



## Review article

## Trajectories of women's abortion-related care: A conceptual framework

Ernestina Coast<sup>a,\*</sup>, Alison H. Norris<sup>b</sup>, Ann M. Moore<sup>c</sup>, Emily Freeman<sup>d</sup><sup>a</sup> Dept. of International Development, London School of Economics and Political Science, Houghton Street, London, WC2A 2AE, UK<sup>b</sup> Ohio State University, United States<sup>c</sup> Guttmacher Institute, United States<sup>d</sup> PSSRU, London School of Economics and Political Science, UK

## ARTICLE INFO

## Keywords:

Induced abortion  
 Conceptual framework  
 Systematic mapping

## ABSTRACT

We present a new conceptual framework for studying trajectories to obtaining abortion-related care. It assembles for the first time all of the known factors influencing a trajectory and encourages readers to consider the ways these macro- and micro-level factors operate in multiple and sometimes conflicting ways. Based on presentation to and feedback from abortion experts (researchers, providers, funders, policymakers and advisors, advocates) ( $n = 325$ ) between 03/06/2014 and 22/08/2015, and a systematic mapping of peer-reviewed literature ( $n = 424$ ) published between 01/01/2011 and 30/10/2017, our framework synthesises the factors shaping abortion trajectories, grouped into three domains: abortion-specific experiences, individual contexts, and (inter) national and sub-national contexts. Our framework includes time-dependent processes involved in an individual trajectory, starting with timing of pregnancy awareness. This framework can be used to guide testable hypotheses about enabling and inhibiting influences on care-seeking behaviour and consideration about how abortion trajectories might be influenced by policy or practice. Research based on understanding of trajectories has the potential to improve women's experiences and outcomes of abortion-related care.

## 1. Introduction

Abortion is a common feature of people's reproductive lives. An estimated 56 million induced abortions occur annually (Sedgh et al., 2016), of which 54.9% (49.9%–59.4%, 90% C.I.) are unsafe (Ganatra et al., 2017). Unsafe abortion is a major public health problem, especially in contexts where access to legal abortion is highly restricted. An estimated 7.9% (4.7%–13.2%, 95% C.I.) of maternal deaths are due to unsafe abortion (Say et al., 2014); unsafe abortion is also a leading cause of maternal morbidity. While medical procedures for inducing safe abortion are straightforward, whether or not an abortion is available or safe or unsafe is influenced by a complex mix of politics, access, social attitudes and individual experiences. Up to 40% of women who experience abortion complications do not receive sufficient care (Singh et al., 2009). Understanding the complexity around obtaining abortion-related care is urgently needed, especially in light of the intense policy attention abortion receives. Abortion care is a landscape in flux, with rapid increases in access to and use of pharmaceuticals to induce abortion (Kapp et al., 2017), and shifting national and international laws, policies, treaties, protocols and funding provision (Barot, 2017a, b).

In recent years, research has helped elucidate abortion-related

practices. There is increased recognition of the scale and consequences of unsafe abortion, including the costs for both women and health systems, in a range of legal settings (Singh et al., 2014). Inequalities in accessing abortion-related care have been identified in many settings, associated with multiple individual characteristics including, but not limited to, age (Shah and Ahman, 2012), marital status (Andersen et al., 2015), ethnicity (Dehlendorf and Weitz, 2011), geographic location (Jones and Jerman, 2013) and economic circumstances (Ostrach and Cheyney, 2014). Women experience multiple, intersecting inequalities in access to abortion-related care (Becker et al., 2011). The critical role of delays in abortion-related care-seeking (Foster et al., 2008; Sowmini, 2013) and of what happens when women are denied services are better understood (DePiñeres et al., 2017; Gerdts et al., 2014). We know much more about attitudes and stigma around abortion (Faúndes et al., 2013; Hanschmidt et al., 2016). Making sense of this body of research so that it can inform effective policy and help identify salient gaps in knowledge is a substantial endeavour. We lack synthesis of the known time- and context-specific influences on trajectories to abortion-related care. Conceptual frameworks of abortion-related care have dealt only with discrete aspects of women's experiences, such as determinants of use of a safe abortion programme (Benson, 2005) or decisions which lead women to experience post-abortion complications (Banerjee and

\* Corresponding author.

E-mail address: [e.coast@lse.ac.uk](mailto:e.coast@lse.ac.uk) (E. Coast).

**Table 1**  
Presentations of the conceptual framework to expert audiences during its development.

Event	Participants (N)
International Seminar on Decision-making regarding abortion-determinants and consequences. Nanyuki, Kenya. 3–5 June 2014.	Abortion researchers (31)
Abortion@LSE: an e-conference. 8–9 June 2015.	Abortion researchers, activists and providers (156)
Ipas. Chapel Hill, NC. June 26, 2015	Abortion researchers and community advisors (8)
Psychosocial workshop. San Diego, CA. April 29, 2015	Abortion-specific researchers (70)
Population Association of America (2015) Annual Meeting. San Diego, CA. April 30-May 2, 2015	Social science researchers (52)

Andersen, 2012).

The conceptual framework we propose considers all the factors influencing a woman's trajectory to obtaining abortion-related care (safe abortion, unsafe abortion and/or post-abortion care). Obtaining abortion-related care can involve many steps and be non-linear (Marecek et al., 2017). We define an abortion trajectory as the processes and transitions occurring over time for a pregnancy that ends in abortion. We use 'trajectory' because it incorporates the concept of time – critical for understanding abortion-related care-seeking since safe abortion ceases to be an option as pregnancy progresses (the exact limit varies depending on context). We use the shorthand descriptor 'women' but acknowledge adolescents and transgender men within that.

Abortion is distinct from other healthcare-seeking behaviour since: i) legality and understanding of legal rights overlay an individual's pathway to care, ii) women's abortion options are determined by the gestational age of the pregnancy, iii) abortion is episodic, not chronic, iv) abortion is stigmatised, and v) only women receive abortion-related care. Three main groups of health-related theories might be employed to understand and explain abortion-related care-seeking: determinant, socio-ecological, and pathway. These theories have rarely been used to frame research on obtaining abortion-related care. Theoretically-informed research on abortion has tended to employ explanatory frameworks related to other domains including stigma (Lipp, 2011), policy (Aniteye and Mayhew, 2013), lifecourse (Edmeades et al., 2010), reproductive agency (Cleeve et al., 2017), reproductive justice (Katz, 2017), post-colonial feminism (Chiweshe et al., 2017) and social psychological frameworks (Cockrill and Nack, 2013).

