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Managing Unplanned Pregnancies in Five Countries: Perspectives on Contraception and Abortion Decisions

The Contraception and Abortion Study Team*

Abstract

Why is induced abortion common in environments when modern contraception is readily available? This study analyzes qualitative data collected from focus group discussions and in-depth interviews with women and men from low income areas in five countries -- the U.S., Nigeria, Pakistan, Peru and Mexico -- to better understand how couples manage their pregnancy risk. Across all settings, women and men rarely weigh the advantages and disadvantages of contraception and abortion before beginning a sexual relationship or engaging in sexual intercourse. Contraception is viewed independently of abortion, and the two are linked only when the former is invoked as a preferred means to avoiding repeat abortion. Contraceptive methods are viewed as suspect because of perceived side effects, while abortion experience, often at significant personal risk, raised the specter of social stigma and motivation for better contraceptive practice. In all settings, male partners figure importantly in pregnancy decisions and management. Although there are inherent limitations from small sample sizes, the study narratives reveal psychosocial barriers to effective contraceptive use and identify nodal points in pregnancy decision-making that can inform and structure future investigation.

Keywords

pregnancy; unplanned; contraception; induced abortion; contraceptive behavior; couples

Introduction

Why is induced abortion common in environments in which modern contraception is readily available? In 1995, globally there were an estimated 210 million recognized pregnancies (Alan Guttmacher Institute, 1999), of which more than one fifth (46 million) were terminated voluntarily. Little changed over the next decade: preliminary estimates for 2008 (unpublished) show that the total number of pregnancies is about XXX million and the number of induced abortions has declined very slightly to 42 million (Sedgh et. al., 2007a). And yet nearly all women and men have heard of contraception and, with three-fifths of married women of reproductive age currently using, an even higher percentage have lifetime contraceptive experience. Public sponsorship of contraceptive access is the norm: 144 out of

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195 national governments (74%) have policies that directly support contraceptive access (United Nations, 2008). Access has grown in developing countries, with 86% of 146 governments now providing direct support as compared to 64% in 1976. It is also the case that seventy countries containing 60% of the world's population permit abortion under broad criteria; the majority of these countries are in Europe, Central Asia and North America and relatively few in developing regions.¹ And while abortion is still highly restricted legally in most of Latin America, sub-Saharan Africa, the Middle East and North Africa, and in many countries of South and Southeast Asia, since 1998 the legal grounds for abortion have substantially expanded in sixteen countries while narrowing in only three countries (Boland and Katzive, 2008).

Across countries, contrasts in levels of contraceptive and abortion practice are striking. In the U.S., Russia, and China, contraceptive use is high -- 73, 65 and 90 per 100 married women of reproductive age respectively (United Nations, 2008) -- and the induced abortion rate per 1000 women of the same age (married or unmarried) is also relatively high -- 21, 45 and 23 respectively (Sedgh *et al.*, 2007b).² In other parts of the world, induced abortion rates are high, averaging 29–30 per 1000 in the regions of Africa and South and Southeast Asia, (Sedgh *et al.*, 2007a) but contraceptive use levels are low to moderate, 28% and 54–59% respectively (United Nations, 2008). These contrasting patterns of contraceptive use and induced abortion prompt a set of inter-related questions. Do women and men weigh the costs and benefits of contraception vs. abortion when they want to avoid pregnancy? If so, which factors are weighted most heavily? What is the influence of the perceived views of other persons – especially the partner, but others (family, peers) as well? How does experience with one practice affect attitudes towards the other practice? These questions concern fundamentals of pregnancy management and reproductive choice that are germane to couples across diverse societal and resource settings.

It is surprising, given the demographic and programmatic significance of induced abortion, that the research literature contains few probing investigations of the juxtaposition of contraception and abortion in the minds of those exposed to pregnancy risk. Luker's very revealing *Taking Chances* (1975) was published over thirty years ago. What is abundantly clear from the existing literature is that in most settings women and men hold conflicting attitudes about both induced abortion and contraception. Social and personal ambivalence about abortion practices are strongly contextualized by definitions of what responsible sexual and reproductive behavior entails and are often shaped by gender roles. It may be that in higher-resourced settings, the relative influence of social mores is greater compared to the exigencies of economic and health survival in low resource settings. Yet, there are large disparities in levels of unplanned pregnancy and abortion in higher-resourced settings, with low income women having much higher rates than higher-income women (Finer and Henshaw, 2006). In all settings, some women decide to have an abortion for reasons related to economic stress, education, and other domains, but doing so may be in conflict with their

¹Developing countries that permit abortion under the broadest criteria (without restriction as to reason) are: Cambodia, China, Cuba, Democratic People's Republic of Korea, Guyana, Mongolia, Nepal, Singapore, Tunisia, Turkey, South Africa, Vietnam. A few other countries permit abortion on socio-economic grounds: Barbados, Belize, St Vincent & Grenadines, Fiji, India, and Zambia.

²For China, 23 per 1000 women is the rate published by the government; the true rate is almost certainly higher.

personal beliefs and expectations, leading to internalized dissonance. Attitudes towards contraception may in general be less conflicted but are not without ambiguities and tensions. The acceptability of contraception is high -- higher than for induced abortion -- but is not universal. Misinformation, misconceptions and rumor confound women's and men's decisions to use one or another method of birth control. Public faces and private realities of managing pregnancy risk often contradict each other.

Despite the technological promise of perfect contraception, it is safe to assume that for the foreseeable future substantial fractions of couples will place themselves at risk of unplanned and mistimed pregnancies, and that these pregnancies will occur at a rate that generates meaningful economic and health costs, at both the individual and societal level. Gaining an understanding of the cognitive and interpersonal elements relevant to pre- and post-conceptional decisions made by women and men around the world is important. An underlying premise is that interventions intended to respond to and reduce unwanted pregnancy can be designed more effectively if guided by a sounder understanding of women's and men's perceptions of fertility regulation.

Accordingly, our goal in this study was to explore in depth individuals' perceptions of their pregnancy management options -- their risk of pregnancy, and the available pregnancy prevention options and their respective costs. More specifically, the questions addressed are:

- Whether contraception and abortion are perceived as options in preventing unintended pregnancies? How do women and men view the choice between contraception as proactive prevention as contrasted to induced abortion as reactive management?
- If so, what is the calculus of choice? What is the basis for this decision, which factors constrain the decision?
- How do the perspectives of women and men differ? What are the respective roles of the two partners in the decision-making process?

