Trajectories to abortion and abortion-related care:

a conceptual framework

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Short abstract

This paper presents a conceptual framework which captures the macro- and micro-level contexts and processes of a woman's pathway to terminating her pregnancy or seeking abortion-related care. The purpose of this framework is to identify and specify the most salient aspects of abortion decision-making across populations. The framework has global applicability, across legal contexts and safety spectra. It can be applied at all points in the reproductive lifespan and to all individual circumstances. Social scientists as well as policy and programme planners can use the framework to highlight aspects of the macro/micro environment that facilitate or hinder a woman's abilities to terminate a pregnancy safely.

Introduction

The medical procedures for inducing abortion are usually not complex. However, nearly everything else about induced abortion (politics, access, control of reproduction, morals, stigma) is complex and interrelated. Research has tried to understand this complexity by considering focused aspects of it. We developed this conceptual framework to organize the complexity and show how aspects of induced abortion decision-making are interrelated. A conceptual framework is a mechanism for organising evidence and to visually demonstrate how evidence is interrelated. Here, we describe a conceptual framework for the study of trajectories to obtaining an abortion following the decision to terminate a pregnancy. We use the word *trajectories* since obtaining an abortion can be a many-stepped process.

The framework is intended to help researchers studying abortion-related decision-making and care-seeking to consider how contexts and processes intersect. The framework is also intended to be useful for policy and programme planners in designing points of intervention for abortion care. This work complements and extends existing conceptual frameworks developed to understand post-abortion complications (Banerjee and Andersen 2012) and the outcomes of a safe abortion programme (Benson 2005). Our framework, focused on trajectories to seeking abortion and related care, employs a wider lens than previous frameworks: we consider a diverse range of contexts; we situate the individual experience in its macro-environment; and we include a broad time line from the decision to terminate a pregnancy to post-abortion sequelae.

The purpose(s) of a conceptual framework

At its simplest, a conceptual framework is a set of ideas, presented in a structured way to help understand a phenomenon (Reichel and Ramey 1987). The framework we present here is designed to describe the potential components of abortion-related decision-making and care-seeking. It is our explanation of "the main things to be studied" (Miles and Huberman 1994 p.18). Our framework is not constrained by concepts that can be defined and measured. For example, we include emotions about pregnancy, abortion and raising children, none of which have an agreed definition or measurement scale but are nevertheless critical components in abortion decision-making and care-seeking.

Why do we need a framework?

Abortion is a common feature of women's reproductive lives, and unsafe abortion is a major public health problem (Lohr, Fjerstad et al. 2014). Every year 21.6 million women experience an unsafe abortion and 47,000 die as a result (WHO 2011). However, research on abortion is challenging, particularly in settings where abortion is illegal and/or highly

stigmatised (Gipson, Becker et al. 2011; Dobkin, Gould et al. 2014). This difficulty is reflected in the small volume of social science research on abortion relative to the impact of abortion on women's lives. To design research, policies and services to meet girls' and womens' needs, we need to understand better how they navigate abortion procurement (whether safe or unsafe, illegal or legal). The evidence-base on trajectories to abortion decision-making and procurement is small and relatively recent (Jejeebhoy, Kalyanwala et al. 2010; Banerjee and Andersen 2012; Banerjee, Andersen et al. 2012; Drabo 2013; Schwandt, Creanga et al. 2013). A seminar, *Decision-making regarding abortion – determinants and consequences*, organised by the International Union for the Scientific Study of Population (IUSSP) Scientific Panel on Abortion Research in 2014 (hereafter, IUSSP Seminar) was convened to focus attention to this under-researched field. There is increased demand for research that can inform abortion-related policy and practice (Guttmacher Institute and Ibis Reproductive Health 2013). We develop our conceptual framework to facilitate approaches to the study of trajectories to seeking abortion and abortion-related care.
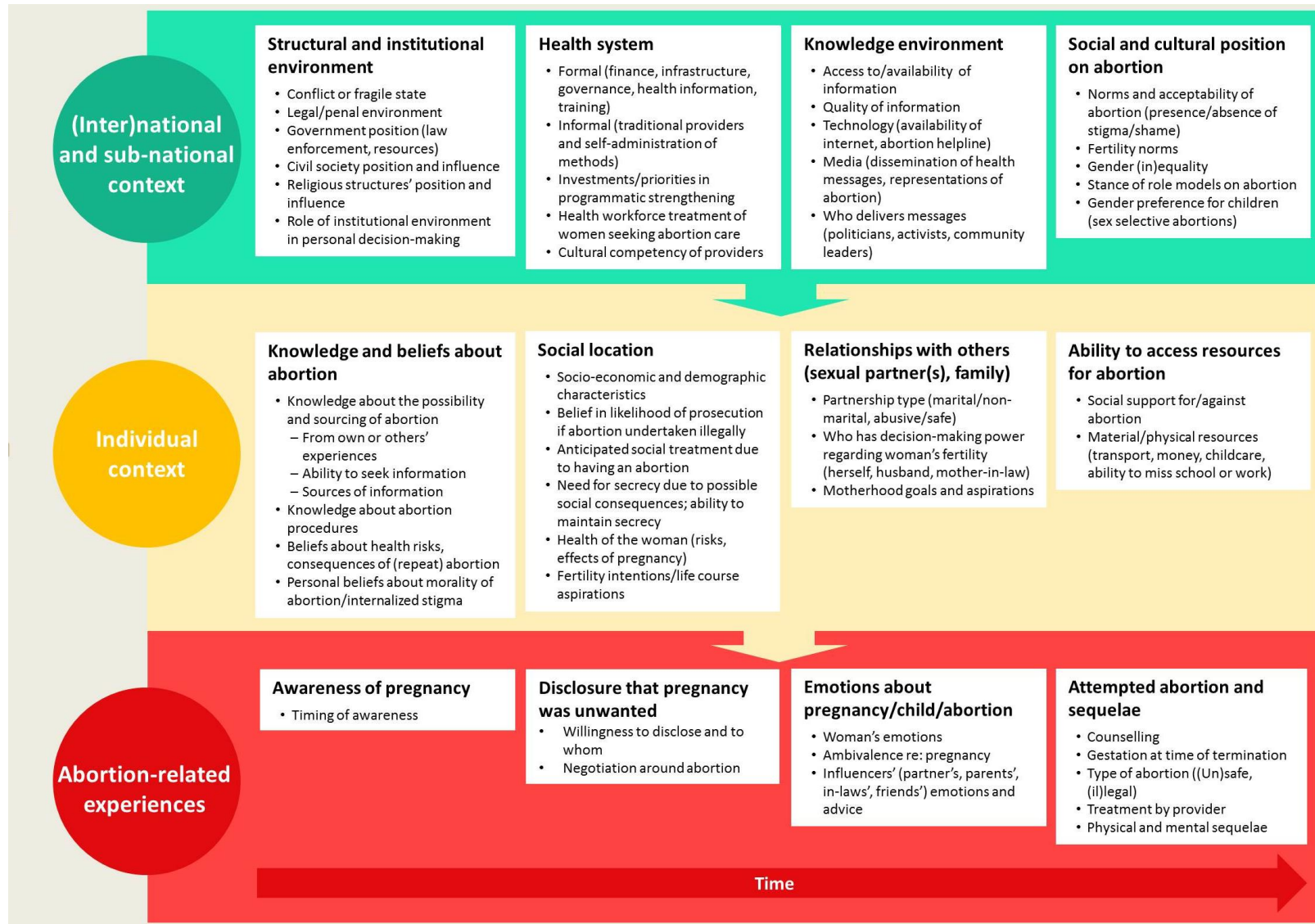

Framework development

This framework arose out of three of the authors' (EC, AN, AM) participation in the IUSSP Seminar. At the seminar, we presented a draft conceptual framework and invited feedback from workshop participants (n=30), all of whom were expert in abortion research and represented a range of disciplinary and geographic perspectives.[1] Reflections and suggestions made by IUSSP Seminar participants were incorporated into a revised framework. Subsequently, we searched the social and biomedical science literature—peer-reviewed and grey—using search terms (abortion, pregnancy termination, post abortion care) to identify examples with which to test the framework's applicability and increase its specificity. We constructed a framework involving three layers of abortion decision-making:

1. macro-level international, national and sub-national contexts;
2. individual contexts; and
3. abortion-related experiences.

These three components are presented in Figure 1 as horizontal layers, from the macro (at the base) to the micro (towards the top), with thematic components within each level (represented in blocks).

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[1] A list of participants and their affiliations is available (need to check and put in URL if publically available from IUSSP www)

Figure 1: Conceptual framework to understand women's trajectories to abortion and abortion-related care

(Inter)national and sub-national context

Structural and institutional environment
- Conflict or fragile state
- Legal/penal environment
- Government position (law enforcement, resources)
- Civil society position and influence
- Religious structures' position and influence
- Role of institutional environment in personal decision-making

Health system
- Formal (finance, infrastructure, governance, health information, training)
- Informal (traditional providers and self-administration of methods)
- Investments/priorities in programmatic strengthening
- Health workforce treatment of women seeking abortion care
- Cultural competency of providers

Knowledge environment
- Access to/availability of information
- Quality of information
- Technology (availability of internet, abortion helpline)
- Media (dissemination of health messages, representations of abortion)
- Who delivers messages (politicians, activists, community leaders)

Social and cultural position on abortion
- Norms and acceptability of abortion (presence/absence of stigma/shame)
- Fertility norms
- Gender (in)equality
- Stance of role models on abortion
- Gender preference for children (sex selective abortions)

Individual context

Knowledge and beliefs about abortion
- Knowledge about the possibility and sourcing of abortion
  – From own or others' experiences
  – Ability to seek information
  – Sources of information
- Knowledge about abortion procedures
- Beliefs about health risks, consequences of (repeat) abortion
- Personal beliefs about morality of abortion/internalized stigma

Social location
- Socio-economic and demographic characteristics
- Belief in likelihood of prosecution if abortion undertaken illegally
- Anticipated social treatment due to having an abortion
- Need for secrecy due to possible social consequences; ability to maintain secrecy
- Health of the woman (risks, effects of pregnancy)
- Fertility intentions/life course aspirations

Relationships with others (sexual partner(s), family)
- Partnership type (marital/non-marital, abusive/safe)
- Who has decision-making power regarding woman's fertility (herself, husband, mother-in-law)
- Motherhood goals and aspirations

Ability to access resources for abortion
- Social support for/against abortion
- Material/physical resources (transport, money, childcare, ability to miss school or work)

Abortion-related experiences

Awareness of pregnancy
- Timing of awareness

Disclosure that pregnancy was unwanted
- Willingness to disclose and to whom
- Negotiation around abortion

Emotions about pregnancy/child/abortion
- Woman's emotions
- Ambivalence re: pregnancy
- Influencers' (partner's, parents', in-laws', friends') emotions and advice

Attempted abortion and sequelae
- Counselling
- Gestation at time of termination
- Type of abortion ((Un)safe, (il)legal)
- Treatment by provider
- Physical and mental sequelae

Time →

We next situate each of the components of the conceptual framework in the literature, drawing upon examples.

1. MACRO-LEVEL CONTEXTS

Influences on women's abortion-related decision-making at this level include the (il)legality of abortion and the punishments to those who violate the law, the provision and availability of safe abortion procedures, and the information around abortion services.

1.1 Structural and institutional environment

Institutions (political, governmental, religious, civil society) operate at a range of scales (global, regional, multilateral, national, sub-national). The influence of institutions on each other, and the salience of each institution's position on abortion, are interwoven. For example, a government's position on abortion is likely to influence law, civil society (e.g. whether civil society is permitted a voice in debates), and abortion services. Similarly, the presence of conflict and/or state fragility influences institutions, including how they deal with selected sub-populations (e.g.: refugees) with respect to abortion (Cohen 2009; Guttmacher Institute 2014).

1.1.1   *Politico-legal environment*

Abortion is regulated in every country. The politics, including the policy environment, will determine the legal and penal positions on abortion (Cook, Erdman et al. 2014). These can operate nationally or sub-nationally if there are varying laws within a country (e.g. USA). The legal position is often specified in a law (e.g. India), a court decision (e.g. Mexico) and/or a penal code (e.g. Rwanda). In some settings abortion is addressed in a country's constitution (e.g. Kenya).