Determinant health-related theories are models that elucidate a set of explanatory factors for the use of healthcare (Ajzen and Fishbein, 1980; Ajzen and Madden, 1986; Andersen, 1995; Bandura, 1977; Becker, 1974; Rosenstock, 1966). They remain influential in the framing of research on health care-seeking, health service use and health behaviour change (Babitsch et al., 2012; Ricketts and Goldsmith, 2005). Determinant theories have been criticised for their underlying individual rational actor orientation, focusing on characteristics of users versus non-users of care but providing little insight into dynamic care-seeking processes (Mackian et al., 2004; Pescosolido, 1992). Socio-ecological models (McLeroy et al., 1988; Stokols, 1996) consider multiple levels (e.g.: structural, community, individual) of influence on behaviour, and reciprocal causation between behaviour and social environments, unlike determinant models that largely conceptualise healthcare decision-making and use as an individual-level process. However, simple socio-ecological models are limited in their representation of time-dependent processes and events. Pathway-based models, which disaggregate healthcare decision-making into constituent steps, challenge frameworks that conceive each health care-seeking event in isolation (Mackian et al., 2004; Pescosolido, 1992). Understanding abortion-related care-seeking requires dynamic process-oriented perspectives; the circumstances of a pregnancy leading to an abortion unfold in the space of a few weeks and can be highly unpredictable. Abortion-related care-seeking cannot be understood only through a linear course of action; it is a process that responds to changing circumstances and experiences. The conceptual framework we present is a mechanism for showing interrelatedness across the various temporal and spatial dimensions that influence and shape

abortion-related care-seeking for one pregnancy. In this paper we i) review all influences on obtaining abortion-related care, ii) organise these into a conceptual framework, and iii) discuss how our framework can facilitate new research to better understand obtaining abortion-related care.

## 2. Methods

We used an inductive two-step approach to build this conceptual framework: initial drafting based on expert research and practice knowledge, and subsequent systematic evidence mapping of peer-reviewed literature.

We originally conceived the conceptual framework at an international seminar (IUSSP, 2014). Thematic analysis of issues reported in the papers presented at the seminar, which included studies from Africa, Asia, Latin America and Europe (n = 24), along with authors' practice knowledge, were used to draft a first iteration of the framework based on a thematic analysis of issues reported in the seminar papers. The first draft of the framework, which was also informed by the authors' practice knowledge, was presented and discussed at the end of the seminar. Subsequent iterations of the framework were intensively discussed among the authors over several months and presented to specialist audiences at national and international meetings (Table 1) and continually revised following their feedback. This process introduced additional components to our framework, such as the importance of national policies not directly related to health (e.g. education and welfare policies), and elaborated specific components (e.g. relief as an impact of abortion on mental health; the addition of caste-based inequalities among those shaping social positions on fertility and abortion). In addition to individual components, presentation and feedback to specialist audiences shaped the structure of the conceptual framework, informing our distinction between this framework and socio-ecological models and our efforts to present the framework visually so as to maximise its utility.

To confirm that the conceptual framework comprehensively captured all documented influences on obtaining abortion care we conducted a systematic evidence mapping of English-language peer-reviewed literature. Evidence mapping is an evidence synthesis methodology that is a variant of the systematic review (Miake-Lye et al., 2016); it is a systematic search of a broad field that describes as widely as possible all of the literature relating to the topic without limiting to studies that assess the strength or direction of relationships. It methodically identifies and develops a map of the literature (Clapton et al., 2009) and is increasingly used in a range of social sciences (Miake-Lye et al., 2016). Evidence mapping can be much more inclusive than a systematic review: our only quality criterion was that the study should be published in a peer-reviewed journal. Multiple references based on the same sample were not excluded (as would be the case in a systematic review) since data generated from one study population might investigate different issues of relevance.

Three electronic databases [PubMed, ScienceDirect, JSTOR] of peer-reviewed literature were searched for items published in English between 01/01/2011 and 30/10/2017. These databases were selected for their coverage of biomedical and social science research. Combinations of relevant search terms were developed and tested for sensitivity. The

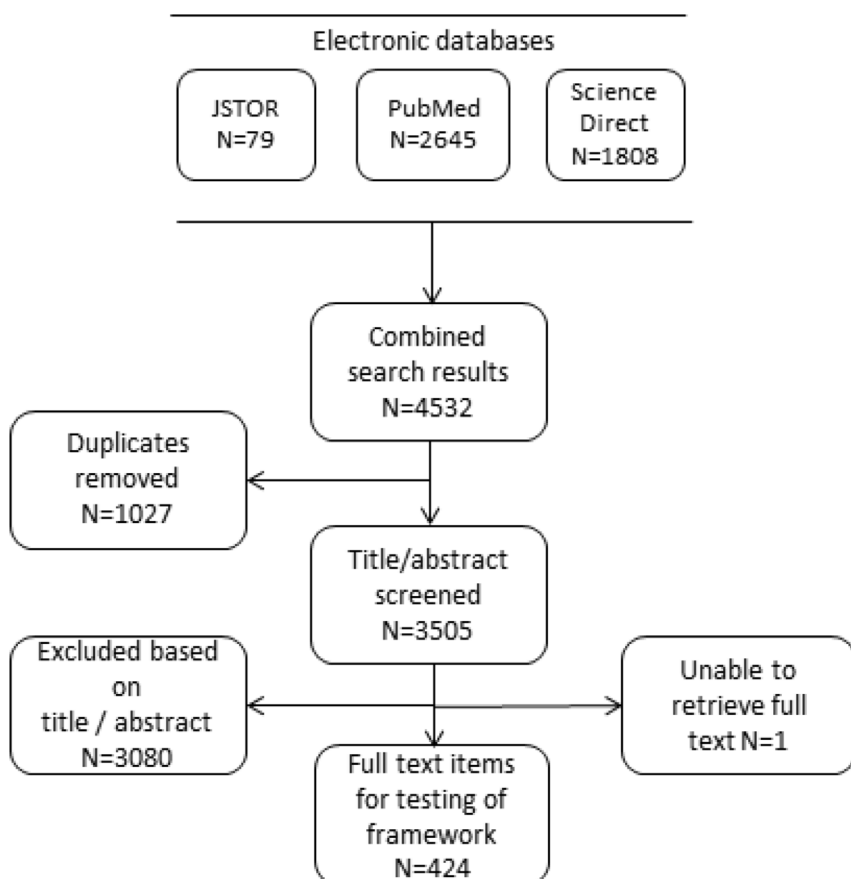


Fig. 1. Systematic evidence mapping process.

final combinations of search terms were: (abortion\* OR termination\* OR (menstru\* AND regul\*)) AND (Deci\* OR Pathw\* OR Passage\* OR Rout\* OR Course\* OR Traject\* OR Trail\* OR Track\* OR Direction\*). Fig. 1 illustrates the process.