Study Design and Methods

The study was conducted by the Contraception and Abortion Study Team (CAST), comprised of researchers from five countries -- Mexico, Nigeria, Pakistan, Peru, and the U.S. The five countries fall in four major regions and encompass a wide range of fertility, contraceptive and abortion levels in varying situations of economic well being, service access, and legal status of abortion. Table 1 provides an overview of key demographic, reproductive health, social and economic indicators for each country. In the U.S., with an abortion rate of 21 per 1000 women of reproductive age and where about 40% of births are unplanned, an estimated 49% of all pregnancies are unintended - that is, the outcome is either an unplanned birth or an abortion (Finer and Henshaw, 2006). In Pakistan, a 2002 national study estimated that the abortion rate was 29 per 1000, and 37% of all pregnancies were unwanted (Sathar *et al.*, 2007). In Mexico, the abortion rate is estimated as 33 per 1000 women age 15-44 in 2006, an increase of 33% since 1990 when the rate was 25 (Juarez *et al.*, 2008). Estimates of the abortion rate in Peru and Nigeria are available only for the 1990s but indicate that abortion (and by implication unplanned pregnancy) is common: in Nigeria,

the abortion rate was 25 per 1000 in 1996 (Henshaw *et al.*, 1998), and markedly higher in Peru at 52 per 1000 in 1998 (Ferrando, 2001). There are intriguing contrasts given the goals of this study. For example, comparing Pakistan and Peru, contraceptive prevalence is far higher in Peru (71% vs. 30% in Pakistan) but the percentage of recent births that were unintended (unwanted or mistimed) is substantially higher in Peru (56%, as against 25% in Pakistan) as is the induced abortion rate (52 per 1000 women, as against 29 per 1000 women in Pakistan) (Sathar *et al.*, 2007; Ferrando, 2001). One might expect higher contraceptive prevalence to be associated with a lower rate of unintended birth, and also a higher induced abortion rate to be associated with a lower rate of unintended birth. In all five countries, contraceptives are accessible from government and private sources. The U.S. has the least restrictive access to abortion, whereas the practice is illegal in the other four study countries, although permitted on different grounds and with varying access to safe clandestine services. As is apparent, the five countries represent very different contexts and therefore enable a comprehensive and in-depth investigation of contraception and abortion decision-making.

The empirical data consist of interviews with women and men in Mexico City, Mexico; Ile-Ife and Ilesa, Nigeria; Tret, rural Punjab, Pakistan; metropolitan Lima, Peru; and New York City, U.S. To increase the likelihood of capturing unplanned pregnancy experiences, the study participants were drawn from low-income communities. (In the U.S. study, middle-income women were also interviewed.)

After concluding that the existing research literature is deficient in its evidence on women's and men's perceptions of their pregnancy management options and resulting decision-making processes, the study team decided to conduct a qualitative investigation. Focus group discussions [FGD] and semi-structured in-depth interviews [IDI] were used to explore the following abortion-related topics: awareness and beliefs about abortion (personal and community level); social norms about abortion; and factors influencing decision-making about abortion. In addition, the FGDs and IDIs also explored issues related to contraceptive use, including: attitudes about methods; cost of methods; roles of males and females in contraceptive decision-making; "contraceptive sabotage"; and knowledge about pregnancy risk. Using common interview guides, each study site investigator conducted at least 17 in-depth interviews with women (10) and men (7) and up to four focus group discussions (typically two with each sex).

All five study teams used common focus group and interview guides to ensure that similar topics were covered at all sites. Although the IDIs were semi-structured, interviews were conducted in a 'freestyle' manner so as to permit participants to share freely without restriction or unnatural re-direction of the conversation. The interview guides suggested an ordering of questions but interviewers were instructed to let the interview flow naturally instead of re-directing questions to follow the interview guide. Interviewers were trained to probe on key topics, and to encourage participants to tell their personal stories in their own voice.

A total of 15 FGDs and 96 IDIs were conducted in the period April – December 2006. The recruitment of study participants was conducted by collaborating organizations in each of the five countries, with recruitment strategies differing by site (Table 2). In Mexico,

participants were recruited from a local family planning organization and a technical school. In Nigeria, participants were recruited from the local university and surrounding community, as well as from a public hospital that provides post-abortion care. Pakistan recruited its participants directly from the general population of the selected community, and Peru's participants were recruited from a public hospital, a private family planning service and from the general Lima population. The participants in New York City were recruited at abortion clinics and through a professional recruitment agency. Informed consent was obtained from all participants for the FGDs and IDIs, and this research was approved by the Institutional Review Boards affiliated with each partner organization.

Purposive sampling was used to select women and men of reproductive age, with or without abortion experience. Nigeria and Pakistan also selected individuals based on their marital status. The demographic characteristics of IDI participants are presented in Table 3. The mean age of IDI participants across the sites ranged from 25–35 years of age for females and 29–40 years of age for males. The IDI participants were fairly evenly distributed between married and unmarried individuals except in Pakistan where all participants were married. The average number of pregnancies ranged from about 2 in Nigeria to 8 in Pakistan, and women reported an average of between 1–6 live births across the different sites. Between 50–83% of participants had experience with abortion, reflecting the fact that some country teams recruited women from post-abortion care facilities or from abortion clinics. Some participants were recruited based on their abortion history but others (e.g. in Pakistan) provided abortion histories during the interview process.

Interview and discussion transcripts were thematically analyzed within each country setting. All FGDs and IDIs were audio-recorded; a note-taker was also present during the FGD sessions. If an IDI participant did not want to be recorded (which occurred only once), the interviewer took notes and wrote up notes from the interview immediately following its termination. The audio recordings of all IDIs and FGDs were transcribed verbatim using standard transcription techniques. Prior to sharing data with collaborating organizations, all transcripts were de-identified. Each site was responsible for maintaining participant confidentiality by keeping all informed consent documents, audio recordings and transcripts under lock-and-key. Any documents shared electronically were completely void of any identifying characteristics that could link the transcript back to the original participant. The research activities in the United States were carried out in English. Mexico and Peru conducted their FGDs and IDIs in Spanish, and these Spanish language transcripts were not translated into English. The Nigerian FGDs and IDIs were conducted in both English and Yoruba and the Yoruba transcripts were later translated into English. The Pakistan interviews were conducted in Potohari (a local dialect of Punjabi), and then the transcripts were translated into English.

Findings

Six main themes relating to contraceptive and abortion decision-making emerged from the FGDs and IDIs. The findings for each theme are summarized below.³ These results are based on reviewing and synthesizing key findings from reports written for each study

country. Excerpted statements by participants are generally those cited in the reports but some have been extracted from the transcripts.

