortion practices.

The second paper developed an instrument to measure abortion stigma at the community level, examine its prevalence and understand how stigma relates to abortion public opinion, in Mexico. Authors conducted factor analysis to determine the multiple dimensions of community-level stigma. Support was found for five previously hypothesized dimensions of abortion stigma: silence, religion, autonomy, discrimination, and guilt/shame. Exploratory factor analysis was performed as a robustness check to determine the independence of these five dimensions, and revealed a strong co-dependence between discrimination and guilt/shame, resulting in a single dimension and a four-factor model of abortion stigma. The authors conclude that the measurement of community-level abortion stigma in Mexico could support the development of interventions to reduce abortion stigma and protect women from its consequences.

The third paper aims to provide a narrative-discursive analysis of abortion decision-making in Zimbabwe. It is at an early stage of data collection and reported on the theory, methods used and preliminary results based on 6 interviews collected at one site in Harare. The paper describes the theoretical framework of the study and shows how a Foucauldian postcolonial feminist approach can illuminate abortion decision-making in the context of Zimbabwe. The methods section discusses the narrative-discursive method.

International Seminar on

Decision-making regarding abortion—determinants and consequences

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Organized by the IUSSP Scientific Panel on Abortion Research,

- with technical and financial support from STEP UP (Strengthening Evidence for Programming on Unintended Pregnancy) Research Consortium, funded by UK aid from the UK Government

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Tentative Programme

Tuesday 3 June

8:30	**Registration**	
9:00 – 9:45	**Opening - Remarks, Welcome & Introduction**	M.E. Zuppan, Susheela Singh Harriet Birungi
	Logistics	Joyce Ombeva

Session 1: Abortion Decision Making – Access and Safety

Chair: Harriet Birungi
Discussant: Ndola Prata

10:00 – 10:20 *Women's experiences of induced abortion in settings with highly restrictive legislations in Mexico: old and new emerging abortion behaviour*
Fatima Juarez, Jose Luis Palma, Thoai D. Ngo, Isaac Maddow-Zimet, Akinrinola Bankole, Susheela Singh

10:20 – 10:40 *"At the end of the day it was my decision": Abortion decision-making among women in the Western Cape, South Africa*
Jaynia Anderson, Pamela Naidoo, Monique Hennink, Roger Rochat

10:40 – 11:00 *Factors that affect women's choices about when and whether to seek a safe and legal pregnancy termination: Results from post-abortion client exit interviews in Zambia*
Tamara Fetters, Stephen Mupeta, Bellington Vwallika, Cheryl Hendrickson

11:00 – 11:30 *Coffee break*

11:30 – 11:50 *Decision-making regarding abortion and abortion care-seeking in Zambia*
Ann Moore, Mardieh Dennis, Akinrinola Bankole, Henry Muloongo, Jessica Price

11:50 – 12:10	*To prevent or to abort pregnancy; whose decision matters? Contraceptive use and abortion decision making among sexually active women: A case of PPAG, Cape Coast, Ghana* Kobina Esia-Donkoh
12:10 – 12:30	Discussant: Ndola Prata
12:30 – 1:00	Open Discussion
1:00 – 2:30	*Lunch*

Session 2: Social and Economic Factors and Abortion

Chair: Susheela Singh
Discussant: Sabina Rashid

2:30 – 2:50	*Are menstrual regulation clients also at high risk of intimate partner violence? Evidence from Dhaka slums* Sigma Ainul, Irfan Hossain, Ashish Bajracharya, Sajeda Amin, Syeda Nazneen Jahan, Ruchira Tabassum Naved
2:50 – 3:10	*Moving beyond the known: How 'culture' shapes abortion decision-making* Sylvie Schuster, Mitchell Weiss, Corina Salis-Gross, Sibel Gezer-Dickschat, Ali Cöplü, Brigitte Frey-Tirri, Johannes Bitzer
3:10 – 3:40	*The association between the timing of abortions and births and socioeconomic position later in life in Finland* Heini Väisänen
3:40 – 4:00	*Abortions doubly unsafe for poor women in rural Pakistan* Iram Kamran, Kanwal Eshai
4:00 – 4:20	*Coffee break*
4:20 – 4:40	Discussant: Sabina Rashid
4:40 – 5:00	Open Discussion

Wednesday 4 June

Session 3: Adolescents and Abortion Decision Making

Chair: Ndola Prata
Discussant: Agnes Guillaume

9:00 – 9:20	*« Je n'étais pas prête ». Trajectoires décisionnelles dans le recours à l'avortement à Ouagadougou (Burkina Faso)* Ramatou Ouedraogo
9:20 – 9:40	*Socio-structural context of decision-making regarding induced abortion in Nigeria: University of Lagos students' example* Lekan Oyefara