After removing duplicates, all items identified by the search were screened on their title and abstract to determine inclusion. Items were included if: published in full text in English in a peer-reviewed journal between 01/01/2011 and 30/10/2017, and the abstract included any factor that either influenced, or was mentioned as potentially influencing, obtaining abortion care. Non-peer-reviewed items (e.g. comment, book review, letters) were excluded. Where inclusion or exclusion could not be determined on the basis of title and abstract, the full text was screened. Articles were included if they considered trajectories, or influences on trajectories, to abortion-related care. Details of included items are available [Appendix A Supplementary Data]. We compared the full text of each included item ( $n = 424$ ) to the draft conceptual framework. Components we identified to be inadequately captured by the draft framework were incorporated in subsequent iterations. These included both an additional component ‘quality of care’, which superseded a previous inclusion of ‘health workforce treatment of women’, as well as amendments to components, such as broadening ‘perception of provider care’ to ‘perception or experience of provider care’. All decisions about changes to framework components were made as a team, drawing on our reading, expertise and the discussions we had about the framework with experts during its development.

Our search methodology has limitations. Language and date restrictions mean that including additional languages or years might have yielded additional information; however, our search did yield evidence from all geographic regions, including research conducted in non-English languages but published in English. By focusing on more recently published evidence (post-2010), our framework reflects a contemporary summary of the field of abortion-related care-seeking

evidence. We searched only three databases, selected for their range (biomedical and social science); additional databases might include additional evidence, although the number of duplicates ( $n = 1027$ ) yielded by our search suggests that our strategy is robust. Our search only included abortion-related terms (abortion, termination, menstrual regulation); our search will not have yielded articles that discuss pregnancy decision making without reference to abortion. Our mapping approach means that the relative weight and rigour of evidence on the factors identified remain unknown. The final conceptual framework represents all aspects of trajectories to abortion-related care as illuminated by expert researchers, practice knowledge, and in 424 articles.

### 3. Conceptual framework of trajectories to abortion-related care

A conceptual framework is a set of ideas, presented in a structured way to help understand a phenomenon (Reichel and Ramey, 1987). Our framework (Fig. 2) represents “the main things to be studied” (Miles and Huberman, 1994 p.18) with regard to trajectories to obtaining abortion-related care. It synthesises influences shaping these trajectories, grouped in three domains to highlight the individual- and macro-contexts shaping abortion-related care:

1. Time-oriented abortion-specific experiences: beginning with pregnancy awareness, events that women may experience in seeking abortion-related care.
2. Individual contexts: characteristics that influence whether a woman obtains abortion-related care, including interpersonal networks.
3. (Inter)national and sub-national contexts: the context within which an individual – and her abortion – are situated.

To understand the trajectory of a pregnancy that ends in abortion, it must be situated within individual- and macro-contexts; all three

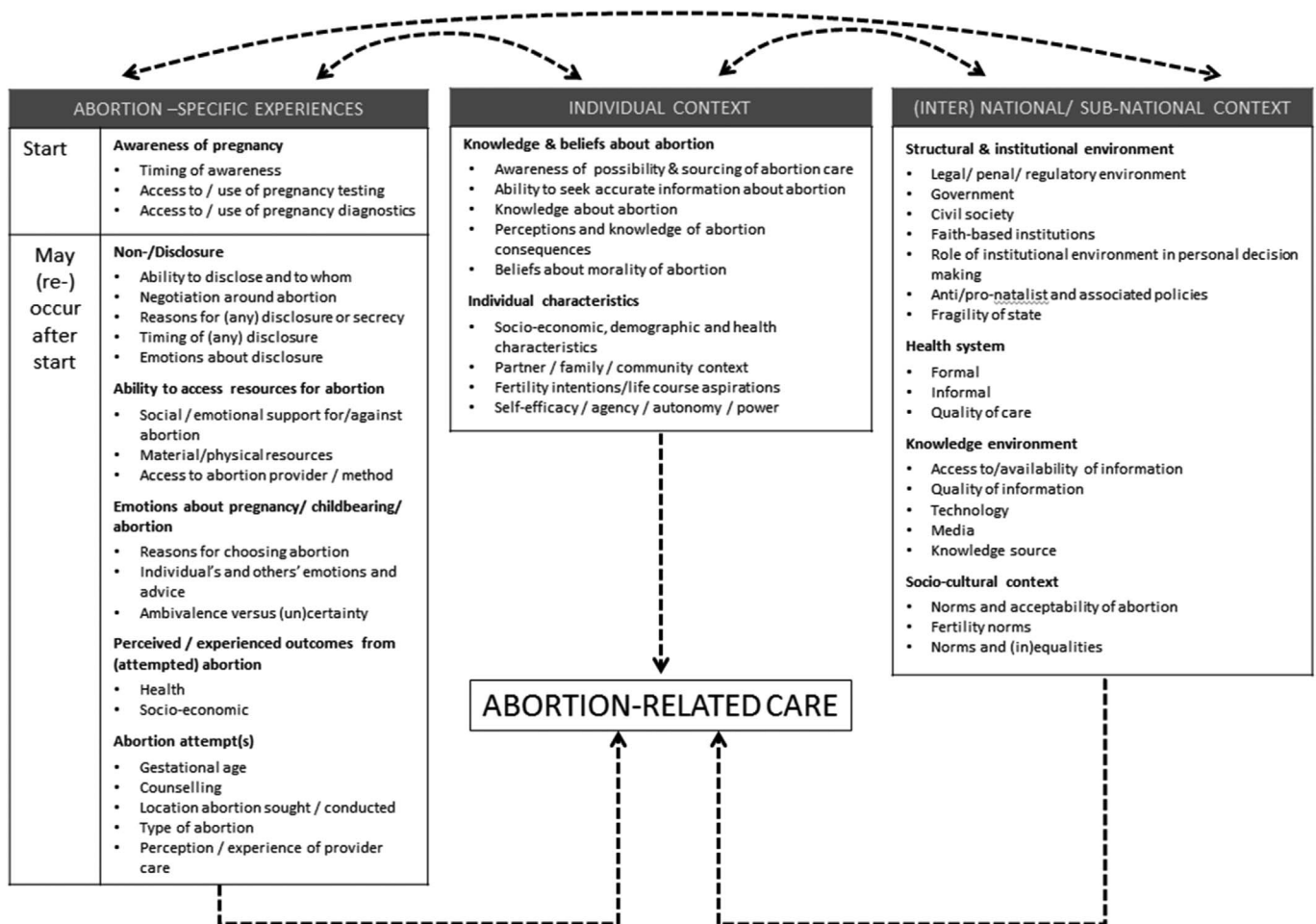


Fig. 2. A conceptual framework for understanding women's trajectories in seeking abortion-related care.