1. Reproductive planning is largely non-existent

Especially in the IDIs, but also in the FGDs, there is a great deal of discussion that is revealing of the reproductive decision-making process. Some of this discussion is in response to direct questioning on this subject, and some of it is incidental to the discussion of other subjects. What is most impressive about the picture that emerges is the unplanned character of reproductive careers. Most individuals seem to be proceeding essentially from one month to the next, with little in the way of mid-term plans (e.g. 1–2 year time-horizon) and very vague long-term plans. This generalization applies least well to the U.S. transcripts, but even here the glimpses of deliberate planning are embedded in a more pervasive pattern of minimal planning:

I just spoke to her in bed one time it was like, want to have kids? She said yes, I said yes. And it just started happening from there, you know... so I guess it was a decision made. [US FGD M]

You don't decide when you want the kids, when you got the babies and they're coming along, it is something that happens then really you say I am planning a kid. [US FGD M]

In the FGD among middle-income women, respondents said that half of women plan their pregnancies while the other half get pregnant unexpectedly. The respondents in the other US focus groups predominantly said that pregnancies are not planned.

I think more often it's unplanned, whether you're married or unmarried. I don't think people plan for pregnancy and, I don't know, I just don't think they do that much anymore. [US FGD F]

So I think it's half and half. Half the people plan them, half the people have them. [US FGD F]

As the story unfolds in the U.S. transcripts, planning is not only a function of social class but also of relationship status and financial/employment circumstances -- those in secure relationships are more willing to place themselves at risk, and those with more to lose economically (because they are poor, because they are invested in education or a career) appear to be less likely to place themselves at risk. Even with these qualifiers, the modal pattern is an unplanned reproductive career and frequent risk-taking.

The lack of deliberate planning is even more the norm in the other countries. In Peru:

It wasn't within my plans... [PE FGD F]

We hadn't planned for it all and suddenly I got pregnant... [PE FGD F]

I already have a child, it wasn't planned either. [PE FGD F]

³The following abbreviations are used: PK=Pakistan; PE=Peru; US=United States; NG=Nigeria; and MX=Mexico. FGD and IDI indicate comments come from focus group discussions and in-depth interviews, respectively. M (male) or F (female) indicates the participant's sex.

For me, neither of my two pregnancies was planned. [PE FGD F]

In Pakistan, it is clear that couples in Tret had not planned their fertility from the outset, i.e. they had not planned in advance the number of children they wanted, when they wanted them, or what actions they might take to achieve their reproductive goals.

We never planned and never even discussed (reproductive goals) with each other.
[PK IDI F]

(We) never planned the next child. [PK IDI F]

In all five study countries, however, there is recognition that couples can have some influence on whether or not pregnancies occur: there is a high level of awareness of contraceptive methods, as well as a belief that they can be efficacious. Yet conception is commonly described as beyond the control of the woman or the couple. Study participants with abortion experiences speak of engaging in sex without much forethought to preventing pregnancy, either believing themselves not likely to be at risk, not wanting to address the risk of conception, or not knowing how. Especially in Nigeria and Pakistan, conception is attributed to divine intervention (with the same notion also expressed but less intensely in Peru and the U.S.), i.e., pregnancy is a gift of God and therefore to be welcomed, or at least it is God's will and therefore to be dutifully accepted.

I was disturbed at first because I wasn't prepared for it. I wasn't prepared for a pregnancy. I didn't want it that early. So I wasn't initially too happy but along the line, I got to accept it. It was a gift from God ... I ran to God and he encouraged me. He gave me reasons why I should accept the pregnancy. It was his gift and it was the time for me to be pregnant. [NG FGD F]

A further factor that conditions respondents' views as to whether their reproductive career can be planned is the fact of contraceptive failure, as known from personal experience or the experience of others. This observation is made in all five countries and especially in Peru and Pakistan.

The picture that emerges is of individuals/couples who are an enormous distance from achieving a fully planned reproductive career, i.e., a career that is visualized in its entirety and in which a relatively small number of pregnancies -- usually between two to five -- are strategically placed during the 25+ years of risk of pregnancy. Rather, women and men are coping as best they can from one month to the next. This is one of the strongest impressions to emerge from the interviews -- the struggle to get from one month to the next in most matters, including reproductive matters. But this month-to-month coping does include strongly-held views on the part of most respondents about whether it is desirable to become pregnant any time soon. As abundantly revealed by the transcripts from all five countries, these views about the desirability of pregnancy are in turn a function of health situations (of the woman and young children), financial situation, and relationship factors.

The high level of knowledge about contraception would seem to provide a basis for reproductive careers in which unwanted pregnancies are rare. In such a situation, the practice of contraception would need to have an almost taken-for-granted, non-thinking quality about it to ensure that month-by-month use is feasible, with minimal strain and

without much in the way of deliberate decision-making. Month-by-month use would not be so much in the service of a long-term planned reproductive career but rather a solution to current problems (i.e. avoiding pregnancy and its accompanying risks – relationship, health, economic, etc.). Relatively easy practice of contraception would be a prerequisite for such a reproductive process; this in turn would require that the cost of contraception be low along all important dimensions – both direct costs and "opportunity" costs. This would be a contraceptive regime quite different from what is revealed in these transcripts. Even in the U.S. transcripts, contraceptives were perceived to have many negative attributes (see Theme #3). Judging from the FGDs and IDIs, however, it would be easier for women and men to transition to a contraceptive regime involving minimal effort and cost, such as just described, than to a fully planned reproductive career.

2. Contraception or induced abortion? Not a matter of choice

Researchers (especially demographers) often view contraception and induced abortion as alternative choices for preventing unplanned births. But there is relatively little evidence in these transcripts that men and women think in these dichotomous terms. Instead, the decision-tree is first whether to practice contraception or not; once pregnant with an unwanted pregnancy, the decision tree progresses to whether to resort to induced abortion or not.

The U.S. transcripts are clear on this point--abortion is described in general as an option of last resort to be availed of when an accidental pregnancy occurs. The consensus in the FGDs is that relying on abortion instead of contraception is not an overt decision; rather it is by default that some couples resort to induced abortion after failing to locate or adopt an acceptable and effective contraceptive option. Women chose to avail themselves of abortion as a method of last resort. Relying on abortion as a method of birth control is widely seen as incomprehensible. This same view is articulated in Peru, where the majority thinks that women (possibly with support from male partners) turn to abortion not because it is preferred to contraception but as an *a posteriori* decision when an unwanted pregnancy occurs (due to irresponsibility, lack of information about consequences, or other reasons such as contraceptive failure). The Pakistan respondents also draw a distinction between induced abortion as a "backup" (i.e. to contraception) and an "alternative", with the former perceived as the dominant phenomenon.

Indeed, one of the objectives of this study was to learn whether, from the respondents' points of view, induced abortion is used deliberately as an alternative to contraception for fertility regulation or as backup for contraception. We only gain a glimpse of this attitude in the discussions with men in the U.S., some of whom posit that abortion availability influences couples' willingness to be lax about contraception and are more supportive of repeat abortion.