The legal context does not necessarily reflect either how the law is applied or the quality of services. Analysis of data from more than 160 countries on the association between grounds for abortion in national laws and unsafe abortion demonstrated "a clear pattern": where legislation allows abortion on broader grounds, there is lower incidence of unsafe abortion and lower mortality attributable to unsafe abortions (Berer 2004). A fifty year (1960-2010) review of abortion laws in western Europe shows a trend towards decreased restrictiveness, albeit with inter-country variation, and no clear relationship between the law and access to services (Levels, Sluiter et al. 2014). In countries with longstanding legality of abortion and service provision (e.g.: Estonia, Cuba, Kazakhstan), an "abortion culture" of women seeking repeat abortions has been identified (Agadjanian 2002; Bélanger and Flynn 2009; Laanpere, Ringmets et al. 2014).

Abortion laws, policies and services shift in response to religious, political, and societal change, including the influence of international institutions.   A comparative analysis of abortion policymaking in South America examines why legal reforms have occurred in some settings (Colombia, Mexico City) but not in others (Brazil, Chile, Peru), and highlights the role of national network building (Kulczycki 2014).   In some countries a change in law is linked to political shifts. In South Africa, the *Choice on Termination of Pregnancy Act* (1997), only became possible after the 1994 election of the African National Congress, which included access to legal abortion in its national health plan (Althaus 2000; Hodes 2013).   In some countries the speed and scale of political and legal change related to abortion can be very rapid. In less than a decade, Nepal has changed from a country with strong enforcement of abortion restrictions, from imprisonment for abortion-related crimes (pre-2002) to a 2009 ruling from the Supreme Court finding that denial of access to abortion services was a violation of constitutional rights. This rapid change, however, followed several decades of political and social action (Upreti 2014). Elsewhere, the speed and scale of change is slower. Mozambique legalised abortion in 2014, largely in response to lobbying and advocacy from civil society, replacing a colonial-era Penal Code that had banned abortion entirely[2]. In some settings, despite its illegality, doctors provide abortions, and this is tolerated by government. A study of five Caribbean islands found that abortions were routinely provided—for a fee— by licensed physicians, although abortion is illegal (Pheterson and Azize 2005).

Changes to law can occur piecemeal and apply only to specific geographic regions. First trimester abortion on demand was made legal in Mexico City in 2007 (Sánchez Fuentes, Paine et al. 2008) after substantial political, popular, religious and civil society debate (Lamas and Bissell 2000). Outside of Mexico City, however, access to legal abortion services remain limited (Billings, Moreno et al. 2002). In the United Kingdom, the 1967 Abortion Act, which legalized abortion by registered practitioners and provided that abortion should be free through the National Health Service does not apply to Northern Ireland, where abortion is only allowed on a very restricted basis[3]. In some countries, the political and legal situation is far from clear. For example, Uganda's abortion laws are "contradictory and ambiguous" (Moore, Kibombo et al. 2013 p.2).

Some countries do not specify gestational limits on legal abortion (e.g. Vietnam, Ethiopia and China) while many others do (e.g. Bulgaria and Denmark). There is large heterogeneity in the grounds upon which second trimester abortions can take place (if at all), with higher income countries more likely to permit them on a wider range of grounds than lower and middle income countries (Boland 2010). A US study of changing regulations shows that

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clinics which provide second trimester abortions are affected by an increasing number of regulations, leading clinics to reduce the maximum gestational age at which they perform abortions in order to avoid legal risk (Jones and Weitz 2009). Language clarity about abortion can vary greatly. It can be specific, such as in India where abortion cannot be performed after 20 weeks gestation. Or, it can be vaguer, for example that abortion cannot be performed after viability (e.g. USA), the meaning of which changes with advances in medical technology.

The legal landscape is further complicated by who is permitted or obligated to provide approval of an abortion. In some countries multiple doctors have to approve an abortion for it to be provided legally (e.g. Uganda, Rwanda), elsewhere, multiple doctors are needed to certify second-trimester abortions only (e.g. India) and yet elsewhere two medical practitioners are required to certify non-emergency abortions but only one is required to have seen and examined the pregnant woman (e.g. UK).

The complexity of abortion laws can mean that policy makers, service providers, and the public alike have low levels of knowledge about abortion legality. A study of changes in levels of knowledge about abortion legality in Nepal between 2006 and 2011 showed that improvement in knowledge were largely limited to wealthier and more educated women (Thapa, Sharma et al. 2014). Low levels of knowledge and high uncertainty about abortion legality have been found in Kenya (Marlow, Wamugi et al. 2014), India (Banerjee, Andersen et al. 2014), South Africa (Morroni, Myer et al. 2006) and Ghana (Konney, Danso et al. 2009). These findings are reflected in studies of medical practitioners' knowledge from Guatemala (Kestler 2012), Ethiopia (Abdi and Gebremariam 2011) and Argentina (Ramos, Romero et al. 2014) which show partial knowledge and understanding of a country's laws and their application.

Levels of knowledge about abortion laws among policymakers and politicians also tend to be low. In Nigeria, where abortion is permitted only to save the life of a woman, policymakers and politicians assumed that abortion was illegal under any circumstances (Okonofua, Hammed et al. 2009). Just half of Ugandan policy-makers, cultural leaders, local politicians and leaders knew the current abortion law (Moore, Kibombo et al. 2013). Sometimes it is the arbiters of law, including police and prosecutors, who lack clarity. In Zambia, Ghana, and Nigeria, this has led to the development of a toolkit to support police engagement with abortion law (Skuster 2014).

Finally, politico-legal environments may extend beyond a country's jurisdiction. In poorer countries, international funding for governmental and non-governmental organisations can

be tied to donor counties' positions on abortion. For example, since 1973, USAID has followed the Helms Amendment ruling, banning use of U.S. government funds to provide abortion. The Mexico City Policy (or "global gag rule") enacted by the USA government in 1984 specified that funding be withheld from any government and non-governmental organisations performing or promoting abortion services. Since many developing countries rely on international funding to support their health care system, the implementation of this restriction resulted in a reduction in abortion provision in countries even when abortion may have been legally provided otherwise (Crane and Dusenberry 2004; Senanayake and Hamm 2004). An analysis of induced abortion rates and United States per capita assistance for family planning in 20 sub-Saharan African countries concluded that, ironically, reduced financial support for family planning may have led women to substitute abortion for contraception (Eran, Patrick et al. 2011). The Mexico City Policy led to the removal of funding for the Reproductive Health Response in Conflict (RHRC) Consortium in 2003, with significant implications for the provision of services to refugees and internally displaced people (Cohen 2009). Finally, the role of transnational laws can influence domestic laws. For example, 2010 abortion law reform in Ireland was influenced by procedural rights at the European Court of Human Rights (Erdman 2014).

1.1.2   Penal environment

The legal position on abortion is distinct from the penal position. There can be punishments specified for providers and/or procurers. In some places where abortion is not allowed, punishment for providing abortion or obtaining an abortion is not specified. In other places where it is specified, it is not enforced or it is enforced unequally (e.g. Mexico or Nigeria[4]). In El Salvador, with a total ban on abortion, even when a woman's life is at risk, poorer and/or less educated women who are unable to procure a safe (but illegal) termination are more likely to be criminally prosecuted (Salvador 2014).

1.1.3   Civil society

In some countries, civil society is extremely active and visible (e.g.: USA, Brazil) while in other countries, sometimes due in part to women's disempowerment or lack of political voice, the participation of civil society on abortion issues is negligible. Depending on the contemporary provision and legality of abortion and political debates, civil society can be relatively homogenous or more polarised in its messages, campaigning both for more liberal and more restrictive laws and/or provision. Well-organised civil society networks can use "policy windows", with opposing sides often operating simultaneously. In Colombia, following the liberalisation of the abortion law in 2006, feminist civil society organisations pursued a series of strategic litigations as a pre-emptive measure to counter backlash from state and civil society actors opposed to the law reform (Ruibal 2014).

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Civil society includes international non-governmental organizations (INGOs) and local NGOs and has been shown to have the power to be influential on the issue of abortion in some settings (Taracena 2002). Professional associations, such as the International Federation of Obstetricians and Gynaecologists (FIGO) can allow medical practitioners working in more restrictive contexts to participate in international efforts such as the *Initiative for the Prevention of Unsafe Abortion and its Consequences* (Shaw 2010; Jaldesa 2014; Leke 2014; Macha, Muyuni et al. 2014). To counteract abortion stigma, which has been shown to contribute to social, medical and legal marginalisation of abortion globally, the International Network for the Reduction of Abortion Discrimination and Stigma (INROADS) was launched in April 2014 (LeTourneau, Batchelder et al. 2014). Marie Stopes International, a UK-based INGO, provides safe abortion services and/or post-abortion care through its private, free-standing clinics using local providers in over 40 countries[5]. Other NGOs, including many member associations of the International Planned Parenthood Federation (itself an INGO), provide reproductive health services including abortion, and provide capacity-building, training and funding. These NGOs often play a vocal part in advocating for women's rights to a safe abortion. The International Federation of Women's Lawyers (FIDA) plays an active role at international and local levels using the legal system to improve access to safe abortion (e.g.: Uganda, Tanzania). Communities can mobilise (and be mobilised), even in settings intolerant of abortion, to improve access to services (Coeytaux, Hessini et al. 2014). Transnational advocacy, often web-based, has become increasingly used as a tool to increase the visibility of debates (e.g. www.September 28.org[6]).

1.1.4 Religious institutions

Religious institutions' influence on trajectories to abortion-related care depends on the extent to which religion influences governance, and the dominance of religion(s) in public life. For example, although Catholicism is against induced abortion in most circumstances, the influence of the Church's teaching on national laws and policies differs across Catholic countries: in much of Catholic Latin America, women's access to abortion is severely restricted, while in Catholic Western Europe, abortion is typically legal (Blofield 2008). A national public opinion survey in Mexico showed that most Mexican Catholics supported provision of abortion in public facilities for cases deemed as legal, and that neither the church nor legislators' personal religious beliefs should affect abortion legislation (García, Tatum et al. 2004). Another survey of Mexican Catholics found that while 61% of respondents had stigmatising attitudes about abortion, more than four fifths thought abortion should be legal under some circumstances (McMurtrie, Garcia et al. 2012). A comparative analysis of abortion rights in Muslim-majority countries showed considerable

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[5] EF COMMENT: You asked for a reference but I can't see where this is from! It's not how they describe themselves on their website.

[6] Ann you suggested adding the activism in Texas summer of 2013 – can you provide a REF or link?

heterogeneity between countries: 38% did not permit abortion under any circumstances, and 21% permitted abortion "on request" (Shapiro 2014).

Even in settings in which religion and governance are not strongly linked, religion can exert a structural-level influence on access to abortion-related care if religious institutions are major providers of free or affordable health care (e.g. mission hospitals) or own health care companies which refuse to provide (or reimburse for) abortion (e.g. Seton Healthcare Network in the USA).

Religion influences local and personal contexts through its teachings and messages on abortion, delivered through sermons and preaching as well as through the way that women who have abortion are treated within their religious community or institution. These messages shape the sociological landscape of information about, and attitudes towards, abortion (Frohwirth, Coleman et al. 2014).

1.2 Health system

We conceive of the health system as the infrastructure, health information, and investment in formal training, including formal and informal components, and acknowledging the complexity of health systems and their functioning (Bloom 2014).

Access to safe abortion is influenced by who is legally permitted to give services. In some settings, midlevel providers are not allowed to provide post-abortion care or contraception, which severely restricts access to abortion-related care. In Sudan, where abortion is only legally available to save a woman's life or following a rape, midlevel providers are not allowed to provide either post-abortion care or contraception, resulting in delays and failure to provide services (Kinaro, Ali et al. 2009). Countries where only obstetrician/gynaecologists are allowed to provide abortion (e.g. USE, India) have a more restrictive health environment than countries where task-shifting has occurred and midlevel staff can provide abortion (e.g. UK, Sweden, Norway). However, it is not only the law that influences what services are provided, and by whom, but also the interpretation of the law by medical professionals.

Time lags often occur between changes in abortion law and the ability or willingness of service providers to provide newly legal abortion care. In Colombia, where abortion was banned until 2006, few facilities are either able or willing to provide abortion services. Where services are provided, they focus on PAC, rather than abortion (Darney, Simancas-Mendoza et al. 2014). Following the liberalisation of abortion law in Nepal, substantial efforts were made to expand the availability of, and access to, safe abortion. While these

changes are associated with significant declines in serious abortion morbidity (Henderson, Puri et al. 2013) some Nepalese abortion providers reported frustration about perceived "misuse" of services—women relying on abortion rather than using contraception (Möller, Öfverstedt et al. 2012). Research from India suggests strong support from midlevel providers that they be able to provide medical abortion, but much less uniform support among obstetricians-gynaecologists and physicians (Patel, Bennett et al. 2009).