domains are interrelated. For example, access to pregnancy testing (abortion-specific experiences) might be influenced by a woman's wealth (individual context) and the health system (inter/national context). The framework is globally applicable, capturing concepts that are relevant across time and space. For readability, our framework includes brief phrases or single words for each component. This comprehensive visual overview is the primary contribution of our article. To illustrate its relevance across settings, in the following sections we explicate the framework's components using examples.

We begin at the individual level – a woman's abortion-specific experiences, her context and characteristics, and then discuss the macro-level influences on trajectories to obtaining abortion-related care. Unlike the conceptual framework itself (Fig. 2), this requires us to present the three domains in some order. We start with experiences of a specific abortion since a woman may have more than one abortion in her lifetime, and a single trajectory to obtaining care might be composed of more than one abortion attempt. Our evidence-based illustration of each component is preceded by bullet points that provides further examples.

#### 4. Abortion-specific experiences

The actions women take on their trajectories to (attempt to) terminate a pregnancy are shaped by factors in their individual contexts and by their macro-environments. We consider in this section the multiple events that women may experience in obtaining an abortion. The trajectory begins with becoming aware of a pregnancy and ends with abortion-related care; in between there may be (non-) disclosure and negotiation about abortion, seeking resources to obtain the

abortion, and more than one attempt to terminate the pregnancy, with sequelae of those attempts. These events may not be linear; for example, a woman may disclose to an individual who provides information that the woman acts upon; this information may not lead to an abortion, so the woman might disclose to a different person in order to seek different or additional information or resources to procure an abortion (Moore et al., 2011b). Emotions about pregnancy, abortion and parenting influence all steps of abortion-specific experience. Each step is embedded in contexts both micro (individual) and macro; we address the importance of these contexts in subsequent sections.

##### 4.1. Awareness of pregnancy

- Timing of awareness (e.g. knowledge of pregnancy symptoms or pregnancy testing, denial of pregnancy)
- Access to/use of pregnancy testing (e.g. cost, availability, source)
- Access to/use of pregnancy diagnostics (e.g. foetal abnormality, sex determination)

Decision making around abortion-related care is highly time-sensitive. Abortion at earlier gestations is safer than later gestations and laws and guidelines vary about the maximum gestation at which abortion is permitted, under which conditions and with which method. Time between conception and awareness of pregnancy is inversely related to how much time a woman has to decide about abortion. In many settings, pregnancy tests are unavailable or unaffordable (Stanback et al., 2013) and women's estimation of gestational age – particularly for younger and/or nulliparous women – can be incorrect (Foster and Kimport, 2013; Janiak et al., 2014).

The timing of action to confirm a pregnancy can be linked to the social risks of pregnancy. When a pregnancy is undesirable a woman may avoid acknowledging the pregnancy to herself (Sowmini, 2013). For example, young unmarried women in an Indian study were less likely to recognise (or acknowledge) their pregnancy than their married counterparts, and unmarried women had higher levels of second trimester abortions (Jejeebhoy et al., 2010). In addition, the gestational age at which diagnostic testing (if available or used) for foetal abnormality and/or sex - factors that may influence whether the woman wants an abortion - varies by context (Gawron et al., 2013).

#### 4.2. Disclosure

- Ability to disclose, to whom (e.g. family, friend, partner, health professional, provider, acquaintance) and the implications of that (e.g. the confidant's knowledge, experience, advice, reaction)
- Negotiation around abortion with (any) others involved in the decision (e.g. partner, relatives, (potential) abortion providers)
- Reasons for disclosure or non-disclosure (e.g. policies around partner or parental notification)
- Timing of (any) disclosure(s)
- Emotions about disclosure (e.g. fear of reactions, shame, stigma, relief)

Some women do not disclose their pregnancy and take abortion decisions alone (Bowes and Macleod, 2006). For women who do disclose their pregnancy, the person(s) to whom they disclose may influence abortion decisions, be a source of (mis-)information, and/or provide access to resources for abortion-related care. Disclosure may lead to negotiation about whether or how to abort. Decisions about disclosure are influenced by wider social norms and belief systems. For example, both the choice of confidant(s) and their influence are embedded in the woman's larger context of relationships and ability to access resources (Nyanzi et al., 2005). In a study among young women in urban Cameroon, disclosure to male partners was influenced by the need for financial support for the abortion (Calvès, 2002). Disclosure discussions are enmeshed in the macro-context; more limited abortion options may necessitate more disclosure in order to seek information about care (Rossier, 2007), or disclosure may be enforced due to partner or parental notification protocols. Disclosure may lead to emotional support around an abortion decision or pressure to abort or not abort (Schwandt et al., 2013). Disclosure of pregnancy may lead to a range of negative outcomes, including condemnation and abandonment (Tangmunkongvorakul et al., 2005) or punishment (Umuhoza et al., 2013). Fears about the implications of disclosure of the pregnancy or the desire to abort may delay initiating the abortion (Labandera et al., 2016) or compel a woman to seek a less safe abortion (Schuster, 2005).