And then you just say ok we just go with the flow you know and if it happens it happens. And some people actually say, say to themselves, you know, when it happens I'll just get an abortion. It could probably be used as some form of birth control. I mean it's bad but it's true they do. [US FGD M]

Among U.S. women and in the other four settings, knowing that the option of induced abortion exists seems to play a very small role in generating unwanted pregnancies. Rather, unwanted pregnancies occur because of non-rational contraceptive practices, a lack of viable contraceptive options, contraceptive sabotage, and perceived harm caused by using contraception. To this one might add, drawing from the Nigerian and Pakistan transcripts, method failure (especially condoms in Nigeria) and poor understanding about when the woman might conceive. The transcripts from all five countries provide vivid portraits of why contraception is not used, or not used effectively, by women, men and couples who want to avoid pregnancy. But in all this discussion, there is virtually no mention that induced abortion as an alternative means of birth control provides a disincentive to use contraception.

Furthermore, in all countries respondents were asked directly about the relative desirability of contraception and induced abortion as means of birth control. Consistently and overwhelmingly, contraception is preferred when the choice is framed in these terms. The reasons are manifold. Perhaps most profoundly, induced abortion raises ethical concerns; this emerged most strongly from the interviews in Nigeria, Pakistan, and Mexico, where it is explicitly viewed by almost all respondents as against religious norms. Ethical misgivings are also expressed in Peru and the U.S. Accompanying induced abortion's questionable moral standing is social unacceptability. Induced abortion is also evaluated as more damaging (potentially) to the woman's health than contraceptive practice. This latter view coexists, however, with clear perceptions on the part of most respondents that many methods of contraception themselves have detrimental health effects (this is further explored in Theme #3). Finally, induced abortion is recognized as costlier financially than contraception, although the picture is more mixed in this respect: in Pakistan, induced abortion is regarded as both far costlier and more difficult to access than contraception; in Peru, the range of financial costs of abortion offered by respondents does appear, at its lower end at least, to be burdensome, and moreover induced abortion is viewed as easy to access; in Nigeria, induced abortion services are relatively easy to locate, especially in cities, but they are perceived as expensive as compared to contraception.

In short, the dominant picture that emerges from these transcripts is that decisions about contraception and decisions about induced abortion are largely separate. Induced abortion is not viewed as a direct alternative to contraception. There are separate social constructions of these modalities of fertility management, as well as separate social constructions of pre- and post-conception decisions.

3. Contraceptive methods are negatively viewed

In all study settings, contraceptive methods were discussed largely in negative terms. The attributes that were disliked and cited regularly are entirely familiar and include: health side effects of hormonal methods, IUDs and sterilization, particularly fear of infertility and weight gain; condom's inconvenience, detraction from intimacy, and risk of breakage; and the high failure rates of periodic abstinence (rhythm) and withdrawal.

The transcripts contain extensive and vivid discussion of this topic. A few excerpts are given below:

... I did family planning. I was taking the injectables (Noristerat) and it was three monthly. I was taking that and along the line I realized that I was adding weight, so I had to stop because the weight was becoming embarrassing and I had to stop. [NG IDI F]

Then someone advised me to take the injection. I took the one for three months. During those three months, I didn't enjoy myself and my menses became irregular and was not flowing well. So I stopped. [NG FGD F]

She tried to do proper family planning. Sometimes I used condom, but she was not feeling okay when I use condom. [NG FGD M]

You can use a condom and even so you get pregnant. [PE FGD F]

... when she got out of the hospital, they gave her an injection and she started getting bloated. PE FGD M]

They alter the organism, they produce headaches, ah, they can also produce hemorrhage. Some make you gain weight. [PE FGD F]

There was one of our relatives. She was very beautiful and young. She got an IUD insertion and after that she started swelling up and then she died. It became difficult to lift up her dead body. I don't know if her ring moved to her heart or somewhere else in her body. [PK IDI F]

My husband does not want more children but he says that sterilization can be harmful for health and the other thing is, we heard that one of the children dies if a woman gets herself sterilized. It has happened here with two women. [PK IDI F]

Although I became pregnant twice again due to condom rupture, but I am still using this method because my body is already swollen and the IUD can harm me more; injectables and pills do not suit me and my husband does not allow sterilization. [PK IDI F]

When viewed more benignly, contraceptive methods were discussed in terms of their free or low cost and accessibility:

... We have it everywhere now and it's free, even at [hospital name]." [NG FGD F]

It is very easy in this area because we have chemist shops everywhere and condom is very affordable. It is about N30 [22 US cents] only. [NG FGD M]

Now family planning is provided free of cost. A woman goes to the FP center where they charge just 20 rupees for IUD insertion. Pills are delivered free at our doorstep. Injectables and condoms are provided free. Now there are many facilities, every method is being provided free of cost. [PK IDI F]

When couples reach their desired family size, not all of them limit their fertility by using contraceptives; this is particularly the case in Pakistan, even when women have a large number of births. Women express fear of side effects; and while many are clearly in favor of using contraceptive methods to achieve their reproductive goals, they also continue to claim that effective contraceptive methods are not available in their community. Even in the US

setting, where it might be assumed that women have access to a greater variety of methods and a higher level of health services, enabling them to select a method optimal for their individual situation, issues of access and fear of side effects were frequently mentioned. While women spoke about these issues at great length, men likewise mentioned the challenges they encountered in finding an acceptable contraceptive.

The shot? Well, I am scared of that because after my last kid I started shedding. Like I had a lot of hair and a lot of my hair started falling out. I mean, to this day I am like crying all the time like, "No, no please!" and I have heard that when you get the shot, a lot of your hair falls out. [US FGD F]

The pill just made me depressed and it made me want to eat, I tried like 10 brands and it was all the same. [US FGD F]

Oh the condom is not good. I mean it's good because it's the easiest, probably, one of the easiest but you just, it's not as good. [US FGD M]

There was widespread distrust and dissatisfaction with contraceptive methods based on personal experience as well as what respondents have heard from their friends and mothers. While we know from other empirical evidence that many persons do not experience significant side effects, mothers and friends impart advice based on the assumption that if they have experienced certain side effects from use of a contraceptive method, or they have heard such side effects can occur, then others will experience the same.