Providers' attitudes and values can work with, or against, national legal and policy prescriptions, and whether providers are willing to provide abortion influences abortion availability. Even though South Africa legalised abortion broadly in 1994, the country has suffered from a consistent understaffing of providers willing to provide this service, leading to highly fragmented service provision that women have to navigate (Harries, Stinson et al. 2009). In Ghana, while 80% of physicians supported establishing abortion units in public health facilities, fewer than half would conduct the procedure themselves (Morhe, Morhe et al. 2007). A study of Nigerian doctors found that just 13% would conduct abortion services themselves if abortion were legalised (Okonta, Ebeigbe et al. 2010). In Mexico, where abortion is legal in cases of rape, physicians act as gatekeepers to services post-rape. Physicians with negative attitude towards abortion-seekers and those who reported church attendance were less likely to agree that abortion should be provided in cases of rape (Silva, Billings et al. 2009).

In contrast, analysis of medical documents in Senegal, where abortion is highly restricted, shows how health providers obscure their provision and treatment of induced abortion (to circumvent the possibility of police enquiry) (Suh 2014). A survey of providers in Argentina showed that they would support abortion in situations excluded from the current abortion law (Vasquez, Das Neves et al. 2012). A study of midwives in Mexico revealed that although they were aware and supportive of the restrictive abortion law, they assisted women to "bring the period down" if menstruation was delayed for 3 months or less. The technique, performed on women whose pregnancies are not confirmed, was not perceived by midwives to be an abortion and therefore perceived as exempt from criminality or sinfulness (Castañeda, Billings et al. 2003).

Conscientious objection, the practice of provider opposition to the provision of, or assistance in, abortion on moral, ethical or religious grounds, is a largely unregulated practice. Some countries allow providers (medical doctors as well as pharmacists) to formally register as conscientious objectors (Global Doctors for Choice 2014; Harries, Cooper et al. 2014). The extent to which conscientious objection is enshrined in laws, penal codes and protocols is highly variable (Law and Worldwide 2014; Ngwena 2014). A review (1998-2013) found that there is no consensus about criteria for refuser status and no standardized definition of the

practice of conscientious objection (Chavkin, Leitman et al. 2013). Levels of knowledge about the grounds on which medical practitioners might invoke conscientious objection have been shown to be low in South Africa (Harries, Cooper et al. 2014).

Medical practitioners have to navigate professional hierarchies to provide or withdraw abortion services. In Ghana, tensions between personal beliefs (moral and religious) and duty to provide safe abortion care operate differently for service providers. Obstetricians-gynaecologists are more exposed to international debates, safe abortion techniques and research on public health implications of unsafe abortion. Midwives were more likely to rely on religious values, and their need to navigate personal social stigma as a provider of abortion, creating a highly-selective abortion service which operates at the discretion of individual health professionals (Aniteye and Mayhew 2013). A study from India shows that health professionals influence a woman's ability to access abortion services: village health nurses were instrumental in advising married women where to procure an abortion; unmarried women were not seeking nurses' advice because of the women's need for secrecy (Ramachandar and Pelto 2002).

The quality of abortion-related interpersonal care is important in influencing women's experiences, and how they might then report this to others. A study of women's experiences of post-abortion care in Argentina revealed disrespectful care, including discriminatory and humiliating treatment by some health providers (Steele and Chiarotti 2004). Even if they are willing to provide care, health providers' punitive attitudes and treatment of women seeking abortion and/or post abortion care may influence women's willingness to access these health services (Prada, Kestler et al. 2005). Lack of confidentiality due to lack of space or provider attitudes towards privacy and/or confidentiality may also prevent women from seeking safe services or follow-up care from an induced abortion (Jewkes, Gumede et al. 2005; Marlow, Shellenberg et al. 2014). Women who had an abortion in Mexico City following legal reforms felt that staff needed to be more sympathetic in their care (Olavarrieta, Garcia et al. 2012). The judgmental attitudes of health practitioners against women seeking abortion, both perceived and experienced, are widely reported, with examples from Ghana (Schwandt, Creanga et al. 2013; Tagoe-Darko 2013), USA (Kimport, Foster et al. 2011), Kenya (Marlow, Wamugi et al. 2014) and South Africa (Jewkes, Gumede et al. 2005).

The formal health system is just one site where women access abortion. In some settings, a range of practitioners, including public sector practitioners who also have private clinics at their homes, herbalists, traditional birth attendants, and pharmacists, play a role in provision of less-regulated abortion-related care. For example, in rural Cambodia the deep abdominal massage performed by traditional midwives is considered by women to provide a reasonably

reliable form of abortion (Hukin 2012), and in many counties indigenous medicine provided by herbalists is commonly used (Singh, Wulf et al. 1997; Rasch, Sorensen et al. 2014). These unregulated practitioners may be untrained (or undertrained) in providing safe abortion or may lack the necessary environment, equipment or drugs (such as anaesthetic) to provide safe abortion.

The role of the health system includes the availability and accessibility of abortion-related pharmaceuticals. In some countries where abortion is illegal in all circumstances, misoprostol is available for treatment of postpartum haemorrhage, and is distributed in mother-baby packages to women who may not be able to make it to a health facility to deliver. Its abortion-inducing properties have become well-known enough that women share it/sell it to others seeking abortion[7]. The availability and accessibility of abortion-inducing drugs are not necessarily correlated with the legality of abortion. For example, although relatively few countries have misoprostol brands registered for abortion (e.g. Peru, Russia, Zambia), misoprostol is widely available for safe abortion through off-label use (Fernandez, Coeytaux et al. 2009). In the Palestinian territories, where abortion is permitted only to save the life of the pregnant woman or when the embryo is unviable, pharmacists provide misoprostol to women in conscientious objection of the restriction on women's access to safe services (Hyman, Blanchard et al. 2013). Accessibility of the drug may be largely dependent upon whether it is included in the essential list of drugs stocked in public facilities and provided through the national government (Ipas 2009).

Where abortion is highly restricted, advice about misoprostol might be legal. In Uruguay, although abortion only became legally available up to 12 week gestation in 2012, health providers have legally been able to advise women about misoprostol use since 2004. The legal provision of information about an illegal off-label use of a drug and procedure represents a harm reduction approach to unsafe abortion (Silva, Thibaut et al. 2014). In Kenya, where abortion is permitted only to protect a woman's life and health, and in Tanzania, where it is permitted only to save a woman's life, intervention research has demonstrated the successful dissemination of information on the correct use of misoprostol for both abortion and postpartum haemorrhage by community-based groups (Coeytaux, Hessini et al. 2014).

A review of pharmacy-dispensed medical abortion drugs globally concluded that provision of accurate information about how to use the medications was rare (Sneeringer, Billings et al.

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[7] EF found was this blog that hints at it:
Coeytaux, F. and E. Wells (2013). Misoprostol Is a Game-Changer for Safe Abortion and Maternal Health Care. Why Isn't it More Widely Available? RH Reality Check. **2015**.
(http://rhrealitycheck.org/article/2013/05/28/why-arent-we-taking-advantage-of-the-potentially-game-changing-drug-misoprostol/)

2012). Studies from Latin America show that women are buying the drug from pharmacists for early abortions but that vendors have limited knowledge about effective doses and provide insufficient instructions about side effects and risks (Miller, Lehman et al. 2005; Lara, Abuabara et al. 2006; Billings, Walker et al. 2009). A study in eight Mexican cities found that the majority of pharmacy vendors provided some information, but that information about effective dosage, administration, side effects and complications and where to seek help in case of complications was incomplete. The authors suggest that this may be a vendor strategy to avoid legal consequences (Lara, Garcia et al. 2011). In Bangladesh, where menstrual regulation is legal, a mystery client survey of the availability and provision of misoprostol showed that pharmacists were providing both counterfeit drugs and ineffective regimens (Huda, Ngo et al. 2014). In a Niergian study of women who had attempted to terminate using drugs, very few had accurate information about safety and doses (Adinma, Adinma et al. 2012). Where abortion is restricted and misoprostol has to be acquired clandestinely, there is evidence that counterfeit drugs are sold[8].

For self-administration of medical abortion drugs, the role of information provider is important. Examples of telemedicine or mHealth for women who are able to procure the drugs, in settings where the drugs and/or abortion are illegal (Gomperts, Jelinska et al. 2008) are seen in Brazil (Gomperts, van der Vleuten et al. 2014), Chile (Casas and Vivaldi 2014) and Indonesia (Gerdts, Hudaya et al. 2014). In South Africa, where abortion and the pharmaceuticals are legally available, an RCT showed that mobile phone messages to support women using misoprostol at home for early medical abortion significantly reduced women's anxiety and stress and improved preparedness for abortion symptoms (Constant, de Tolly et al. 2014).

1.3   Knowledge environment

This component reflects the importance of health knowledge-sharing norms, differential access to knowledge (e.g. by education, class, ethnicity), availability and types of knowledge-sharing technologies, and the effectiveness of knowledge-delivery systems (Kavanaugh, Bessett et al. 2013). The information environment determines people's knowledge about the legality of abortion and its restrictions, cost of abortion, the possible dangers of violating the law, and where to obtain an abortion. In legal contexts, it is possible to open a telephone book or online directory and look under the word "abortion" to find a safe abortion provider. However, while there is a great deal of information available, it is not always easy to identify the ideological-motivation of some facilities.

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[8] http://www.womenonwaves.org/en/page/974/warning--fake-abortion-pills-for-sale-online
http://pulitzercenter.org/reporting/africa-nigeria-abortion-pill-maternal-health-misoprostol

The media also plays a role in determining how the issues of abortion are portrayed (Vala-Haynes and Rochat 2007). When the media highlights vocal anti-abortion activists or stories of children orphaned by women who die due to unsafe abortion complications, this shapes, in part, the perception of abortion. The amount of time and space dedicated to abortion, the relevant issues highlighted, which persons are given voice, language used, and the freedom of the media to challenge institutions that restrict safe abortion services, all contribute to how abortion is viewed by the public. One striking example of media's indirect impact on abortion rates follows a 1995 report in The Lancet about increased risks for adverse vascular events for users of some oral contraceptive pills. In Norway, this led to brand-switching and method discontinuation, and a significant increase in the abortion rate, especially among nulliparous students (Skjeldestad 1997).

1.4 Social and cultural positions on abortion

Norms about abortion—including abortion-related stigma and shame—affect the individual experience of abortion. Often operating in parallel and influencing social and cultural positions on abortion are norms and experiences of gender (in)equality. Abortion can hide unsanctioned sexual activity (e.g. before marriage, extramarital); if a given society is invested in punishing those who transgress sexual norms, abortion is a threat to that social order. Other legal restrictions such as waiting periods (in the United States) or husband's consent (sometimes legally specified and sometimes preferred by providers, e.g. India) signify a lack of social confidence in women's decision-making authority.

These social constructions are important in shaping views and perceptions. A survey of attitudes about abortion in Zambia, where abortion has been legal in a wide variety of circumstances since 1972, demonstrates ambiguities in understanding societal attitudes towards abortion and abortion service provision. Whilst beliefs that abortion was immoral were widespread among respondents, this was not associated with lack of support for the legal position of abortion. Rather, people reported disapproval of abortion at the same time as reporting that women need to be able to access safe abortion services (Geary, Gebreselassie et al. 2012). Comparative analysis (Ghana vs. Zambia) of a scale to measure stigmatising attitudes and beliefs about women who have abortions identified three important components of abortion stigma: negative stereotypes about men and women who are associated with abortion; discrimination or exclusion of women who have abortions; and, fear of contagion as a result of coming in contact with a woman who has had an abortion (Shellenberg, Hessini et al. 2014). In rural South Africa, a study using hypothetical vignettes to stimulate discussion about abortion revealed that legal abortion was considered as destructive of traditional culture, strongly associated with a colonialist endeavour, and harmful to intergenerational and gender relations (Macleod, Sigcau et al. 2011). A study of Kenyan adolescents' used an internet-based cartoon to reveal "competing

social scripts" on abortion, contrasting "florid condemnation" of the hypothetical vignette with "frank and sober" description of abortion experiences from the peer group (p.515), and the language used by adolescents was strongly reflective of language and discourse in Kenyan media and curricula (Mitchell, Halpern et al. 2006). A study in Malawi identified mutually reinforcing ideas about the social consequences of abortion, which combined with societal norms that are supportive of high fertility for both men and women, creates a situation in which abortion stigma and shame are locally (re-)produced (Levandowski, Kalilani-Phiri et al. 2012).