9:40 – 10 :00 *De la grossesse non planifiée à l'avortement provoqué chez les adolescents et jeunes à Yaoundé : une analyse des motivations et des parcours pour l'avortement*

Alice Tchoumkeu, Firmin Zinvi, Charles Mouté, Gervais Beninguissé

10:00 – 10:15 Discussant: Agnes Guillaume

10:15 – 10:30 Open Discussion

10:30 – 11:00 *Coffee break*

Session 4. Misoprostol and Decision Making

Chair: Susheela Singh
Discussant: Fatima Juarez

11:00 – 11:20 *Feelings and decisions in voluntary interruption of pregnancy. The Argentine experience.*

Silvia Mario, Edith Pantelides

11:20 – 11:40 *Women who abort with misoprostol in Argentina. Itineraries in a restrictive legal context.*

Raquel Drovetta *(the paper will be briefly summarized by Fatima Juarez)*

11:40 – 12:00 *Harm reduced? Applying decision analysis to Argentina's safer abortion hotline*

Leigh Senderowicz

12:00 – 12:20 *Uruguayan women decide: legal and illegal abortions in the era of Misoprostol*

Martha Silva, Carine Thibaut, Camila Giugliani, Sandrine Simon, Soledad Díaz Pasten

12:20 – 12:40 Discussant: Fatima Juarez

12:40 – 1:00 Open Discussion

1:00 pm – 2:30 pm *Lunch*

Afternoon free. *(Optional visit of the animal orphanage or the game reserve at Sweet Waters ranch).*

Thursday 5 June

Session 5: Decision Making and Pregnancy Outcomes

Chair: Sabina Rashid
Discussant: Ann Moore

9:00 – 9:20 *Fears of unwanted pregnancy versus fears of unsafe abortion: A qualitative community-based study with women who terminated pregnancies in Zanzibar, Tanzania*

Alison Norris, Maryam Hemed, John Casterline

9:20 – 9:40 *Pregnancy termination trajectories in Zambia*

Ernestina Coast, Susan Murray

9:40 – 10:00 *Knowledge, attitudes and decision making process of pregnancy termination in Matlab, Bangladesh*

Abdur Razzaque, Julie DaVanzo, Mizanur Rahman, Shahabuddin Ahmed

10:00 – 10:20 *Factors affecting midwives' decision to provide abortion services after training*

Samuel Kojo Antobam, Marian Smith, Koma Jehu-Appiah, J.C. Mills, Selorme Azuma

10:20 – 10:50 *Coffee break*

10:50 – 11:10 *Decisions about unplanned pregnancies and abortion among women and men in Morocco and Senegal. Influence of norms, practices, and institutional contexts*

Agnès Adjamagbo, Agnès Guillaume, Pierrette Aguessy Kone, Fatima Bakass

11:10 – 11:30 Discussant: Ann Moore

11:30 – 12:00 Open Discussion

12:00 – 1:30 *Lunch*

Session 6: Methodological Papers

Chair: Susheela Singh
Discussant: Harriet Birungi

1:30 – 1:50 *Abortion practices in restricted settings: Can providers be the researchers?*

Kate Reiss, Sharmani Barnarda, Okkar Aung, Claude Ramiro Morales, Moe Moe Aung, Thoai D. Ngo

1:50 – 2:10 *Constructing a validated scale to measure community-level abortion stigma in Mexico*

Annik Sorhaindo, Tahilin S. Karver, Jonathan G. Karver, Claudia Diaz Olavarrieta *(the paper will be presented by Harriet Birungi)*

2:10 – 2:30 *A narrative-discursive analysis of abortion decision making in Zimbabwe*

Malvern Chiweshe, Catriona Macleod

2:30 – 2:50 Discussant: Harriet Birungi

2:50 – 3:10 Open Discussion

3:10 – 3:40 *Coffee break*

Session 7: Wrap Up: Next Steps and Closing

Chair: Agnes Guillaume

3:40 – 4:00 *Summary of themes and key points from papers presented*

Francis Obare

4:00 – 4:30 *Options for output from seminar and next steps*

Susheela Singh, Fatima Juarez (IUSSP Liaison), Open Discussion (all participants)

4:30 – 4:45 *Closing*

Mary Ellen Zuppan (Executive Director of IUSSP)

International Seminar on

Decision-making regarding abortion—determinants and consequences

Nanyuki, Kenya, 3-5 June 2014

Organized by the IUSSP Scientific Panel on Abortion Research

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*(*Unable to attend)*