The perceived attributes that discourage contraceptive use vary according to contraceptive method, by gender, and among countries; while most attributes are cited in most settings, their relative importance varies. What is striking is how the dislike of contraceptive methods so often over-rides the desire to avoid pregnancy. This desire may be grounded in fundamental and strong concerns about health (of the woman or young children) and/or about the family economic situation. One might expect that cost-benefit calculus would result in these considerations winning out over the negative perceptions of specific contraceptive methods. Clearly this is frequently the case; many couples are successfully practicing contraception. Yet what the transcripts from all settings reveal is that men and women often place themselves at risk of an unwanted pregnancy precisely because, on a month-by-month basis, they prefer not to cope with the various negative attributes – at least as perceived -- of contraception. Concerns with rather immediate health effects, inconvenience or interference with intimacy, and/or financial costs drive the decision about whether or not to use contraception. (Note that some of the feared effects are also longer-term, such as health side effects or death of a child as punishment for becoming sterilized). The transcripts repeatedly reveal this logic, which clearly is an important factor in the decision-making process with respect to contraceptive use. The widespread prevalence of these negative perceptions of contraceptive methods helps explain why unwanted pregnancies are so common.

Episodes of partner absence were mentioned with some frequency, suggesting that women perceived their need for contraception to be intermittent rather than prolonged. As mentioned earlier, negative perceptions of contraceptive methods, whether out of concern for impaired fecundity, weight gain, dizziness or other health effects, also contributed to

non-use of contraception. Both couples who experienced an unplanned pregnancy in the absence of contraceptive use and those whose accidental pregnancy was due to method failure tended to rely on ineffective methods, such as rhythm, condoms, withdrawal, or a combination of these. Some respondents were not in stable relationships and as such, sex and protected sex were not planned.

Most women, it's to please the man and they will say "oh, because that man doesn't want me to use the condom, and oh, I like him, so it's okay." And then when you get pregnant and you know that he is not going to do anything, now you're running to the clinic. [US FGD F]

...I did not have much understanding about these issues before that is why I had so many. Then I opted for an induced abortion and prayed to God for forgiveness for the sin, which I had committed. [PK IDI F]

...after he [the abortion provider] told me it was pregnancy, I knew my partner would deny being responsible and I couldn't imagine going about with a protruding tummy for which no one would accept responsibility...and I couldn't tell the guy that he was responsible because he would say we never had sex. [NG IDI F]

4. Male partners and pregnancy management

With few exceptions (e.g., Rossier 2007; Naziri 2007), male partners' perceptions and involvement in pregnancy management—whether deciding on measures to prevent or resolve an unwanted pregnancy—have been understudied. The men in this study discussed their roles as fathers deciding whether to have another child, as a sexual partner sharing pregnancy risk, and as a husband participating in decisions about contraceptive protection and obtaining an abortion.

Male partners are often the first persons to become aware of women's unplanned pregnancies. Their willingness or motivation to exercise paternity rights varies across the settings. In Peru and Nigeria, men draw on their authority as household heads to make reproductive and contraceptive decisions:

The head of the relationship has the final word, right? And the person who holds the reins of the relationship is not only the person who decides the issue of family planning but also the one who decides everything, you know, money and all of that. [PE FGD M]

...I told her the pregnancy wouldn't disturb her education, that the most important thing is for her to pull herself together and face her studies, that she can still cope with the pregnancy...She cooperated just like that. I had told her earlier that at least if she conceives, since I am working I can be able to take care of that. [NG IDI M]

Peruvian men also cite recently established paternity laws impacting their autonomy.

With the new laws that exist, because if you don't want to sign for it, they're going to order you to give a DNA sample. If you don't want to do it, they send you three (judicial) citations. If you don't go, they automatically give him/her (the child) your last name, as if you had signed. [PE FGD M]

In contrast, US men acknowledge women's authority over pregnancy decisions, even if they resist accepting this reality.

Ultimately it's their body. They make the decision. "I don't care," she be like, "Well I don't care what you say, I'm having this child." You have no choice but to sit there and see and take what she just said. [US FGD M]

Most, the majority of the time, when they ask you, before they would even tell you anything, they've already made up their minds what they're really going to do. They just want to bouncing off you're going say, how you respond to it. [US FGD M]

Establishing a future wife's fecundity also factors into some men's commitment toward their partner:

...But at least it's one of those things that I had desired, that before I could eventually marry a person, that at least she must be pregnant for me because I don't want to have problems. You know, sometimes when people marry, they stay for a long time without any pregnancy. So I didn't want to get myself in that situation. [NG IDI M]

Men generally report couple agreement about which method to use, including the timing and switching of methods.

...I reached an agreement with my wife and everything is okay. She uses protection now and we don't have any risk. [PE FGD M]

However, there are also reports of discordance over methods and the consequences. One Latina in the US reports being dissuaded from having a contraceptive sterilization but then subsequently becoming pregnant and having to obtain an abortion. Communication sometimes revealed mistaken assumptions regarding whether the female was using birth control and the need to resort to emergency contraception. Men who used condoms describe themselves not only as active partners in ensuring their female partners are protected from unplanned pregnancy but also frustrated users due to breakage, slippage, lack of intimacy and high cost.

The first condom that we used came out breaking ... The second...I took out the air and put it on the normal way and right, and at the moment we had sex, the condom ended up coming out... and I, without realizing it, ejaculated inside...Then I couldn't do anything...impossible...we thought about the morning after pill, but nothing...because she didn't think she was pregnant. [PE IDI M]

Yes, we took some steps. She tried to do proper family planning. Sometimes I used condom, but she was not feeling okay when I use condom. [NG IDI M]

I think what you mean is it spoils the mood. If you had to reach across the table or to the bed or into your pocket to get a condom, and you're already about to, that just, it just spoils the mood. [US FGD M]

Well, its either you pay \$20 for the pack of condoms or, like, you know you pay for a kid. I don't know the cost to support the kid but I know it's not cheap, you know. [US FGD M]

One Pakistani husband reports that he began using condoms after the seventh pregnancy, but a condom rupture resulted in an eighth pregnancy which was then terminated. In spite of the rupture experience, there are no other acceptable options but to continue using condoms.

The IDIs with men (and women as well) also reveal men's awareness of their partners' menstrual cycles, especially since the rhythm method is frequently used. In Nigeria, Peru and Pakistan the transcripts confirm the use of menstrual markers of pregnancy and safe days for sex.

On his part, I think he is more experienced so he knows when I have just completed my menstrual period; he was the one taking the prevention. [NG IDI F]

He was the person that took care of me. He was the one that was in control and well, he wanted to have a child and that's why we were together [had sex] and I didn't even know but he knew. He told me that he knew I was pregnant because he kept track and since he was already 30 years old and wanted to have a child. [PE IDI F]

At the same time, many unplanned pregnancies result from misconceptions about the safe period and its reliability.

My youngest son was breast feeding when my wife's menstruation stopped. We thought that she could not get pregnant but she did. [PK IDI M]

The transcripts contain reported instances of *contraceptive sabotage*. Contraceptive sabotage occurs when one partner intentionally thwarts the other partner's contraceptive intentions. While this behavior is more frequently mentioned in the U.S. interviews, it is also occasionally reported in other settings. Males believe women sabotage contraception to become pregnant when the man is unprepared, or to ensnare him in a long-term relationship. Females report men sometimes reverse their intent to withdraw prior to ejaculation in order to impregnate them.