Abortion stigma is present in many settings, but is not a universal social fact and is instead locally produced through multiple discourses (media, popular, medical), political and governmental institutions, communities and personal experiences (Kumar, Hessini et al. 2009). Three heterogeneous groups are affected by abortion stigma: women who have abortions; people that provide abortions; and supporters of women who have had abortions (Norris, Bessett et al. 2011). Social narratives around abortion may serve to further reinforce the social undesirability of not only the act of abortion but also women who have abortions (Norris, Bessett et al. 2011). Interviews with US women revealed multiple strategies they deploy to manage and mitigate negative aspects of abortion stigma (Cockrill and Nack 2013).

In some settings, while abortion might be normatively shameful, it is perceived as less shameful than a mistimed pregnancy (Johnson-Hanks 2002). An ethnographic study of induced abortion in Indonesia (1996-8) found that, although illegal, induced abortion was tacitly accepted for married women with two or more children. For unmarried women, however, having an abortion was a highly isolating and stigmatising experience, with abortion providers holding very negative attitudes to these women. Nevertheless, the shame and stigma of a non-marital pregnancy outweighed that of an abortion (Bennett 2001). Interviews with adolescent in Zambia who sought PAC following an abortion shows that stigma and shame around pregnancy were strongly linked with reasons for terminating the pregnancy, including: parental disapproval; abandonment by partner; and, school expulsion (Dahlback, Maimbolwa et al. 2007).

The construction and experience of stigma can be multiple and overlapping. An in-depth study of HIV-positive women's experiences of induced abortion in South Africa shows that whilst most women felt that their abortion was acceptable because of their HIV status, abortion itself was more stigmatised than HIV/AIDS. Women in this setting were negotiating two sets of stigma, abortion and HIV/AIDS, connected by pregnancy (Orner, de Bruyn et al. 2010; Orner, de Bruyn et al. 2011). Comparative analysis of attitudinal data from Zambia and Nigeria about the relative stigma of abortion or birth for HIV positive women revealed

an overwhelming preference for continuing a pregnancy, although this was mitigated in circumstances where antiretroviral therapy to prevent mother to child transmission of HIV was unavailable. There were gendered differences in the responses, with women expressing more stigmatising views about abortion than men, especially in Zambia (Kavanaugh, Moore et al. 2013).

Stigma about pregnancy and abortion can exert important influences over how and when to abort. In Ghana, physicians who provide abortion services highlighted stigma as a major cause of second trimester unsafe abortions as women delay seeking care (Payne, Precourt Debbink et al. 2013). Women who seek care following an unsafe abortion, also in Ghana, report social stigma leading to fear, shame and embarrassment as a significant factor in decision-making about abortion (Tagoe-Darko 2013).

Abortion stigma is also experienced by service providers, although much less researched, especially outside of high income countries. A qualitative study of USA-based health care professionals involved in abortion provision revealed that stigma was experienced in relation to other people (work colleagues, peer professionals, family, friends, strangers) (O'Donnell, Weitz et al. 2011). Harris' analysis of providers' experiences at one USA abortion clinic shows how every provider had to make decisions about whether, how, and to whom to disclose their work (Harris, Debbink et al. 2011). In Australia, nurses identified "affiliate stigma" experienced by those directly involved in abortion care (Lipp 2011). Alblas' personal narrative of providing abortion in South Africa provides an additional insight into challenges experiences by service providers (Alblas 2008).

2. INDIVIDUAL CONTEXT

This level of the conceptual framework deals with the socio-demographic characteristics, knowledge and beliefs, relationships and resources of individual women, each of which interacts with each other (e.g. younger women are less likely to have access to financial resources to pay for a safer termination but might have better access to internet-based sources of information), and also with the (inter)national and sub-national context within which she is situated.

2.1 Knowledge and beliefs about abortion

Pre-existing knowledge about the possibility and sourcing of abortion may influence a trajectory. This might include prior experience or exposure to narratives about abortion from familial or social networks. A study of poor, married women in India who had limited exposure to mass media, showed that women who had knowledge about abortion from family, friends or community health workers were more likely to perceive that services are

available and have positive attitudes toward abortion (Banerjee, Andersen et al. 2012). In Uganda, women reported that friends were their most import source of practical advice about how to terminate, especially in rural areas (Jagwe-Wadda, Moore et al. 2006).

Knowledge and beliefs within a social network may act as a barrier to accessing abortion services. In a study of Malaysian women's experiences of accessing abortion services and information, the main barriers to accessing care had been a lack of information. Most had obtained information about abortion and available services by asking friends or colleagues, but this was often superficial and inadequate (Tong, Low et al. 2012). A case control study in Sri Lanka of unsafe abortion showed that unreliable sources of information and perceptions about safety were important determinants of action (Arambepola and Rajapaksa 2014).

Understandings around the meanings of abortion influence the type of abortion women procure. In many countries, a woman will have the option to choose between a surgical and a medication abortion; having the choice leads to better psychological outcomes after the abortion (Lie, Robson et al. 2008). In some settings, a woman may have options about safety and quality of care; in others, a woman may not (perceive herself to) have any choice (Banerjee and Andersen 2012). In Mozambique, women considered a range of factors to choose between misoprostol and vacuum aspiration, including concerns about privacy, pain, quality of home support, HIV infection risk, and implications for future sex. Women were highly motivated to choose an abortion method that was both clinically and socially "low risk" for them (Mitchell, Kwizera et al. 2010). Women who had had a medical abortion under clinical supervision in four countries (Mexico, Colombia, Ecuador, Peru) reported that they chose medication rather than surgical abortion for reasons related to cost, pain, ease, simplicity and safety; medication abortion was referred to as more natural and linked to period regulation (Lafaurie, Grossman et al. 2005). Similarly, a study of USA women's reasons for choosing a medical abortion over other methods included that it was a "natural" process, avoidance of "surgery," respecting the "baby," more flexibility in scheduling, and the ability to complete the process at home (Cappiello, Merrell et al. 2014). A study of Nigerian adolescents' understandings of contraception and abortion revealed that abortion was considered preferable – for health-related reasons – to contraception. Concerns about future infertility due to prolonged hormonal contraceptive use meant that abortion, by contrast, was perceived to be an immediate and short-term intervention that would have limited negative impact on potential future fertility (Otoide, Oronsaye et al. 2001).

2.2 Social location as a determinant of access to abortion

The socio-demographic characteristics of women (age, wealth, education, residence, marital status, parity, etc.) will influence every aspect of her trajectory (Edmeades, Lee-Rife et al.

2010). A woman's individual characteristics shape or mediate all other issues, including economic power, decision-making power, and access to knowledge. The influence of personal characteristics will, in turn, depend on the context. For example, being female means something different for access to health information and services in the UK than in Pakistan; being married has different implications for decision-making power in Malawi compared to Saudi Arabia.

Socio-demographic individual-level characteristics on women's knowledge about abortion is identifiable at the aggregate level in a wide range of settings (e.g. Ghana (Rominski, Gupta et al. 2014) and Finland (Väisänen and Murphy 2014)). A study of Brazilian adolescents' knowledge and belief about abortion revealed that which school the adolescent attended was significant, whereas age, religion or socio-economic class are insufficient to explain adolescents' understanding and that the social space of the school – involving peers and educators – was critical (Mitchell, Heumann et al. 2014). Analyses of the 2007 Ghana Maternal Health Survey show that women who were younger, poorer and lacked partner support, were most likely to seek an unsafe abortion (Sundaram, Juarez et al. 2012). In Colombia, poorer rural women were more likely to seek an abortion from a traditional midwife or to self-induce (Prada, Singh et al. 2011). Data from Vietnam show that ethnicity, older age and higher education were all associated with increased likelihood of having an abortion (Teerawichitchainan and Amin 2010). In Ghana secondary education, being married, a peri-urban resident, and in formal employment were key associated socio-demographic characteristics (Mote, Otupiri et al. 2010), along with higher levels of female autonomy (Rominski, Gupta et al. 2014). In Bangladesh, women with some education were more likely to terminate their pregnancy (and to do so safely) compared with women who had no formal education (DaVanzo and Rahman 2014).   A Finnish prospective cohort study of women who had a medical abortion showed that the likelihood of a repeat abortion in up to five years after the initial abortion was significantly linked to postponement of post-abortion contraceptive use. Women who initiated contraception immediately following the first abortion were significantly less likely to present for a repeat abortion (Heikinheimo, Gissler et al. 2008).

Rising population mobility, particularly urban-rural migration in low income countries, can be important. A comparative analysis of urban slum residents in Ghana (migrants vs. lifetime residents) showed that recent migrants have an increased risk of pregnancy but not an increased risk of live birth in the first years post-move compared with lifetime residents, a gap that could be largely explained by an increased risk of miscarriage or abortion among recent migrants (Rokicki, Montana et al. 2014). A study of unsafe abortion among Burmese women who had migrated to Thailand for work showed that poverty, lack of employment rights and experience of domestic violence were all important factors in the decision to terminate the pregnancy (Belton 2007). A comparative Swedish analysis of immigrant and

native women seeking abortion found that immigrant status and educational level were independent risk factors for repeat abortion because immigrant women are likely to have high levels of poverty and unemployment, less well-established pathways to accessing health care (including contraception) and weaker social networks than native-born Swedes (Helström, Odlind et al. 2003).

In settings with recent changes in abortion legislation, analyses reveal socio-demographic disparities in abortion trajectories. A study in Mexico City after the legal liberalisation shows how socio-economic factors interact with the process of obtaining a legal abortion: difficulty in getting an appointment was more likely to be reported by women with low education (vs. high school completion); difficulties in either getting time off work or in arranging transportation were more likely to be reported by unmarried women and women with low levels of education; and, women who were divorced or separated were more likely to report opposition from a significant other (partner, family member) than married women (Becker, Diaz-Olavarrieta et al. 2011). Post-1996 legalisation of abortion in South Africa, the epidemiology of abortion changed substantially. Among women presenting with an incomplete abortion, older women (>30 years) were significantly less likely than younger women to have low severity diagnoses. The authors conclude, that abortion legislation had a rapid and positive impact on abortion morbidity, particularly for younger women (Jewkes, Rees et al. 2005). Analyses (2006-2011) following liberalisation of the abortion law in Nepal show an overall improvement in the levels of knowledge about the law and of a place for obtaining abortion services. However, these increases in knowledge were significantly associated with being from higher wealth quintiles and/or higher levels of educational attainment (Thapa, Sharma et al. 2014).

2.3 Relationship with others (sexual partner(s), family)

Dimensions of the sexual relationship (marital status, relationship duration, power differential between partners, whether commercial or transactional, whether consensual or not), all have implications for abortion. An Indian study of abortion-seeking among unmarried adolescents revealed that conflicting emotions between wanting to have sex and feeling guilty about non-socially sanctioned behaviour led to high levels of distress upon becoming pregnant (Sowmini 2013). Also, expectations about the relationship have implications for consequences of a pregnancy: is the relationship stable and ongoing? Are future goals shared between partners? Does the woman have children with this partner already? For some women, a pregnancy with the 'wrong' partner is what makes the pregnancy unwanted. In a study of women in the United States, nearly a third cited unspecified 'partner-related reasons' for why they sought an abortion (Biggs, Gould et al. 2013).

Whether the pregnancy is the result of coerced or forced sex can be important in affecting abortion trajectories. A study in Cameroon found that women who had experienced intimate partner violence were more likely to have an induced abortion (Alio, Salihu et al. 2011). A study of the relationship between intimate partner violence and pregnancy loss among married women in Bangladesh found an insignificant increased risk for induced abortion among women who had experienced violence (Silverman, Gupta et al. 2007). A study of nulliparous young women in India who had an abortion found that unmarried young women were far more likely to report non-consensual sex leading to the pregnancy compared with their married counterparts (Jejeebhoy, Kalyanwala et al. 2010). The legal (and social) context for termination of pregnancies conceived in rape are often quite different from that of pregnancies conceived consensually, with different macro- influences on a woman's decision to terminate a pregnancy. In yet other circumstances, a pregnancy resulting from commercial sex may similarly be unwanted but may not fall into a legal category in which abortion is allowed (Marlow, Shellenberg et al. 2014; Zhang, Kennedy et al. 2014).

In general, we know much less about adolescent men's attitudes towards abortion. A comparative (Australia, Ireland, Italy) study of male adolescents using a computer-based interactive drama shows the Australian adolescents were much more likely to choose abortion than their Irish or Italian counterparts, which the authors suggest is due to internalisation of national debates and norms about abortion (Lohan, Giulia Olivari et al. 2013).