#### 4.3. Ability to access resources for abortion

- Social/emotional support for/against abortion (e.g. from partners, relatives, friends, providers, doula)
- Material/physical resources (e.g. transport, money, childcare, ability to miss education or work, insurance, commodities, information)
- Access to abortion provider/method (e.g. border crossing, journey time, face-to-face versus web-based provider)

Women's ability to access resources to procure an abortion is important in every setting. Social and emotional support for or against abortion-related care is linked to whether, and to whom, the pregnancy is disclosed. A friend or partner providing support may influence the location and type of abortion (Conkling et al., 2015). Access to financial resources, frequently linked to social support, may be critical to a woman's ability to access abortion information and services. In Latin

American countries where abortion is illegal, access to economic resources and emotional support were critical for accessing a medically supervised medical abortion in a clandestine clinic (Zamberlin et al., 2012). One quarter of urban Mozambican women who sought a first trimester termination at a public hospital delayed care in order to have sufficient funds to pay user fees (Mitchell et al., 2010). Women's sources of information extend beyond their social networks to include advertising, agents, the internet and other clients of abortion providers (Gerdtts et al., 2017; Osur et al., 2015). The difference between a safe or unsafe abortion may be whether someone can pay for a safer procedure (Moore et al., 2011b) or whether she can travel to avoid more restrictive laws to locations with more permissive laws (Foster et al., 2012). Accessibility of abortion services is multidimensional and closely linked to macro-environmental factors including legality, distance and cost (Sethna and Doull, 2013) and individual contextual factors such as mobility (Azmat et al., 2012).

#### 4.4. Abortion attempt(s)

- Gestational age
- Counseling (e.g. (non-)directed, (un)supportive, waiting period, referrals)
- Location abortion sought or conducted (e.g. home, (un)regulated facility)
- Type of abortion (e.g. (un)safe, (il)legal, medical, surgical, self- or provider-initiated)
- Perception or experience of provider care (e.g. (dis)respectful, judgmental, confidential, private, pain management, exposure to protests/harassment)

The complexity and length of abortion trajectories is heterogeneous, influenced not only by a woman's context, but also her experiences relating to that specific pregnancy, and may range from a legal, straightforwardly-accessed safe process, to multiple unsafe attempts (Coast and Murray, 2016). In some settings, women may have options about what kind of abortion to access; in others, women may not (perceive themselves to) have any choices (Banerjee and Andersen, 2012). Gestational age at the time of the abortion may have implications for the woman's health and affect the type of abortion provided; if women present beyond a gestational limit, they can be denied a legal abortion (Harries et al., 2015). Especially, but not only, in contexts where abortion is stigmatised and/or illegal (or perceived to be illegal) in general or at advanced gestational age, women self-induce using household objects, traditional methods, and abortion medications (Rasch et al., 2014; Valley et al., 2015).

Abortion trajectories may also be influenced by professional advice. Provision of counselling may differ depending upon a woman's circumstances (Ramachandar and Pelto, 2002), policies including mandated waiting periods, and the socio-legal (Gerdtts and Hudaya, 2016) and funding (discussed below) context of abortion. Although good counselling should be non-directive, this does not necessarily happen (Vincent, 2011). Counselling may play an important role in women's choice of abortion method (Tamang et al., 2012), however not all women who seek abortion want counselling (Cameron and Glasier, 2013) or the counselling that is provided (Moore et al., 2011a). A woman who expects judgemental or disrespectful advice or counselling from one provider may seek care elsewhere. The perception and experience of negative responses from health practitioners against women seeking abortion are widely reported (e.g. Ghana (Schwandt et al., 2013), Brazil (Diniz et al., 2012), Vietnam (Nguyễn et al., 2007)).

When women have a choice about abortion type, their decision may be informed by their understandings of abortion-related care and its quality, including comfort, pain (Allen et al., 2012), flexibility of when the abortion can occur, (perceived) confidentiality, provider attitudes towards privacy, and stigmatising provider behaviours (Labandera et al., 2016). In some settings, anti-abortion protests outside abortion

providers may affect abortion care-seeking by encouraging women to avoid providers where they may have to confront them (Kimport et al., 2012a).

#### 4.5. Perceived and experienced outcomes from (attempted) abortion

- Physical health (e.g. pain, side effects, future fertility, resulting or avoidance of morbidity or mortality)
- Mental health (e.g. depression, relief, guilt, shame)
- Socio-economic effects (e.g. out of pocket payments, legal/penal consequences, maintaining a relationship, education or occupation)

Once a woman has obtained or attempted an abortion, she may require treatment for abortion complications. Physical health consequences of abortion are almost entirely confined to events following unsafe abortion (Gerdtz et al., 2015). Whether and how a woman who needs post-abortion care seeks it has parallels to those factors that influenced obtaining the abortion: recognition of the need for care (post-abortion complications) (Ngoc et al., 2014), availability or cost of post-abortion care (Leone et al., 2016), and social support for managing complications (Lubinga et al., 2013). Delays in initiating or receiving post-abortion care, which might be due to practitioners withholding care or women withholding information or both, are an established cause of maternal morbidity and mortality. A woman may experience a range of emotional sequelae after an abortion, including relief, regret, ambivalence, shame and guilt (Andersson et al., 2014; Subramaney et al., 2015) that may change over time (Rocca et al., 2015). In many settings, women worry about their future fertility following a termination (Moore et al., 2011c).

#### 4.6. Emotions about pregnancy, childbearing or abortion

- Reasons for choosing abortion (e.g. foetal anomaly, social, economic, health [including HIV status], age, parity)
- Individual's and others' (e.g. partners', parents', in-laws', friends', medical professionals', counsellors') emotions and advice
- Emotions (e.g. ambivalence, certainty) about pregnancy or childbearing or abortion

Women may have conflicting and changing emotions about being pregnant, childbearing, and abortion (Aiken and Potter, 2013; Andersson et al., 2014), which may be influenced by reactions received or anticipated from disclosure. A pregnancy has short- and long-term economic and opportunity costs for women; these may be exacerbated when the pregnancy is unintended (Gipson et al., 2008). Individual circumstances influence whether abortion provides a better outcome for a woman than bearing a child at that time, and women give many reasons for having an abortion. For example, in Bangladesh, women and their husbands described challenging life circumstances (poor health, poverty) that influenced their decisions to terminate (Gipson and Hindin, 2008). In some contexts, a pregnancy with close birth spacing may be unacceptable; evidence from Ghana suggests that child spacing played an important role in some women's abortion trajectories (Oduro and Otsin, 2014). These intersecting realities (social, cultural, economic, health) may influence women's feelings about abortion (Biggs et al., 2013), and their self-efficacy to achieve one (Kavanagh et al., 2012). For abortions due to foetal abnormality, emotions may be additionally complex (Lafarge et al., 2013).

### 5. Individual context

The individual level domain focuses on the characteristics of an individual that influence if, where and how she obtains abortion-related care, including her interpersonal networks. The experiences related to abortion-related care for a pregnancy (a woman may have more than one abortion in her lifetime) are shaped by a woman's context at that

point in time: her knowledge and beliefs about abortion (which may change over time) and her characteristics at the time of the pregnancy. This next framework domain considers how factors associated with a woman's individual context combine, and are affected by other domains, to influence an abortion trajectory.