And I am like, "I am pregnant, I know, I know you did it." And, wow, three days later I took a test at home, I knew I was pregnant and then he told me, he confessed, "I did it, sweetie, but it is because I love you and I want to spend the rest of my life with you." And I was furious, because I was not ready and I really was not at all, like I said, not even now, and for him to do that to just go against my word and not respecting my wish, it was like a big betrayal, to mean, like "How could you do that to me?" [US FGD F]

Yes, my sister. He said he had a condom on and he didn't ... He said he had a condom on and I guess she didn't look ... and she actually got pregnant that time. [US FGD F]

...I remember, we were having sex and she said to me, "No, no, just like that, don't worry, I can't get pregnant." And I said to her, "(Are you) sure?" ... and I ejaculated inside, right?...That's why she got pregnant. [PE IDI M]

There are also reports of *abortion sabotage* when one partner thwarted the other's intention to terminate the pregnancy:

He said he would not like to abort the baby here but at his hometown. So, he took me to his hometown where his grandmother lived. ... They both tried to persuade me against the abortion and eventually I had the baby. [NG IDI F]

She says that my son is all alone and by having another son, he could have a companion. Although I don't have any such desire, my wife's desire dominates. [PK IDI M]

Men's emotional, material and financial support for their female partners' abortions is frequently cited.

Well if they agree, if they got the abortion, yeah, you should pay and then after that, it is very clear that they are not going to be together no more. [US FGD M]

...I went to a doctor and that doctor said okay, fine, if she's pregnant and she injects her, that she (the girlfriend) is going to flush out (the pregnancy) through her urine, that if she's not pregnant that nothing will happen to her. ... The option I took actually was the pills. I got a pill "ganichosid7" that was the pill I got and she used the pill. [NG IDI M]

Yes, in my circle I've heard people talk about it that way "that I got a woman pregnant but I have to get money, 200, 300 soles to get her an abortion. 200, 300, it depends on what month she's in, if it's the first month, 300 soles, if she's in month 6, it costs more. [PE FGD M]

In all settings, it is clear that husbands/partners play a key role in managing pregnancy in terms of sexual risk, fertility intentions, contraceptive protection, and determining the pregnancy outcome. But our knowledge of the factors bearing on their involvement remains limited; more research is warranted on couple perspectives and concordance on sexual and reproductive behaviors, and how relationship factors influence the calculus of each partner's decisions and choices.

5. Abortion stigma: collective and personal dimensions

Very limited measurement of the impact of social stigma of abortion is available worldwide. Yet abortion stigma is probably the single most important factor preventing personal disclosure and thus accurate measurement of abortion behavior even in settings where the procedure is legal. The modal design for abortion studies tends to be clinic-based (e.g., Oliveras *et al.*, 2008; Adanu *et al.*, 2005).

More than for any other theme, the contrasts in group versus individual commentary distinguish social norms from individual decision-making. The transcripts reveal that private choices to terminate pregnancy tend to prevail despite social sanctions against abortion. The significance of religious beliefs, parental norms and peer expectations are evident in the

FGDs, while the anxiety and desperation to resolve an unplanned or unwanted pregnancy and the complexity of personal interactions with partners, abortion care providers, and friends or relatives in whom the pregnant female confided and sought support emerge in the IDIs. Many females opt to ignore stigma's consequences and obtain an abortion, typically if the respondent's economic or occupational circumstances are threatened and if the male partner is fully supportive and enabling.

We conducted a separate analysis of the group and individual commentary on abortion stigma, examining its presence, intensity and influence on disclosure and decisions regarding an unwanted pregnancy (Shellenberg *et al.*, 2007). The key findings from this analysis are summarized here.

Abortion is described by many participants, especially in the FGDs, as highly stigmatized behavior. Participants use terms such as “murderer”, “evil”, and “not normal” in describing women who obtain abortions. While stigmatization is less clearly articulated in the U.S. FGDs, repeat abortion and abortion-as-contraception behavior is frowned upon.

Our society does not support abortion and if they see anybody that did it, they would look at that person as a prostitute, that the person is not responsible. [NG FGD F]

People from the neighborhood think the worst ... that she's a prostitute. Similar to what anyone would think, right? [PE FGD M]

If a woman opts for an abortion, people try to avoid her because they believe she is possessed and that can affect children and other women. [PK FGD F]

Like so many girls in my high school had abortions like they were birth control. And I was just like, “Don't you realize after your first mistake, to get on the pill, use a condom, or have them pull out or something?” [US FGD F]

Male and female participants also cite numerous consequences of having an abortion, such as divorce, termination of a relationship, domestic violence, community and family harassment, infertility and other adverse health problems befalling themselves or other family members.

In the community in general, when people find out that a woman had an abortion, they get horrified, they say she is a bad woman and they treat her bad. [MX FGD F]

Abortion is a sinful act. I was worried that my daughter fell sick because I had an abortion. When my husband came to know about the abortion, he started saying that I was being punished because of the abortion. [PK IDI F]

When they have an abortion, God punishes them, because when they go to have their first child, they are no longer going to be able to have it. [PE FGD F]

Despite the potential sanctions, abortion is generally viewed as unacceptable but necessary. Participants make exceptions for themselves and for other women because of their life circumstances. Women and men in all five countries recognize abortion as a necessity to resolve an unwanted pregnancy, and they condone individual decisions to do what is best, all things considered. In Pakistan, a common stance among men is to oppose induced

abortion in principle publicly while accepting it as a necessary private decision when an unwanted pregnancy occurs.

I did not want my husband or family to know [about the abortion] because of the rejection, but I feel I did the correct thing, the best for my family. [MX IDI F]

Pregnancies should not be aborted but it is okay if there is a [good reason]. [PK FGD F]

The need to have abortions clandestinely is stressed by both women and men. In the four countries where abortion is illegal, non-disclosure about an abortion appears to be motivated more by concerns about reactions of family and friends than concerns about illegality. Some participants are reluctant to discuss their abortion experiences and refer to the procedure in vague terms.

I know if I had an abortion, I wouldn't tell Tom, Dick and Harry. I might not even tell my closest friend. [US FGD F]

My wife discussed it with me and no one else was aware. We live in a joint family system – we were afraid if someone knew about it, he/she would pass bad remarks. [PK IDI M]

Where social stigma from having an abortion is internalized, women and men voice feelings of guilt and sadness during IDIs. At times these feelings were articulated in religious terms.