2.4 Ability to access resources

Women's ability to access resources (social, economic, emotional) to procure an abortion is important in every setting. Financial resources, or ability to access them for an abortion, are a common theme. In settings where men are much more likely to be earning income and controlling the finances, the difference between a safe abortion and an unsafe abortion can come down to whether a man (partner, brother, friend) made money available to pay for a safer procedure (Moore, Jagwe-Wadda et al. 2011). A review of women's experiences of procuring a medical abortion in Latin American countries where abortion is illegal highlighted that access to both economic resources and emotional support were critical in a woman being able to access either a medically supervised medical abortion in a clandestine clinic and/ or information about medical abortion (Zamberlin, Romero et al. 2012). A study of urban Mozambican women who had sought a first trimester termination at a public hospital showed that one quarter had delayed care for more than one week in order to have sufficient funds to pay user fees (Mitchell, Kwizera et al. 2010). A political economy analysis of the costs of abortion in India showed that the costs to women are determined largely by supply-side factors. The cost of abortion in India varies considerably, depending on:

gestation; marital status; abortion method; whether it is a sex-selective abortion; if diagnostic tests are used; whether the provider is registered; and, whether hospitalised. Abortions in the public sector in India are often free only if the woman accepts some form of contraception and other fees may also be charged (Duggal 2004). In Central Eastern European and Central Asian countries (e.g.: Moldova, Russian Federation), many women seek unregulated abortions performed clandestinely within or outside of medical facilities despite legal provision and a well-developed network of facilities because of administrative barriers and the costs of abortion services (Hodorogea and Comendant 2010).

Two studies from the USA highlight how an (in)ability to access financial resources influence abortion care-seeking. A survey of women obtaining abortions found that of those women who did not use insurance for their abortion, over half (52%) found it difficult to pay for the procedure and had to rely on (an)other to help pay costs (transportation, lost wages, childcare) – particularly the man involved in the pregnancy – or had to delay the payment of other bills (rent, food) to pay for the abortion (Jones, Upadhyay et al. 2013). A study of US women who had ever attempted to self-induce an abortion showed that financial constraints were reported among retrospective reasons given for self-inducing. (Grossman, Holt et al. 2010).

Women with resources are not necessarily bound by the laws of their own country. For example, wealthier women from the Muslim theocracy of the Maldives – where abortion is severely restricted - travel to India and Sri Lanka in order to procure an abortion (Hameed 2012).

In some settings, accessing contraceptive services might be more difficult than accessing abortion services. An investigation into persistently high abortion rates in Serbia showed that large barriers to access contraceptive services, combined with relatively low levels of contraceptive knowledge, against a context of relatively easy access to abortion services, meant that women have used abortion in order to manage their fertility (Raševic and Sedlecky 2009).

3. ABORTION-RELATED EXPERIENCES

Having considered the macro-context (1) for abortion decision-making processes, and the individual contextual factors (2) that shape women's options, we turn now to the personal actions (3) an individual woman makes on the trajectory to (attempt to) terminate a pregnancy. Women proceed through time-ordered experiences of: sexual intercourse, contraception (non-)use/failure, becoming aware of a pregnancy, (non-)disclosure and

negotiation, emotions about pregnancy, emotions about having a child and emotions about abortion, attempts to terminate the pregnancy, and the sequelae of those attempts. Each of these is embedded within the inter/sub/national context and the individual context of a woman's life. We next consider these decision steps.

3.1 Awareness of pregnancy

The decision to terminate a pregnancy is highly time sensitive. Unlike other health care decisions, it may cease to be an option in the span of a few months. Likewise, the safety of abortion changes dramatically in a matter of weeks. Terminating a pregnancy early is easier and safer than terminating it later (Niinimaki, Pouta et al. 2009). As the pregnancy advances, termination becomes more complicated and eventually is no longer an option. Thus the amount of time that lapses between conception and a woman's awareness of her pregnancy is critical and directly related to the amount of time she has to decide whether to proceed with a termination. While in developed country contexts pregnancy tests are widely available, they can be expensive. In the USA poorer women may access for free pregnancy tests at 'pregnancy crisis centers,' to avoid buying pregnancy tests, but then may be provided with misinformation about abortion's risks (Rosen 2012). In other contexts pregnancy testing is widely available at no or little cost (e.g. UK), facilitating women's ability to have knowledge of their pregnancy. In many developing country contexts, pregnancy tests may be unavailable or unaffordable. A woman may wait weeks or months before concluding that she is pregnant as each missed period provides her further confirmation.

Taking action to obtain a pregnancy test is tightly linked to the social value or social risk of having a pregnancy. In contexts where a pregnancy is highly socially undesirable, a woman may avoid acknowledging to herself that she is pregnant, so as to avoid the consequences that such a situation will bring about (Sowmini 2013; Coast and Murray 2014). Here, parallels might be drawn with the literature on voluntary counselling and testing for HIV, where evidence shows that some people choose not to be tested for HIV because of the implications that a positive result might bring. Jejeebhoy's study of young (15-24 years) Indian women who had sought an abortion shows how unmarried young women were far less likely to recognise (or acknowledge) that they were pregnant compared to their married counterparts. This delay in pregnancy identification, combined with the need to find a service provider where they could be assured of confidentiality, was associated with higher levels of second trimester terminations among unmarried women relative to married young women (25% and 9%, respectively) (Jejeebhoy, Kalyanwala et al. 2010).

3.2 Disclosure that the pregnancy was unwanted

After acknowledging a pregnancy, a woman may disclose her pregnancy to other people who may influence her decision about terminating the pregnancy and/or help (financial, logistic, support) to arrange the abortion. This disclosure and/or negotiation is embedded in the woman's larger context of relationships and ability to access both social and economic resources. Other people to whom a woman might disclose include the woman's male partner, her family members, and trusted confidants (Sedgh, Rossier et al. 2011). The decisions a woman makes around disclosure are situated in the larger context of her relationships with others (Calvès 2002). These decisions are further enmeshed in the macro-context and the more limited these options are, the more an individual many need to disclose her situation to others and to rely on assistance from them (Rossier 2007). A study of who was involved in abortion decision-making in Ghana revealed that mothers, male partners, friends and employers were "instrumental" in decision-making (Kumi-Kyereme, Gbagbo et al. 2014). A study of unmarried women in India found that for those that sought an abortion at ≥ 12 weeks gestation, the reasons for the delay in abortion care-seeking and included fear of disclosure, lack of support and lack of economic resources. The decision to terminate involved other family members, particularly the mother (Sowmini 2013).

Disclosure may lead to emotional support around an abortion decision and/or pressure to have an abortion or not. In a US-based study a majority of younger women (aged <18) reported that their mothers and partners were involved in the abortion decision, with most reporting that these people were supportive of their decision. A minority of women expressed that they were having an abortion because someone else wanted them to, with mothers most often identified as the source of this pressure (Ralph, Gould et al. 2014).

A woman's autonomy in decision-making may influence to whom she discloses her plans to terminate a pregnancy, and how she manages any negotiations in cases of discordant expectations. A Ghanaian study of women who had sought PAC following an unsafe abortion illustrates the complexities; 11% reported that their pregnancy was planned and 31% reported that their pregnancy was wanted but that they were unable to resist pressure from others (family, partner) to continue the pregnancy and aborted (Aniteye and Mayhew 2011).

A woman may decide to seek an abortion, and not to disclose her decision. Abortion is often covert because abortion is stigmatised and also because keeping the abortion secret means protecting the secrecy of the pregnancy. Across cultural settings, for some women the decision to abort and subsequent abortion procurement are taken alone (Bowes and Macleod 2006). A Cameroon study found that the imperative to keep an abortion secret increased the health complications of abortions that women conducted (Schuster 2005).

3.3 Emotions about Pregnancy/Childbearing/Abortion

A woman may have conflicting and changing emotions about being pregnant, bearing a child, and terminating a pregnancy. These emotions are influenced by the response she receives from any pregnancy disclosure. For a woman (and potentially her partner and/or family as well) there are likely to be on-going and significant economic and social responsibilities in raising a child. In addition to these expenses, bearing a child has short- and long-term economic and opportunity costs to the woman, particularly with respect to attending school or working (Gipson, Koenig et al. 2008). These economic realities may influence a woman's feelings about her pregnancy.

A woman and her partner's feelings about the pregnancy and bearing a child may be influenced by the financial situation of the woman and/or of the partner. For example, in a mixed-methods study of pregnancy termination in Bangladesh, many women and their husbands described challenging life circumstances (poor health, poverty) that influenced their decisions to terminate (Gipson and Hindin 2008). Each woman's particular situation with respect to her reproductive career will influence whether the termination of a pregnancy provides a better outcome for the woman than bearing a child at that time (Norris, Hemed et al. 2014). The timing of a pregnancy in the context of woman's reproductive career may be important to her feelings about a pregnancy and bearing a child. In some contexts, a pregnancy before marriage may be highly undesirable. A meta-analysis of Chinese data indicated that 86-96% of unmarried women experiencing a pregnancy in China terminated it (Qian, Tang et al. 2004), whereas a pregnancy immediately after a marriage would be highly desirable EG+ REF[9]. In some contexts, a pregnancy with close birth spacing may be unacceptable EG+REF[10], whereas a pregnancy with two year spacing would be considered ideal EG+REF[11].

There may be discordance between the woman's plans to terminate or continue with the pregnancy and the man's desires. A male partner may be against abortion, and try to obstruct the woman's efforts to terminate the pregnancy (Moore, Frohwirth et al. 2010). Or, the male partner may deny his role in the pregnancy or refuse to help the woman to obtain an abortion. A Ghanaian study of women post-abortions shows the range of roles played by men, from direct "orders" to abort to indirect influence by denying pregnancy paternity (Schwandt, Creanga et al. 2013). A study of the role of male partners in abortion decision-making by adolescents in Tanzania showed that while nearly half (46%) told their male partner first about the pregnancy, 27% did not reveal the pregnancy to their partner. For those that did reveal their pregnancy, nearly two thirds (62%) were advised by their male

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partner to abort. Overall, however, less than a third (31%) of adolescents reported that their male partner was instrumental in finding someone to provide the abortion; the majority of cases sought information from others (relative, friends, neighbours, work colleagues). The authors highlight age asymmetry between the adolescents and their male partners as being important in influencing the role (if any) of the male partner in abortion care-seeking (Mpangile, Leshabari et al. 1998). Men in Uganda facilitated access to safer abortions for their partners although men recounted how a partner's desire to have an abortion was often punished as it was perceived as a sign of infidelity (Moore, Jagwe-Wadda et al. 2011). A study of the drivers of Kenyan women's choices about unwanted pregnancies highlighted the role played by male partners (Izugbara and Egesa 2014).

For a woman who terminates a pregnancy due to foetal abnormality, the emotions about the pregnancy and coping with its termination may be additionally complex, and may include acknowledging a 'baby', disassociating from the procedure, and attributing meaning to the birth experience (Lafarge, Mitchell et al. 2013). The macro-contextual factors (laws, norms, policies, stigma) are also significantly affected in cases of foetal abnormality, and a woman's decision will be influenced by those[12]. EG+REF[13]

3.4 Attempted Abortion and Sequelae from Abortion

Where abortion is legally restricted, many women will attempt self-induction of abortion. The legal and penal environments, as well as the health care context, shape the options that an individual accesses. After attempting to terminate a pregnancy, a woman may experience physical consequences, emotional consequences, or both. Physical consequences for a woman may include the expected side effects of abortion (cramping, bleeding), and may include mild, moderate or severe complications. In settings where abortion is legally restricted, a woman may have access to safe and legal PAC services after an illegal termination (COUNTRY EXAMPLES)[14]. Following a complication from abortion, a woman may experience consequences that result in long term disability (including infertility and fistula) or even death[15].

Women who have an abortion in the USA can experience stigma, misinformation about the sequelae, and broad societal disapproval. An intervention to develop a "culture of support" for women who have had an abortion included: information to identify and avoid sources of abortion misinformation; provision of supportive messages; and, information about support groups and services. In-depth interviews with women who received the intervention felt

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[12] AM comment: Maybe cite some of the Wendy Davis hoopla in Texas?
[13] Ref needed
[14] Ref needed: Tanzania, others working w EngenderHealth
[15] Ref needed

that it had helped them personally to deal with the actions and judgements of others (Littman, Zarcadoolas et al. 2009).