#### 5.1. Knowledge & beliefs about abortion

- Awareness of possibility and sourcing of abortion care (e.g. pre-existing knowledge/knowledge sought as a result of pregnancy)
- Ability to seek accurate information about safe abortion-related care
- Knowledge about abortion (e.g. methods, legality)
- Perceptions and knowledge of abortion consequences (e.g. risks [health, social, penal], benefits, side effects, social, economic, legal, relationship, health)
- Beliefs about morality of abortion (e.g. faith, internalised stigma)

Women use a range of networks to access abortion information (Carlsson et al., 2016; Kimport et al., 2012b; Osur et al., 2015), but their ability to obtain accurate information about abortion varies (Ramos et al., 2015). Knowledge about the possibility and sourcing of abortion-related care might include prior experience or exposure to abortion from social networks (Arambepola and Rajapaksa, 2014). Low levels of knowledge about abortion legality may act as a barrier to accessing abortion services (Marlow et al., 2014).

Women's perceptions about the consequences – positive and negative – of care-seeking may be linked to their reasons for seeking an abortion (Gipson et al., 2011; Ralph et al., 2014). How women, and others involved, make sense of relative risks is important for understanding trajectories (Izugbara et al., 2015). Trajectories are additionally shaped by the need to maintain secrecy (Marlow et al., 2014) or fear of prosecution (Schuster, 2010). Whether the need to maintain secrecy is out of fear of punishment from others or fear of exposure – for socially-unsanctioned sex or abortion – can shape her trajectory. Construction and experiences of stigma are multiple and overlapping (Orner et al., 2011) and can impact delays in obtaining an abortion or post-abortion care, and how that care is sought (Izugbara et al., 2015). These trajectories may be influenced by women's strategies to manage their religious and moral beliefs (Cockrill et al., 2013; Schuster, 2005) and internalised stigma (Kebede et al., 2012; Palomino et al., 2011).

#### 5.2. Individual characteristics

- Socio-economic, demographic and health characteristics (e.g. age, wealth, education, sexuality, gender identity, ethnicity/race, language, legal status [e.g. legal minor, refugee, undocumented migrant], partnership type [e.g. (non-)marital, (non-)consensual, romantic, commercial, transactional, incestuous], pre-existing health condition [e.g. HIV, substance abuse])
- Partner/family/community context (e.g. status in household, family role [e.g. daughter-in-law])
- Fertility intentions (e.g. non-use of contraception, contraceptive failure, parity, sex of foetus)
- Life course aspirations (e.g. education, employment, fertility, partnership)
- Self-efficacy/agency (e.g. autonomy, power)

Individual characteristics, that is, a woman's social location, aspirations and efficacy, influence abortion-related trajectories in multiple and intersecting ways. These include: education (DaVanzo and Rahman, 2014), age (Clyde et al., 2013), economic status (Sundaram et al., 2012), experience of violence (Nguyen et al., 2012; Perry et al., 2015), health including pre-existing conditions such as HIV status or mental illness (Barbosa et al., 2012; van Ditzhuijzen et al., 2015), partner characteristics (Chibber et al., 2014), previous experience of abortion (Asplin et al., 2013), ethnicity or race (Cowan, 2013), parity

(Puri et al., 2011), sexual orientation and gender identity (Beaumont and Bond-Therriault, 2017) and religiosity (Liang et al., 2013). Relationship expectations have implications for the consequences of pregnancy, while the roles played by men in women's trajectories are heterogeneous, from non-involvement to mutual decision-making (Freeman et al., 2017). Women's aspirations – or others' aspirations for them – including (future) fertility, education, employment and relationships can contribute to the decisions around abortion (Gbagbo et al., 2015; Gomez-Scott and Cooney, 2014). In contexts where women have control over their fertility decisions, women's autonomy or self-efficacy to obtain an abortion is mediated by factors such as age (Domingos et al., 2013) or mobility (Azmat et al., 2012).

The extent and direction of the influence of individual social, economic, demographic and health characteristics depends on context. Abortion access for young people who have not reached the age of majority varies by regulations about parental notification (Kavanagh et al., 2012). The role of men's involvement in abortion trajectories reflects not only the type of relationship in which the pregnancy occurred but also the gendered norms and roles of the woman's culture. Women may seek abortion to prevent anticipated negative relationship consequences (Vallely et al., 2015). Fertility decision-making power may not rest with the pregnant woman, and others (e.g. her partner, mother-in-law, mother) may be important influencers (MacQuarrie and Edmeades, 2015; Madkour et al., 2013). Individual characteristics intersect to affect women's trajectories; a study of women who had an abortion in the Netherlands found that, compared to women without prior mental disorders, women with a psychiatric history were more likely to score lower on abortion-specific self-efficacy (van Ditzhuijzen et al., 2015).

## 6. The (inter)national and sub-national context

This framework domain describes the context within which an individual woman – and her abortion – is situated. It includes components operating at a range of scales, from an individual's community to international influences. Abortion-specific and individual-level factors occur within and are shaped by (and shape) macro-level structural and institutional environments. Influences include (il)legality of abortion, punishment of those who violate laws, accessibility of safe abortion, and normative constructs of abortion and fertility.

### 6.1. Structural and institutional environment

- Legal/penal/regulatory environment (sub-national, national, regional, international) (e.g. penalties for providers/procurers of abortion; constitution; (non-)commitment to regional/international treaties; treatment protocols [including gestational limits, mandated waiting times/referrals]; commodities registration, marketing and licensing)
- Government (e.g. law enforcement, judicial role, resources [e.g. financial, human])
- Civil society: position and influence
- Faith-based institutions: position and influence
- Role of institutional environment in personal decision-making
- Anti/pro-natalist and associated policies (e.g. education, employment)
- Fragility of state (e.g. (post-)conflict, crisis)

Institutions (e.g. political, governmental, faith-based, private, civil society) operate and interact at global, regional, multilateral, national and sub-national levels to shape availability of abortion care in local contexts. The influence of institutions on each other, and each institution's position on abortion, is interwoven. International institutions can shape the availability of abortion in other national and sub-national contexts, both ideologically and financially. For example, the issue of a USA Presidential Memorandum that reinstated and extended the