The weight of having an abortion is even heavier than giving the birth up for adoption, because of the guilt and because she is considered a bad woman. [MX FGD F]

...Then I opted for an induced abortion and prayed to God for forgiveness for the sin, which I had committed. I used to meditate and pray for His forgiveness. [PK IDI F]

People are just judgmental, and you have to be strong enough to make whatever decision it is you want to make and ignore everyone else. People are going to talk. [US FGD F]

It is not uncommon, therefore, for women to state that they made the best decision for themselves and their families, while simultaneously reporting feelings of shame and guilt. Despite decisions to terminate pregnancies, very few women report actually experiencing social stigmatization or discrimination. Perceived stigma, rather than experienced or internalized stigma, appears to be the major emotional cost of an induced abortion.

6. Abortion experience affects subsequent reproductive behaviors

Several points emerged from women's and men's narratives about their experiences with abortion, including the health costs of abortion complications and the abortion experience as a catalyst for contraception.

Women and their partners recounting unsafe abortion experiences offer vivid descriptions of the difficulties and physical risks they assumed and endured to end unwanted pregnancies. In the IDIs, several respondents openly detail the life-threatening complications that

followed incomplete abortions, the attitudes of the abortion providers, their personal anguish and guilt with undergoing the procedure, and the relief in putting the unwanted pregnancy behind them. Their personal narratives reveal the psychosocial and physical costs of unsafe abortions.

I have a friend that gave that to his girlfriend. “These herbs are excellent”, she tells me. Ah, I wouldn’t know what to tell you. “I could see in her face that she was feeling bad, every so often she would go to the bathroom and that’s where she would lose it.” [PE FGD M]

The doctor used some instruments inside my uterus but she could not take anything out of it. Rather she inserted an IUD, and my pains started right from her clinic. My younger daughter was with me. I asked her to call my husband. He came and he cursed me first and then hired a van to take me home. [PK IDI F]

The doctor went and came back and used an instrument to check me...He then used an object to check again, and said there was a lot of blood there, that he couldn’t do it hurriedly, so I should wait till tomorrow morning...At about 10pm the blood started flowing again, much more than before. It was gushing out, it was gushing out so much that I couldn’t stand it again. I began to feel dizzy...That was how they brought me here [a hospital] and they started treating me here immediately. [NG IDI F]

While U.S. participants did not experience physical costs of unsafe abortions, they relate significant emotional costs.

I didn’t want to go through it again, I think I was just like, you know, it’s been three – and I didn’t want to have a fourth one. [US IDI F]

And I was crying. I went through a trauma, you know, like, I am killing something. But I had no choice, like, you know, I wasn’t ready, you know, he didn’t want it. [US IDI F]

Contraception is far preferred over induced abortion as a means of managing pregnancy risk. However, women’s and men’s motivations to use contraception is often defined and elevated by their abortion experiences. The women indicate that post-abortion their commitment to use contraception is stronger; this transformation appears to be especially marked among those who had no contraceptive experience prior to the abortion.

Now family planning is provided free of cost. A woman goes to the FP center where they charge just 20 rupees for IUD insertion...Obviously pregnancy termination is expensive in addition to its bad effects on health. Induced abortion has worse effects on health than bearing a child. [PK IDI F]

Now I repent – I would have used any method if it was available here. [PK IDI F]

Among contracepting individuals who experienced method failure, the tone is one of disappointment that they had to resort to abortion combined with a determination not to repeat this experience in the future. The fact that women do not support repeat abortions is further evidence of the limited support for induced abortion as a substitute for contraception.

Yeah, after that [having an abortion] I definitely continued with the pill and, you know, making sure that I was setting an alarm, just to make sure that I knew it was the time that I needed to take it, so that was good. [US IDI F]

Above (theme #2), we suggested that induced abortion is for the most part not viewed as a direct alternative to contraception. But in terms of forward-planning of fertility regulation, it does seem to be the case that the experience of an induced abortion can motivate persons to become better contraceptors:

Ah! I have been taught a lesson. I would go for family planning ... Ah! I wouldn't go to a mushroom clinic since they have almost killed me ... I would come to a big hospital such as this, get money and do a proper family planning. [NG IDI F]

Once a person has resorted to an induced abortion, contraception may then be viewed as a preferred alternative means of avoiding unwanted births -- preferred because contraception reduces the likelihood of experiencing once again an induced abortion (with all its costs). In this more roundabout way, contraception and induced abortion may come to be viewed as alternative means of birth control, with the former preferred.

We should also note a view expressed by some participants that not all those who obtain abortions are remorseful. The FGD and IDI participants do not admit this about themselves, rather it is attributed to other persons.

There are women who are addicted to these methods, as they say, abortion. It doesn't matter to them that they are taking away life from a child, from someone who is defenseless. They are people who are bad in the head... They make that decision, they prefer having sex without using protection, without anything... [PE FGD F]

Discussion

This five-country study analyzes qualitative data collected from focus group discussions and in-depth interviews. Our aim is to better understand how couples manage their pregnancy risk exposure, and more specifically how contraceptive and abortion practices co-exist as alternatives for managing unplanned pregnancy. We acknowledge the study's limitations: sample sizes are rather small and selectively recruited (from specific health facilities or localities). Some important population subgroups are not represented, for example adolescences (female and male). While unplanned pregnancies occur at all income levels, the study has confined itself to women and men from poor households, who experience such pregnancies disproportionately. Thus while the transcripts yield many insights about women's and men's perceptions of pregnancy management issues – insights that can guide more extensive and quantitative research -- they cannot be a basis for generalizations about contraception and abortion decision-making in any of the study countries.

Our findings reveal that, across all five country settings, it is very rare for women or men to engage in a deliberate weighing of the advantages and disadvantages of contraception and abortion before beginning a sexual relationship or before sexual intercourse. This is the conclusion from all five settings. The costs and benefits of a pregnancy are defined largely

post-conception and post-family formation. The transcripts also reveal that contraceptive methods are generally viewed as suspect, in particular because of perceived side effects; this is the case even in the U.S., Mexico and Peru, where contraception is widely practiced. Contraceptive practice is often highly inconsistent and characterized by short serial episodes of use and non-use. Couples manage their options month-by-month, rather than as part of a conscious strategy for pursuing lifetime reproductive intentions and family building plan. The lack of contraceptive forethought, however, is not linked by participants to the availability of induced abortion as a means of resolving unintended pregnancies. To be sure, contraceptive failure (accidental pregnancy) is frequently cited, as is its resolution by abortion. Although most respondents, especially in the focus group discussions, condemn repeat abortion and favor contraceptive use after experiencing an abortion, the transcripts provide little evidence that contraception is used successfully for any length of time after an induced abortion.