Delays in diagnosis, care-seeking and care provision are well-established causes of maternal mortality REF. A comparative study of maternal deaths at a hospital in Gabon, where access to legal abortion is severely restricted, showed substantial delays in the provision of care for women who presented with a need for care following an unsafe abortion, compared to women who presented for care due to other conditions. Medical record analysis of the time between diagnosis of the condition and initiation of care showed that the mean time between admission and treatment was 1.2 hours for women who died from post-partum haemorrhage or eclampsia and 23.7 hours for women who died of abortion-related complications (Mayi-Tsonga, Oksana et al. 2009). The delays in care initiation for women with induced abortion complications could be due to deliberate withholding of care by the care providers, or the withholding of information by the woman that would have allowed an earlier diagnosis to be made, or a mixture of the two. A comparison of women seeking abortion-related care (Abortion at hospital vs. PAC at hospital vs. spontaneous abortion) in Nigeria showed that women who sought PAC were poorer and later in gestation than women who sought abortions directly from a hospital. This group of women also paid significantly more for their treatment (Henshaw, Adewole et al. 2008).

A woman may experience a range of emotional sequelae after a pregnancy termination. Some women experience regret for the pregnancy and/or the abortion[16]. Others experience relief that they are no longer pregnant (Watson 2014). In many settings globally, both in contexts where abortion is legal and illegal, women worry about their future fertility following a termination (Moore, Singh et al. 2011). An online study of British women's coping strategies following an abortion for foetal abnormality showed that whilst women used coping strategies to navigate the psychological consequences of abortion, the health service provision for such needs was inadequate and meant that women had to draw on their own coping resources (Lafarge, Mitchell et al. 2013). Some women experience guilt about the abortion. Whether women experience guilt or not, most choose to keep their pregnancies and abortions secret, to hide the stigma of the socially unsanctioned sex, the unwanted pregnancy, and the stigmatised abortion. Abortion can be emotionally upsetting, but for many women it simultaneously represents a pragmatic solution to a problematic pregnancy.

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[16] Ref needed

DISCUSSION AND CONCLUSION

Our conceptual framework offers a point of departure for new research by drawing attention to primary components and linkages in describing and explaining women's trajectories to abortion decision-making and behaviour. In so doing, it highlights the ways in which abortion trajectories are influenced by macro- and micro-level factors that operate in multiple (and sometimes conflicting) ways. The conceptual framework that we have developed reflects the decision-making process of women in a range of contexts around the world—economic, social, cultural, political, and legal. Our review of the literature gives specificity to the concepts in our framework, and highlights areas of importance—and often scarce evidence—especially from settings where abortion is illegal and/or highly stigmatised. The framework pushes us to move well beyond the sorts of research that simply describes trajectories through a narrow lens. Rather, the existing research body needs to be complemented by more holistic ways of understanding the trajectories (and their influencers) on girls and women seeking abortion-related care to understand how abortion fits into their social circumstances and with their reproductive careers.

LIMITATIONS OF THE CONCEPTUAL FRAMEWORK

Our framework reflects our backgrounds and knowledge, and therefore our implicit initial biases in developing it. It reflects our empirical observation, a priori reading and observations, alongside our need to organise our thinking about complex scenarios. We have tried to confront (but not eliminate) these biases by "testing" the framework through applying it to presentations and publications that deal with abortion decision-making and trajectories, drawn from as wide a geographic and conceptual range as possible. In constructing this conceptual framework, we remain open to unexpected and new evidence, and its potential influence to change the proposed framework.

In any two dimensional representation there are limitations to the illustration of complexity and the inter-relationships between the different levels. Our representation implies clear boundaries between the components and levels – and simplifies the complexity and messiness of trajectories of abortion decision-making and behaviours. However in our opinion they still serve as useful organisers from which to develop departure points for future research agendas and points of policy/programmatic intervention.

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REFERENCES

Abdi, J. and M. B. Gebremariam (2011). "Health Providers' Perception towards Safe Abortion Service at Selected Health Facilities in Addis Ababa." African Journal of Reproductive Health 15(1): 31-36.

Adinma, E. D., J. I. B.-D. Adinma, et al. (2012). "Knowledge and practices among medical abortion seekers in southeastern Nigeria." Southeast Asian Journal of Tropical Medicine and Public Health 43(2): 471-478.

Agadjanian, V. (2002). "Is "abortion culture" fading in the former Soviet Union? views about abortion and contraception in Kazakhstan." Studies in Family Planning 33(3): 237-248.

Alblas, M. (2008). "A Week in the Life of an Abortion Doctor, Western Cape Province, South Africa." Reproductive Health Matters 16(31): 69-73.

Alio, A. P., H. M. Salihu, et al. (2011). "Association between intimate partner violence and induced abortion in Cameroon." International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics 112(2): 83-87.

Althaus, F. A. (2000). "Work in progress: the expansion of access to abortion services in South Africa following legalization." International Family Planning Perspectives 26(2): 84-86.

Aniteye, P. and S. Mayhew (2011). "Attitudes and experiences of women admitted to hospital with abortion complications in Ghana." African Journal of Reproductive Health 15(1): 47-55.

Aniteye, P. and S. H. Mayhew (2013). "Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation." Health Research Policy and Systems 11(23).

Arambepola, C. and L. C. Rajapaksa (2014). "Decision making on unsafe abortions in Sri Lanka: a case-control study." Reproductive Health 11: 91.

Banerjee, S., K. Andersen, et al. (2014). "Evaluation of a multi-pronged intervention to improve access to safe abortion care in two districts in Jharkhand." BMC Health Services Research 14(1): 227.

Banerjee, S., K. Andersen, et al. (2012). "Woman-centered research on access to safe abortion services and implications for behavioral change communication interventions: a cross-sectional study of women in Bihar and Jharkhand, India." BMC Public Health 12(1): 175.

Banerjee, S. K. and K. Andersen (2012). "Exploring the Pathways of Unsafe Abortion in Madya Pradesh, India." Global Public Health Journal Forthcoming.

Banerjee, S. K., K. L. Andersen, et al. (2012). "Pathways and consequences of unsafe abortion: A comparison among women with complications after induced and spontaneous abortions in Madya Pradesh, India." International Journal of Gynecology and Obstetrics 118(Suppl 2): S113-S120.

Becker, D., C. Diaz-Olavarrieta, et al. (2011). "Sociodemographic Factors Associated With Obstacles to Abortion Care: Findings From a Survey of Abortion Patients in Mexico City." Women's Health Issues 21(3, Supplement): S16-S20.

Bélanger, D. and A. Flynn (2009). "The Persistence of Induced Abortion in Cuba: Exploring the Notion of an "Abortion Culture"." Studies in Family Planning 40(1): 13-26.

Belton, S. (2007). "Borders of fertility: Unplanned pregnancy and unsafe abortion in Burmese women migrating to Thailand." Health Care for Women International 28(4): 419-433.

Bennett, L. R. (2001). "Single women's experiences of premarital pregnancy and induced abortion in Lombok, Eastern Indonesia." Reproductive Health Matters 9(17): 37-43.

Benson, J. (2005). "Evaluating Abortion-care Programs: Old Challenges, New Directions." Studies in Family Planning 36(3): 189-202.

Berer, M. (2004). "National laws and unsafe abortion: the parameters of change." Reproductive Health Matters 12(24): 1-8.

Biggs, M., H. Gould, et al. (2013). "Understanding why women seek abortions in the US." BMC Women's Health 13(1): 29.

Billings, D. L., C. Moreno, et al. (2002). "Constructing Access to Legal Abortion Services in Mexico City." Reproductive Health Matters 10(19): 86-94.

Billings, D. L., D. Walker, et al. (2009). "Pharmacy worker practices related to use of misoprostol for abortion in one Mexican state." Contraception 79(6): 445-451.

Blofield, M. (2008). "Women's choices in comparative perspective: Abortion policies in late-developing Catholic countries." Comparative Politics: 399-419.

Bloom, G. (2014). Tuesday, 2 September 2014New methods needed: How can complexity science help us to understand pluralistic health systems? . IDS Knowledge, Technology and Society. I. o. D. Studies. 2014.

Boland, R. (2010). "Second trimester abortion laws globally: actuality, trends and recommendations." Reproductive health matters 18(36): 67-89.

Bowes, T. and C. Macleod (2006). "The characteristics of women seeking termination of pregnancy at an urban-based government hospital in the Eastern Cape." Curationis 29(4): 12-18.

Calvès, A.-E. (2002). "Abortion Risk and Decisionmaking among Young People in Urban Cameroon." Studies in Family Planning 33(3): 249-260.

Cappiello, J., J. Merrell, et al. (2014). "Women's Experience of Decision-Making With Medication Abortion." MCN Am J Matern Child Nurs 39(5): 325-330.

Casas, L. and L. Vivaldi (2014). "Abortion in Chile: the practice under a restrictive regime." Reproductive Health Matters 22(44): 70-81.

Castañeda, X., D. L. Billings, et al. (2003). "Abortion beliefs and practices among midwives (parteras) in a rural Mexican township." Women & health 37(2): 73-87.

Chavkin, W., L. Leitman, et al. (2013). "Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences, and policy responses." Int J Gynaecol Obstet 123 Suppl 3: S41-56.

Coast, E. and S. Murray (2014). Pregnancy termination trajectories in Zambia. International Seminar on Decision-making regarding abortion-determinants and consequences. I. S. P. o. A. Research. Nanyuki, Kenya, IUSSP.

Cockrill, K. and A. Nack (2013). ""I'm Not That Type of Person": Managing the Stigma of Having an Abortion." Deviant Behavior 34(12): 973-990.

Coeytaux, F., L. Hessini, et al. (2014). "Facilitating women's access to misoprostol through community-based advocacy in Kenya and Tanzania." International Journal of Gynecology & Obstetrics 125(1): 53-55.

Coeytaux, F. and E. Wells (2013). Misoprostol Is a Game-Changer for Safe Abortion and Maternal Health Care. Why Isn't it More Widely Available? RH Reality Check. 2015.

Cohen, S. A. (2009). "The Reproductive Health Needs of Refugees and Displaced People: An Opening for Renewed U. S. Leadership." Guttmacher Policy Review 12(3): 15-19.

Constant, D., K. de Tolly, et al. (2014). "Mobile phone messages to provide support to women during the home phase of medical abortion in South Africa: a randomised controlled trial." Contraception 90(3): 226-233.

Cook, R. J., J. N. Erdman, et al. (2014). Abortion Law in Transnational Perspective: Cases and Controversies University of Pennsylvania Press

Crane, B. B. and J. Dusenberry (2004). "Power and politics in international funding for reproductive health: the US Global Gag Rule." Reprod Health Matters 12(24): 128-137.

Dahlback, E., M. Maimbolwa, et al. (2007). "Unsafe Induced Abortions Among Adolescent Girls in Lusaka." Health Care for Women International 28(7): 654-676.

Darney, B. G., W. Simancas-Mendoza, et al. (2014). "Post-abortion and induced abortion services in two public hospitals in Colombia." Contraception 90(1): 36-41.

DaVanzo, J. and M. Rahman (2014). "Pregnancy Termination in Matlab, Bangladesh: Trends And Correlates of Use of Safer and Less-Safe Methods." International Perspectives on Sexual and Reproductive Health 40(3): 119-126.

Dobkin, L. M., H. Gould, et al. (2014). "Implementing a prospective study of women seeking abortion in the United States: Understanding and overcoming barriers to recruitment." Women's Health Issues 24(1): e115-e123.

Drabo, S. (2013). Access to Post Abortion Care (PAC) in Burkina Faso: an ethnographic study. Master, Universitetet i Oslo.

Duggal, R. (2004). "The Political Economy of Abortion in India: Cost and Expenditure Patterns." Reproductive Health Matters 12(24, Supplement): 130-137.

Edmeades, J., S. M. Lee-Rife, et al. (2010). "Women and reproductive control: the nexus between abortion and contraceptive use in Madhya Pradesh, India." Stud Fam Plann 41(2): 75-88.

Eran, B., A. Patrick, et al. (2011). "United States aid policy and induced abortion in sub-Saharan Africa." World Health Organization. Bulletin of the World Health Organization 89(12): 873.

Erdman, J. N. (2014). "Procedural abortion rights: Ireland and the European Court of Human Rights." Reproductive Health Matters 22(44): 22-30.

Fernandez, M. M., F. Coeytaux, et al. (2009). "Assessing the global availability of misoprostol." Int J Gynaecol Obstet 105(2): 180-186.

Frohwirth, L., M. Coleman, et al. (2014). Managing Religion and Morality within the Abortion Decision: Data from Qualitative Interviews with Women Obtaining Abortions in the U.S. Population Association of America 2014 Annual Meeting. Boston, MA.

García, S. G., C. Tatum, et al. (2004). "Policy Implications of a National Public Opinion Survey on Abortion in Mexico." Reproductive Health Matters 12(24, Supplement): 65-74.

Geary, C. W., H. Gebreselassie, et al. (2012). "Attitudes toward abortion in Zambia." International Journal of Gynecology & Obstetrics 118, Supplement 2(0): S148-S151.