'Mexico City Policy' in 2017 prevents non-governmental organisations and agencies operating anywhere in the world from providing, referring or giving information about abortion services if they receive federal funding for any part of their work, regardless of local context (laws, bills of rights) or the professional codes of health practitioners employed in these organisations (Singh and Karim, 2017). Abortion is regulated almost everywhere; to date only Canada has effectively decriminalised abortion (Berer, 2017). Regulation is heterogeneous regarding abortion methods and gestational limits, including the grounds upon which second trimester abortions can occur (Boland, 2010). Laws may be made nationally or sub-nationally, and might apply to specific geographic regions (Sánchez Fuentes et al., 2008) or population sub-groups (Grindlay et al., 2011). The legal position on abortion might be specified in penal codes, but is also set out in health legislation, court decisions, constitutions, or clinical guidelines (WHO, 2017), and may change over time (Bergallo and Ramón Michel, 2016) or be affected by international convention (Daly, 2011). For example, priorities for health services may change in conflict settings (Palmer and Storeng, 2016), along with social rules governing sexual behaviour, increasing risks of unwanted pregnancy and unsafe abortion (McGinn and Casey, 2016). Abortion for rape victims is legal under the Geneva Conventions, customary international law, and international humanitarian law regardless of national laws, but provision is variable (GCJ, 2011).

However, legal position only partly determines access to abortion care (Berer, 2013). Policymakers and service providers alike have may low levels of knowledge about abortion legality, influencing how and whether they provide care (Moore et al., 2014). Inaccurate knowledge of the law may prevent otherwise willing practitioners from providing legal services (Ramos et al., 2014), while practitioners may provide services clandestinely despite legal restrictions (Pheterson and Azize, 2005). Abortion regulation may be at best difficult to understand, and at worse contradictory (Boland, 2010) so that arbiters of law themselves, including police and prosecutors, lack clarity about what is (il) legal (Suh, 2014). Where abortion is legally restricted, there may be punishments specified for providers and/or procurers; these punishments may be rarely enforced or enforced unequally (Bankole et al., 2008). Abortion laws, policies and services shift in response to religious, societal and political change (Hodes, 2013). National and international civil society includes advocates for both increased and reduced access to abortion services (Berer, 2017; Castle, 2011). For example, following legal reform in Colombia, feminist civil society organisations used strategic litigations to counter backlash from institutions opposed to abortion (Ruibal, 2014). Communities mobilise (and can be mobilised); an intervention to educate communities about gynaecologic uses for misoprostol in Kenya and Tanzania, where abortion is legally restricted, showed it was possible to share information without political backlash (Coeytaux et al., 2014). Transnational advocacy is increasingly used to increase the visibility and scale of abortion debates and information (Stevenson, 2014).

Faith-based organisations influence access to abortion depending on the dominance of religion(s) in a setting, the extent to which religion influences governance and health service delivery, and permissibility of abortion within religious teaching and local interpretation (Al-Matary and Ali, 2014). For example, the Roman Catholic Church has a strong stance against abortion yet its influence on national laws and policies is stronger in Catholic Latin America, where abortion is severely restricted, than in Catholic Western Europe, where abortion is widely available (Blofield, 2008). Religious institutions' messages on abortion can have multiple influences including how a woman perceives the morality of abortion and how women who have abortions are treated by society. Faith-based organisations may also shape abortion trajectories as healthcare providers (Eisenberg and Leslie, 2017). Institutional influence on reproduction, including abortion, range from coercive and/or explicit mandates to implicit disincentives or inducements (Barot, 2012). These might be linked to policies, such as school exclusion of pregnant pupils, or legality of anti-abortion protests.

## 6.2. Health system

- Formal (e.g. finance [public, private, insurance], infrastructure, governance, health information, training, investment priorities, provision for conscientious objection, commodities [including drug regulation, marketing and distribution], human resources, stigma/harassment experienced by providers, diagnostic testing, abortion conditionality, parental/spousal notification)
- Informal (e.g. alternative and/or illegal providers [e.g. traditional healers or herbalists, unlicensed doctors or pharmacists], self-administration of abortion)
- Quality of care (e.g. health workforce treatment of women, accessibility of (il)legal and/or (un)safe services, privacy, confidentiality)

Trajectories to abortion care are shaped by complex health systems that incorporate formal and informal components, government and non-government provision, infrastructure (e.g. where health facilities are located and how they receive resources, including commodities), flows of information (e.g. health messages about where, how and for whom abortion is provided), and level of investment. For example, access to safe abortion is influenced by who is legally permitted to provide services. In many settings only doctors provide services; where services are delivered by mid-level providers, safe abortion care has become more accessible (Berer, 2009). Less- or un-regulated abortion care is delivered by a range of practitioners, including public sector practitioners with private clinics at their homes, herbalists, traditional birth attendants, and pharmacists (Norris et al., 2016). The safety of abortion provided outside of the formal health system or by less-regulated providers varies. Informal abortion may be sought because: these services are more established; of limited knowledge regarding how to access care from formal health systems; of understandings about quality of care provided within each system; or, because of perceptions or expectations of poor and/or non-confidential treatment within formal systems. Health system financing (e.g. free, subsidised, insurance, co-payments) affects how abortion-related care is sought and paid for (Foster and Kimport, 2013). Funding and services in some settings can be tied to laws and policies of donor countries (Barot, 2017b). Health systems may delay or act as barriers to women seeking abortion care, including requirements such as multiple referrals or follow-up visits, mandatory diagnostics (including ultrasound), or waiting times, parental or spousal notification (discussed above), and conditionality (French et al., 2016; Janiak et al., 2014).

Abortion-related care is additionally shaped by providers' attitudes and practice, which may reflect (in)adequate training (Birdsey et al., 2016; Holcombe et al., 2015). The kind of treatment women expect to receive from providers, including judgemental or punitive attitudes, influences where and when abortion care is sought. Provider attitudes towards abortion influence the availability of abortion care – both numbers of practitioners and information about finding them (Harries et al., 2009). Providers may support abortion where it is legally prohibited (Vasquez et al., 2012), or refuse to provide abortion where it is legal (Harries et al., 2009). Conscientious objection to abortion may reflect stigma or violence providers themselves perceive or experience (Holcombe et al., 2015), and/or serve to further stigmatise abortion care-seeking.