This latter observation warrants some discussion with respect to the acceptability of long-term contraceptive methods (LTMs), such as the IUD, implant and sterilization. LTMs are common methods in some of the most populous countries -- notably China, India and Egypt -- and also in the U.S. and Mexico (IUD) among the study countries, but not in the other three countries. LTMs' advantage is to relieve the user of the recurring risk of an unplanned pregnancy. Proactive adoption of contraception to prevent unplanned pregnancy seems a distant prospect from our study interviews; however, LTM acceptance might be higher in the context of post-abortion contraceptive provision.

Based a review of the research literature prior to fieldwork, the project team developed a contraception and abortion decision-making tree to guide the data collection, shown in Figure 1. Returning to this tree after analysis of the qualitative data, we conclude that it should be modified only slightly. One new pathway is denoted with double lines, and the pathways of decision and action most frequently cited by study participants are denoted by heavy lines. The most significant changes are (i) the element of uncertainty regarding the timing of an intended future pregnancy and (ii) an additional pathway recognizing the catalytic effect of an abortion on subsequent adoption of contraception. The nodal decision points appear to be whether to: have children, use contraception, end a pregnancy, and adopt or resume contraception. In a prospective and larger quantitative study, these nodal decision points can be the focus of inquiry, and in later data analysis evaluated for their relative importance in determining successful avoidance of unplanned pregnancies.

This exploratory study provides revealing portraits of the key reasons women do not use contraception, in so doing confirming the more general results from national demographic surveys: fear of the health side effects of contraception; the perception of low risk of becoming pregnant (even among women who are sexually active and fecund); opposition to contraceptive use by the woman, her husband/partner, or others; and poor access to contraceptive services and supplies (Sedgh *et al*, 2007b). That there is so little mention of the positive aspects of contraceptive methods may be a consequence of the fact that the guidelines focused on induced abortion experience and contraceptive experience that contained discontinued use and failure.

Although this study is limited by its scale and qualitative design, its findings highlight topics that merit more research that as input to efforts to strengthen the effectiveness of family planning services. Frequent expressed concerns by participants about contraceptive side effects and related health concerns suggest a need to focus on improving contraceptive counseling efforts to counter misperceptions and misunderstandings. The study's finding that abortion experience motivates women and men to become better contraceptors also points to potential payoff from comprehensive post-abortion contraceptive counseling, an avenue to pursue in operations research.

Overall, the interviews, which took place in five different countries with varying social, religious, economic and legal settings, uniformly reveal that contraception is viewed independently of abortion and the two are linked only when contraception is invoked as a preferred and desirable means to avoid repeat abortions. Significant challenges face the effective use of contraception, primarily from perceptions of side effects and misinformation, poor knowledge about pregnancy risk, as well as difficulties accessing contraceptives (more often mentioned by respondents in Nigeria and Pakistan than in the other three countries). It will be important for future research to explore more deeply and frame and measure more fully the barriers to successful contraceptive practice, including rumor, misinformation, and inconvenient access. Similarly, the deconstruction of the stigma concept and its psychosocial impact on individuals and societies in their acceptance and practice of abortion must necessarily be part of future research investigations.

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Figure 1.
Flow of Contraception and Abortion Decision-Making Based on Contraception and Abortion Study Findings

Table 1

Key demographic, reproductive, social and economic indicators for the five study countries, various years.

Country	Female population 15–49 years (mills) ¹	GNP PPP per capita (US \$) 2007 ²	% women 15–49 living in rural areas ⁴	% population age 15+ with >6 years of education ⁴	Median age at first union ⁴⁺⁺	Total fertility Rate ¹	% Married women 15–49 using any contraceptive method ⁴	Abortion rate per 1000 women 15–49 years ³	% of recent births that are unplanned ⁴	% Married women 15–49 with unmet contraceptive need ⁴
Column	1	2	3	4	5	6	7	8	9	10
Mexico	30.0	12,580	24	85 [*]	21.8	2.2	71	33	27 ^{**}	12
Nigeria	35.4	1,770	60	39	18.5	5.9	13	25	14	17
Pakistan	42.3	2,570	67	21	20.3	4.1	30	29	25	25
Peru	7.6	7,240	30	72	22.9	2.4	71	50	56	8
United States	75.2	48,850	19	90 [*]	25.3	2.1	73	21	35	na

Sources:

¹ Population Reference Bureau, 2008a; TFR for Mexico - ENADID, 2006.

² Population Reference Bureau, 2008b.

³ Estimates for various years: Mexico, 2006 (Juarez et al., 2008); Nigeria, 1996 (Henshaw et al., 1998); Pakistan, 2002 (Sathar et al., 2007); Peru, 1998 (Ferrando, 2001); United States, 2005 (Finer and Henshaw, 2006).

⁴ Demographic and Health Surveys, Nigeria, 2003; Pakistan, 2006/7; Peru, 2004. Mexico: ENADID, 2006; United States: NSFG, 2002.

Explanatory Notes:

⁺ This value is for 15–19 years olds; the comparable figure for 15–49 year olds would be a little lower.

⁺⁺ Median age at first union: For Mexico, Nigeria, Pakistan and Peru the medians are among women age 25–29. For the United States, it is for women age 30–34.

^{*} The percent with completed high school (12 years education) or higher among women 15–44 in 2002.

^{**} Percent unplanned among women who were pregnant at the time of interview, ENADID, 2006.

na - Not Available

Table 2

Recruitment location, by country and data collection mode

Country	Data Collection Mode	
	IDI (≈10 women, ≈7 men)	FGD (2–4 groups)
Mexico (Mexico City)	Family planning organization, augmented by snowball sampling	Family planning organization and a technical school
Nigeria (Ile-Ife and Ilesa)	Local and university communities and public hospital	Local and university communities
Pakistan (Tret, Rural Punjab)	General population of the selected community	
Peru (Metropolitan Lima)	Public hospital and private family planning service	General Lima population
U.S. (New York)	Abortion clinics and professional recruitment agency	

Table 3

Characteristics of In-Depth Interview respondents, by country and gender

Participant characteristic	Mexico		Nigeria		Pakistan		Peru		US	
	Female n=16	Male n=10	Female n=10	Male n=7	Female n=10	Male n=7	Female n=12	Male n=7	Female n=10	Male n=8
Mean Age	30.0	29.6	24.7	35.4	35.0	40.0	26.8	29.0	25.7	29.8
% Married	50	40	40	57	100	100	67	57	50	13
Mean Number of Pregnancies *	2.1	1.8	1.7	2.7	7.8	n/a	2.6	1.9	n/a	2.4
Mean Number of Live Births *	1.3	0.6	1.3	1.6	5.7	n/a	1.6	1.1	0.9	n/a
% w/ Abortion Experience *	50	70	50	57	n/a	n/a	83	57	50	50

* Reported by males of female partners