Gerdts, C., I. Hudaya, et al. (2014). "Mobile health innovations for improved access to safe abortion in Indonesia." Contraception 90(3): 299.

Gipson, J. D., D. Becker, et al. (2011). "Conducting Collaborative Abortion Research in International Settings." Women's Health Issues 21(3, Supplement): S58-S62.

Gipson, J. D. and M. J. Hindin (2008). ""Having another child would be a life or death situation for her": understanding pregnancy termination among couples in rural Bangladesh." Am J Public Health 98(10): 1827-1832.

Gipson, J. D., M. A. Koenig, et al. (2008). "The effects of unintended pregnancy on infant, child, and parental health: a review of the literature." Stud Fam Plann 39(1): 18-38.

Global Doctors for Choice. (2014, 2014). "Who We Are."   Retrieved September 2014, 2014, from http://globaldoctorsforchoice.org/about-us/who-we-are/.

Gomperts, R., K. van der Vleuten, et al. (2014). "Provision of medical abortion using telemedicine in Brazil." Contraception 89(2): 129-133.

Gomperts, R. J., K. Jelinska, et al. (2008). "Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services." BJOG: An International Journal of Obstetrics & Gynaecology 115(9): 1171-1178.

Grossman, D., K. Holt, et al. (2010). "Self-induction of abortion among women in the United States." Reproductive Health Matters 18(36): 136-146.

Guttmacher Institute (2014). Forcibly displaced populations' sexual and reproductive health needs must not be overlooked. Media Update.

Guttmacher Institute and Ibis Reproductive Health (2013). Using Research to Make the Case for Investments in Safe Abortion Care.

Hameed, S. (2012). Sexual health policies and youth: a case study of the Maldives., LSE.

Harries, J., D. Cooper, et al. (2014). "Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study." Reproductive Health 11(16): 1-7.

Harries, J., K. Stinson, et al. (2009). "Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa." BMC public health 9(1): 296-296.

Harris, L. H., M. Debbink, et al. (2011). "Dynamics of stigma in abortion work: Findings from a pilot study of the Providers Share Workshop." Social Science & Medicine 73(7): 1062-1070.

Heikinheimo, O., M. Gissler, et al. (2008). "Age, parity, history of abortion and contraceptive choices affect the risk of repeat abortion." Contraception 78(2): 149-154.

Helström, L., V. Odlind, et al. (2003). "Abortion rate and contraceptive practices in immigrant and native women in Sweden." Scandinavian journal of public health 31(6): 405-410.

Henderson, J., M. Puri, et al. (2013). "Effects of Abortion Legalization in Nepal, 2001–2010." PLoS ONE 8(5): e64775.

Henshaw, S. K., I. Adewole, et al. (2008). "Severity and cost of unsafe abortion complications treated in Nigerian hospitals." International Family Planning Perspectives: 40-50.

Hodes, R. (2013). "The medical history of abortion in South Africa, c.1970-2000 " Journal of Southern African Studies 39(3): 527-542.

Hodorogea, S. and R. Comendant (2010). "Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia." International Journal of Gynecology & Obstetrics 110, Supplement(0): S34-S37.

Huda, F. A., T. D. Ngo, et al. (2014). "Availability and provision of misoprostol and other medicines for menstrual regulation among pharmacies in Bangladesh via mystery client survey." International Journal of Gynecology and Obstetrics 124(2): 164-168.

Hukin, E. F. (2012). Contraception in Cambodia: Explaining Unmet Need. PhD, London School of Economics and Political Science.

Hyman, A., K. Blanchard, et al. (2013). "Misoprostol in women's hands: a harm reduction strategy for unsafe abortion." Contraception 87: 128-130.

Ipas (2009). Misoprostol and medical abortion in Africa. Chapel Hill, USA, Ipas.

Izugbara, C. and C. Egesa (2014). "The Management of Unwanted Pregnancy Among Women in Nairobi, Kenya." International Journal of Sexual Health 26(2): 100-112.

Jagwe-Wadda, G., A. M. Moore, et al. (2006). Abortion Morbidity in Uganda: Evidence from Two Communities. Occasional Report. New York, Guttmacher Institute. 26.

Jaldesa, G. W. (2014). "Contribution of obstetrics and gynecology societies in East, Central, and Southern Africa to the prevention of unsafe abortion in the region." International Journal of Gynecology & Obstetrics 126, Supplement 1(0): S13-S16.

Jejeebhoy, S. J., S. Kalyanwala, et al. (2010). "Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages." Reproductive Health Matters 18(35): 163-174.

Jewkes, R., H. Rees, et al. (2005). "The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change." BJOG-AN INTERNATIONAL JOURNAL OF OBSTETRICS AND GYNAECOLOGY 112(3): 355-359.

Jewkes, R. K., T. Gumede, et al. (2005). "Why are women still aborting outside designated facilities in metropolitan South Africa?" BJOG: An International Journal of Obstetrics & Gynaecology 112(9): 1236-1242.

Johnson-Hanks, J. (2002). "The lesser shame: abortion among educated women in southern Cameroon." Social Science & Medicine 55(8): 1337-1349.

Jones, B. S. and T. A. Weitz (2009). "Legal barriers to second-trimester abortion provision and public health consequences." American Journal of Public Health 99(4): 623-630.

Jones, R. K., U. D. Upadhyay, et al. (2013). "At What Cost? Payment for Abortion Care by U.S. Women." Women's Health Issues 23(3): e173-e178.

Kavanaugh, M. L., D. Bessett, et al. (2013). "Connecting Knowledge about Abortion and Sexual and Reproductive Health to Belief about Abortion Restrictions: Findings from an Online Survey." Women's Health Issues 23(4): e239-e247.

Kavanaugh, M. L., A. M. Moore, et al. (2013). "Community attitudes towards childbearing and abortion among HIV-positive women in Nigeria and Zambia." Culture, health & sexuality 15(2): 160-174.

Kestler, E. (2012). "Obstetrician–gynecologists' knowledge of and attitudes toward medical abortion in Guatemala." International Journal of Gynecology & Obstetrics 116(2): 120-123.

Kimport, K., K. Foster, et al. (2011). "Social Sources of Women's Emotional Difficulty After Abortion: Lessons from Women's Abortion Narratives." Perspectives on Sexual and Reproductive Health 43(2): 103-109.

Kinaro, J., T. Ali, et al. (2009). "Unsafe Abortion and Abortion Care in Khartoum, Sudan." Reproductive Health Matters 17(34): 71-77.

Konney, T. O., K. A. Danso, et al. (2009). "Attitude of women with abortion-related complications toward provision of safe abortion services in Ghana." J Womens Health (Larchmt) 18(11): 1863-1866.

Kulczycki, A. (2014). "A Comparative Study of Abortion Policymaking in Brazil and South America: The Salience of Issue Networks and Policy Windows." Journal of Comparative Policy Analysis: Research and Practice 16(1): 62-78.

Kumar, A., L. Hessini, et al. (2009). "Conceptualising abortion stigma." Culture, Health & Sexuality 11(6): 625-639.

Kumi-Kyereme, A., F. Gbagbo, et al. (2014). "Role-players in abortion decision-making in the Accra Metropolis, Ghana." Reproductive Health 11(1): 70.

Laanpere, M., I. Ringmets, et al. (2014). "Abortion trends from 1996 to 2011 in Estonia: special emphasis on repeat abortion." BMC Women's Health 14(1): 81.

Lafarge, C., K. Mitchell, et al. (2013). "Women's experiences of coping with pregnancy termination for fetal abnormality." Qual Health Res 23(7): 924-936.

Lafaurie, M. M., D. Grossman, et al. (2005). "Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and Peru: A Qualitative Study." Reproductive Health Matters 13(26): 75-83.

Lamas, M. and S. Bissell (2000). "Abortion and politics in Mexico: 'context is all'." Reproductive Health Matters 8(16): 10-23.

Lara, D., K. Abuabara, et al. (2006). "Pharmacy provision of medical abortifacients in a Latin American city." Contraception 74(5): 394-399.

Lara, D., S. G. Garcia, et al. (2011). "How often and under which circumstances do Mexican pharmacy vendors recommend misoprostol to induce an abortion?" International Perspectives on Sexual and Reproductive Health 37(2): 75-83.

Law, O. N. I. f. N. a. G. H. and W. s. L. Worldwide (2014). Conscientious Objection and Abortion: A Global Perspective on the Colombian Experience.

Leke, R. J. I. (2014). "Contribution of obstetrics and gynecology societies in West and Central African countries to the prevention of unsafe abortion." International Journal of Gynecology & Obstetrics 126, Supplement 1(0): S17-S19.

LeTourneau, K., M. Batchelder, et al. (2014). Establishing a global network to identify, challenge and mitigate abortion stigma Background Report. Chapel Hill, NC, Ipas.

Levandowski, B. A., L. Kalilani-Phiri, et al. (2012). "Investigating social consequences of unwanted pregnancy and unsafe abortion in Malawi: The role of stigma." International Journal of Gynecology and Obstetrics 118(Supplement 2): S167–S171.

Levels, M., R. Sluiter, et al. (2014). "A review of abortion laws in Western-European countries. A cross-national comparison of legal developments between 1960 and 2010." Health Policy 118(1): 95-104.

Lie, M. L., S. C. Robson, et al. (2008). "Experiences of abortion: a narrative review of qualitative studies." BMC health services research 8(1): 150.

Lipp, A. (2011). "Stigma in abortion care: application to a grounded theory study." Contemporary Nurse 37(2): 115-123.

Littman, L. L., C. Zarcadoolas, et al. (2009). "Introducing abortion patients to a culture of support: a pilot study." Archives of Women's Mental Health 12(6): 419-431.

Lohan, M., M. Giulia Olivari, et al. (2013). "Adolescent Men's Pregnancy Resolution Choices in Relation to an Unintended Pregnancy : A Comparative Analysis of Adolescent Men in Three Countries." Journal of Family Issues 34: 1037-1058.

Lohr, P. A., M. Fjerstad, et al. (2014). Abortion.

Macha, S., M. Muyuni, et al. (2014). "Increasing access to legal termination of pregnancy and postabortion contraception at the University Teaching Hospital, Lusaka, Zambia." International Journal of Gynaecology and Obstetrics 126(1,SUPPL): 4-6.

Macleod, C., N. Sigcau, et al. (2011). "Culture as a discursive resource opposing legal abortion." Critical Public Health 21(2): 237-245.

Marlow, H. M., K. Shellenberg, et al. (2014). "Abortion services for sex workers in Uganda: successful strategies in an urban clinic." Culture, Health & Sexuality: 1-13.

Marlow, H. M., S. Wamugi, et al. (2014). "Women's perceptions about abortion in their communities: perspectives from western Kenya." Reproductive Health Matters 22(43): 149-158.

Mayi-Tsonga, S., L. Oksana, et al. (2009). "Delay in the provision of adequate care to women who died from abortion-related complications in the principal maternity hospital of Gabon." Reproductive Health Matters 17(34): 65-70.

McMurtrie, S. M., S. G. Garcia, et al. (2012). "Public opinion about abortion-related stigma among Mexican Catholics and implications for unsafe abortion." international Journal of Gynecology and Obstetrics 118(Suppl 2): S160-S166.

Miles, M. B. and A. M. Huberman (1994). Qualitative data analysis : an expanded sourcebook. Thousand Oaks, Calif. ; London, Sage.

Miller, S., T. Lehman, et al. (2005). "Misoprostol and declining abortion-related morbidity in Santo Domingo, Dominican Republic: a temporal association." Bjog 112(9): 1291-1296.

Mitchell, E., S. Heumann, et al. (2014). "Brazilian adolescents' knowledge and beliefs about abortion methods: a school-based internet inquiry." BMC Women's Health 14(1): 27.

Mitchell, E. M., A. Kwizera, et al. (2010). "Choosing early pregnancy termination methods in Urban Mozambique." Soc Sci Med 71(1): 62-70.

Mitchell, E. M. H., C. T. Halpern, et al. (2006). "Social Scripts and Stark Realities: Kenyan Adolescents' Abortion Discourse." Culture, Health & Sexuality 8(6): 515-528.

Möller, A., S. Öfverstedt, et al. (2012). "Proud, not yet satisfied: The experiences of abortion service providers in the Kathmandu Valley, Nepal." Sexual & Reproductive Healthcare 3(4): 135-140.

Moore, A. M., L. Frohwirth, et al. (2010). "Male reproductive control of women who have experienced intimate partner violence in the United States." Social Science & Medicine 70(11): 1737-1744.

Moore, A. M., G. Jagwe-Wadda, et al. (2011). "Men's attitudes about abortion in Uganda." Journal of Biosocial Science 43(1): 1-15.

Moore, A. M., R. Kibombo, et al. (2013). "Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion." Health Policy and Planning [Advance Access published]: 1-9.

Moore, A. M., S. Singh, et al. (2011). "Do women and men consider abortion as an alternative to contraception in the United States? An exploratory study." Global Public Health 6 Suppl 1: S25-37.

Morhe, R. A. S., E. S. K. Morhe, et al. (2007). "Attitudes of doctors toward establishing safe abortion units in Ghana." International Journal of Gynecology and Obstetrics 98(1): 70-74.

Morroni, C., L. Myer, et al. (2006). "Knowledge of the abortion legislation among South African women: a cross-sectional study." Reproductive health 3(1): 7-7.

Mote, C. V., E. Otupiri, et al. (2010). "Factors Associated with Induced Abortion among Women in Hohoe, Ghana." African Journal of Reproductive Health 14(4): 115.

Mpangile, G. S., M. T. Leshabari, et al. (1998). "Abortion and unmet need for contraception in Tanzania-the role of male partners in teenage induced abortion in Dar Es Salaam." African Journal of Reproductive Health 2(2): 108-121.

Ngwena, C. G. (2014). "Conscientious Objection to Abortion and Accommodating Women's Reproductive Health Rights: Reflections on a Decision of the Constitutional Court of Colombia from an African Regional Human Rights Perspective." Journal of African Law 58(02): 183-209.

Niinimaki, M., A. Pouta, et al. (2009). "Immediate complications after medical compared with surgical termination of pregnancy." Obstet Gynecol 114(4): 795-804.

Norris, A., D. Bessett, et al. (2011). "Abortion stigma: a reconceptualization of constituents, causes, and consequences." Womens Health Issues 21(3 Suppl): S49-54.

Norris, A., M. Hemed, et al. (2014). Fears of unwanted pregnancy versus fears of unsafe abortion: A qualitative community-based study with women who terminated pregnancies in Zanzibar, Tanzania. International Union for the Scientific Study of Population International Seminar on Decision-Making Regarding Abortion - Determinants and Consequences. Nanyuki, Kenya.

O'Donnell, J., T. A. Weitz, et al. (2011). "Resistance and vulnerability to stigmatization in abortion work." Social Science & Medicine 73(9): 1357-1364.

Okonofua, F. E., A. Hammed, et al. (2009). "Perceptions of policymakers in Nigeria toward unsafe abortion and maternal mortality." International Perspectives on Sexual and Reproductive Health: 194-202.

Okonta, P. I., P. N. Ebeigbe, et al. (2010). "Liberalization of abortion and reduction of abortion related morbidity and mortality in Nigeria." ACTA OBSTETRICIA ET GYNECOLOGICA SCANDINAVICA 89(8): 1087-1090.

Olavarrieta, C. D., S. G. Garcia, et al. (2012). "Women's experiences of and perspectives on abortion at public facilities in Mexico City three years following decriminalization." International Journal of Gynecology & Obstetrics 118, Supplement 1(0): S15-S20.

Orner, P., M. de Bruyn, et al. (2011). "'It hurts, but I don't have a choice, I'm not working and I'm sick': decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa." Culture, Health & Sexuality 13(7): 781.

Orner, P., M. de Bruyn, et al. (2010). "A qualitative exploration of HIV-positive pregnant women's decision-making regarding abortion in Cape Town, South Africa." SAHARA J-JOURNAL OF SOCIAL ASPECTS OF HIV-AIDS 7(2): 44-51.

Otoide, V. O., F. Oronsaye, et al. (2001). "Why Nigerian adolescents seek abortion rather than contraception: evidence from focus-group discussions." International Family Planning Perspectives: 77-81.

Patel, L., T. A. Bennett, et al. (2009). "Support for provision of early medical abortion by mid-level providers in Bihar and Jharkhand, India." Reproductive Health Matters 17(33): 70-79.

Payne, C. M., M. Precourt Debbink, et al. (2013). "Why Women are dying from unsafe Abortion: Narratives of Ghanaian abortion providers." Afr J Reprod Health 17(2): 118-128.

Pheterson, G. and Y. Azize (2005). "Abortion practice in the northeast Caribbean:"Just write down stomach pain"." Reproductive Health Matters 13(26): 44-53.

Prada, E., E. Kestler, et al. (2005). "Abortion and postabortion care in Guatemala: a report from health care professionals and health facilities." Occasional Report 18.

Prada, E., S. Singh, et al. (2011). Unintended Pregnancy And Induced Abortion in Colombia: Causes and Consequences. New York, Guttmacher Institute.

Qian, X., S. Tang, et al. (2004). "Unintended pregnancy and induced abortion among unmarried women in China: a systematic review." BMC health services research 4(1): 1.

Ralph, L., H. Gould, et al. (2014). "The Role of Parents and Partners in Minors' Decisions to Have an Abortion and Anticipated Coping After Abortion." Journal of Adolescent Health 54(4): 428-434.

Ramachandar, L. and P. J. Pelto (2002). "The Role of Village Health Nurses in Mediating Abortions in Rural Tamil Nadu, India." Reproductive Health Matters 10(19): 64-75.

Ramos, S., M. Romero, et al. (2014). "Health care providers' opinions on abortion: a study for the implementation of the legal abortion public policy in the Province of Santa Fe, Argentina." Reproductive Health 11: 72.

Rasch, V., P. H. Sorensen, et al. (2014). "Unsafe abortion in rural Tanzania - the use of traditional medicine from a patient and a provider perspective." BMC Pregnancy and Childbirth 14(1): 419.

Raševic, M. and K. Sedlecky (2009). "The abortion issue in Serbia." The European Journal of Contraception and Reproductive Health Care 14(6): 385-390.

Reichel, M. and M. A. Ramey (1987). Conceptual frameworks for bibliographic education : theory into practice. Littleton, Colo., Libraries Unlimited.

Rokicki, S., L. Montana, et al. (2014). "Impact of Migration on Fertility and Abortion: Evidence From the Household and Welfare Study of Accra." Demography 51(6): 2229-2254.

Rominski, S. D., M. Gupta, et al. (2014). "Female autonomy and reported abortion-seeking in Ghana, West Africa." Int J Gynaecol Obstet.

Rosen, J. D. (2012). "The Public Health Risks of Crisis Pregnancy Centers." Perspectives on Sexual and Reproductive Health 44(3): 201-205.

Rossier, C. (2007). "Abortion: an open secret? Abortion and social network involvement in Burkina Faso." Reproductive Health Matters 15(30): 230-238.

Ruibal, A. (2014). "Movement and counter-movement: a history of abortion law reform and the backlash in Colombia 2006–2014." Reproductive Health Matters 22(44): 42-51.

Salvador, C. s. C. f. t. D. o. A. o. G. o. H. E. a. F. A. E. (2014). "From hospital to jail: the impact on women of El Salvador's total criminalization of abortion." Reproductive Health Matters 22(44): 52-60.

Sánchez Fuentes, M. L., J. Paine, et al. (2008). "The decriminalisation of abortion in Mexico City: how did abortion rights become a political priority?" Gender & Development 16(2): 345-360.

Schuster, S. (2005). "Abortion in the Moral World of the Cameroon Grassfields." Reproductive Health Matters 13(26): 130-138.

Schwandt, H. M., A. A. Creanga, et al. (2013). "Pathways To Unsafe Abortion In Ghana: The Role Of Male Partners, Women, And Health Care Providers." Contraception.

Sedgh, G., C. Rossier, et al. (2011). "Estimating abortion incidence in Burkina Faso using two methodologies." Studies in family planning 42(3): 147-154.

Senanayake, P. and S. Hamm (2004). "Sexual and reproductive health funding: donors and restrictions." The Lancet 363(9402): 70.

Shapiro, G. K. (2014). "Abortion law in Muslim-majority countries: an overview of the Islamic discourse with policy implications." Health Policy and Planning 29(4): 483-494.

Shaw, D. (2010). "The FIGO initiative for the prevention of unsafe abortion." International Journal of Gynecology & Obstetrics 110, Supplement(0): S17-S19.

Shellenberg, K. M., L. Hessini, et al. (2014). "Developing a Scale to Measure Stigmatizing Attitudes and Beliefs About Women Who Have Abortions: Results from Ghana and Zambia." Women & Health 54(7): 599-616.

Silva, M., D. L. Billings, et al. (2009). "Physicians' agreement with and willingness to provide abortion services in the case of pregnancy from rape in Mexico." Contraception 79(1): 56-64.

Silva, M., C. Thibaut, et al. (2014). Uruguayan women decide: legal and illegal abortions in the era of Misoprostol. International Seminar on Decision-making regarding abortion-determinants and consequences. I. S. P. o. A. Research. Nanyuki, Kenya, IUSSP.

Silverman, J., J. Gupta, et al. (2007). "Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women." BJOG: An International Journal of Obstetrics & Gynaecology 114(10): 1246-1252.

Singh, S., D. Wulf, et al. (1997). "Health Professionals' Perceptions About Induced Abortion in South Central and Southeast Asia." International Family Planning Perspectives 23(2): 59-72.

Skjeldestad, F. (1997). "Increased number of induced abortions in Norway after media coverage of adverse vascular events from the use of third-generation oral contraceptives." Contraception 55(1): 11-14.

Skuster, P. (2014). Engaging police to improve access to safe abortion. 142nd APHA Annual Meeting and Exposition 2014. New Orleans.

Sneeringer, R. K., D. L. Billings, et al. (2012). "Roles of pharmacists in expanding access to safe and effective medical abortion in developing countries: A review of the literature." JOURNAL OF PUBLIC HEALTH POLICY 33(2): 218-229.

Sowmini, C. V. (2013). "Delay in termination of pregnancy among unmarried adolescents and young women attending a tertiary hospital abortion clinic in Trivandrum, Kerala, India." Reproductive Health Matters 21(41): 243-250.

Steele, C. and S. Chiarotti (2004). "With everything exposed: cruelty in post-abortion care in Rosario, Argentina." Reproductive Health Matters 12(24): 39-46.

Suh, S. (2014). "Rewriting abortion: Deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal." Social Science & Medicine 108(0): 20-33.

Sundaram, A., F. Juarez, et al. (2012). "Factors Associated with Abortion-Seeking and Obtaining a Safe Abortion in Ghana." Studies in Family Planning 43(4): 273-286.

Tagoe-Darko, E. (2013). ""Fear, Shame and Embarrassment": The Stigma Factor in Post Abortion Care at Komfo Anokye Teaching Hospital, Kumasi, Ghana." Asian Social Science 9(10): p134.

Taracena, R. (2002). "Social Actors and Discourse on Abortion in the Mexican Press: the Paulina Case." Reproductive Health Matters 10(19): 103-110.

Teerawichitchainan, B. and S. Amin (2010). "The Role of Abortion in the Last Stage Of Fertility Decline in Vietnam." International Perspectives on Sexual and Reproductive Health 36(2): 80-89.

Thapa, S., S. K. Sharma, et al. (2014). "Women's knowledge of abortion law and availability of services in Nepal." Journal of Biosocial Science 46(02): 266-277.

Tong, W., W. Low, et al. (2012). "Exploring pregnancy termination experiences and needs among Malaysian women: A qualitative study." BMC Public Health 12(1): 743.

Upreti, M. (2014). "Abortion law reform in Nepal." International Journal of Gynaecology and Obstetrics 126(2): 193-197.

Väisänen, H. and M. Murphy (2014). "Social Inequalities in Teenage Fertility Outcomes: Childbearing and Abortion Trends of Three Birth Cohorts In Finland." Perspectives on Sexual and Reproductive Health: n/a-n/a.

Vala-Haynes, E. and R. W. Rochat (2007). Abortion-Politics and Media in Mexico. Population Association of America 2007 Annual Meeting. New York, NY.

Vasquez, D. N., A. V. Das Neves, et al. (2012). "Critical care providers' opinion on unsafe abortion in Argentina." International Journal of Gynecology and Obstetrics 116(3): 249-252.

Watson, K. (2014). "Reframing regret." JAMA 311(1): 27-28.

WHO (2011). Unsafe abortion Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Geneva, WHO.

Zamberlin, N., M. Romero, et al. (2012). "Latin American women's experiences with medical abortion in settings where abortion is legally restricted." Reprod Health 22(9): 1.

Zhang, X. D., E. Kennedy, et al. (2014). "High rates of abortion and low levels of contraceptive use among adolescent female sex workers in Kunming, China: A cross-sectional analysis." The European Journal of Contraception and Reproductive Health Care 19(5): 368-378.