Registration, marketing and distribution of drugs for inducing abortion influence the availability of abortion, as well as the safety of medical abortions. Within formal systems, factors including funding, communication across different parts of the health system, and the locality and accessibility of healthcare facilities, influence drug supply chains. Drug accessibility may be dependent upon inclusion in essential drugs lists stocked in public facilities and provided through the national government (Ipas, 2009) and availability for 'off-label' use (Fernandez et al., 2009). For example, 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 under a

greater variety of circumstances than what is legally allowed (Hyman et al., 2013). Availability of abortion drugs is not correlated with legality of abortion: unregulated abortion using drugs is delivered by a range of practitioners, including public sector practitioners who have private clinics at their homes, herbalists, traditional birth attendants, and pharmacists (Norris et al., 2016). Vendors may have limited knowledge about effective doses, dispense drugs without reliable knowledge of gestational age, and provide insufficient instructions about side effects and risks, or where to seek help for complications (Lara et al., 2011; Sneideringer et al., 2012). Poor control of drug marketing and subsequent misuse of abortion drugs is particularly likely when abortion is prohibited (Coêlho et al., 1993). However legal provision of information about illegal off-label use is a harm reduction approach to unsafe abortion used in some settings (Hyman et al., 2013). When drugs are acquired clandestinely, they may be counterfeit (Powell-Jackson et al., 2015). Features of health systems related to the quality of abortion-related care influence women's experiences, including choice of location or type of treatment (Hedqvist et al., 2016) and privacy and confidentiality (McLemore et al., 2015), discussed above. There is little agreement, however, about what constitutes quality abortion care and the indicators to assess it (Dennis et al., 2016).

## 6.3. Knowledge environment

- Access to/availability of information (e.g. safety, availability, legal, financial)
- Quality of information (e.g. (in)correct, (non-)directive)
- Technology (e.g. mobile phone, internet)
- Media (e.g. broadcast, print, social, representations of abortion)
- Knowledge source (e.g. politicians, activists, community leaders, health professionals, peer educators, journalists, medical professional/activist organisations)

The knowledge environment includes general discourses around abortion and the specific information someone might know or seek about abortion-related care (Andersson et al., 2014). This framework component captures the importance of knowledge-sharing norms, differential access to knowledge (mediated by individual contexts, such as wealth, education, language), availability, penetration and types of knowledge-sharing technologies (e.g. internet, phones) and the effectiveness of knowledge-delivery systems for determining individuals' understanding of the legal, financial and practical availability of abortion. Who delivers messages, how they are delivered, and the content of those messages shape the knowledge environment (Purcell et al., 2014) and may affect service availability and use (MacFarlane et al., 2017) or changes in laws and policies (Umuhzoza et al., 2013). Information about abortion may be appropriate to the population's information literacy skills or it may be concealed. In the USA, information may be obscured by facilities (e.g.: "crisis pregnancy centers") that advertise services for women with unintended pregnancies but deliver counselling to dissuade women from having abortions (Rosen, 2012). Information about abortion can include explanations about safety or side effects of medical abortion. In South Africa, mobile phone messages to support women using misoprostol at home for early medical abortion significantly reduced women's anxiety and improved preparedness for abortion symptoms (Constant et al., 2014).

## 6.4. Socio-cultural context

- Norms and acceptability of abortion (e.g. presence of stigma or shame, religious influence)
- Fertility norms (e.g. family size, gender preferences, birth spacing)
- Norms and (in)equalities (e.g. gender, race, ethnicity, wealth, caste, social class)



Socio-cultural context includes a broad range of factors influencing abortion trajectories, and is tightly linked to other components such as the influence of institutions or healthcare practitioners' willingness to provide abortion services. Norms about abortion acceptability, including stigma and shame, are shaped by (in)equalities (e.g. gender, race, ethnicity). In Ghana, women who seek care following an unsafe abortion report social stigma leading to fear, shame and embarrassment which influenced their abortion decision-making (Tagoe-Darko, 2013). Norms are reproduced through discourse (media, popular, medical), institutions, communities and personal experiences (Kebede et al., 2012). In rural South Africa, discussion about abortion revealed that legal abortion was considered to be destructive of traditional culture, strongly associated with a colonialist endeavour, and harmful to intergenerational and gender relations (Macleod et al., 2011). Inequities in access to abortion-related services may be affected by individual or group characteristics, such as ethnicity or religion (Liang et al., 2013; Sethna and Doull, 2013).

In some settings, while abortion might be normatively shameful, it might be perceived as less shameful than a pregnancy in some circumstances (Johnson-Hanks, 2002). In other contexts, the reverse relationship may prevail (Fordyce, 2012). Socio-cultural context influences whether sex-selective abortion is present, reflecting norms around sex preference and family size (Bongaarts and Guilimoto, 2015) and attitudes of providers, institutions and society (Hohmann et al., 2014).

## 7. Conclusions

We present a conceptual framework of women's trajectories to obtaining abortion-related care (Fig. 2). This integrative framework helps develop understandings of women's abortion-related care-trajectories in a way that identifies discrete components while at the same time representing the integration of components operating (sometimes in conflict) at macro- and micro levels. Previous research on women's trajectories to abortion – including that conducted by the authors – has tended to focus on specific aspects of trajectories. In assembling for the first time all of the explanatory factors influencing a woman's abortion trajectory, our framework can be used to test theories and generate hypotheses relevant to obtaining abortion-related care.

Our inductive approach to framework building generated a conceptual framework from evidence. Our framework builds on characteristics of other models of health-related behaviour. The three domains – abortion-specific, individual, (inter)national – have characteristics similar to a socio-ecological model. However, our framework is not a simple socio-ecological model because it additionally incorporates time-dependent processes specific to abortion. The start of any abortion trajectory begins with pregnancy awareness. In this respect, our framework incorporates aspects of pathway models, acknowledging the dynamic care-seeking processes that can be involved in terminating a pregnancy. The framework is not limited by the individual rational actor-oriented framing of determinant models.

Our conceptual framework is built on expert consultation and a systematic literature mapping. Our systematic approach is sufficiently robust and comprehensive to assert that the framework includes the known universe of factors affecting women's trajectories to abortion-related care. Our conceptual framework will need to be modified to reflect future empirical and theoretical evidence generation.

The conceptual framework marks a significant step forward for how researchers might conceptualise and understand trajectories to abortion care. By specifying and linking influences, our framework can be used to inform research design and analyses, across epistemologies, methodologies, and contexts. Each component of our framework can be researched in isolation; and by considering the ways in which each component may be affected by other components, we may gain fuller insight into factors influencing women's trajectories. Our framework components are flexible to adapt to the (sometimes rapidly) changing landscape of abortion care-seeking such as the rapid increase in self-use

of medical abortion (Kapp et al., 2017). It situates the abortion trajectory for a pregnancy, highlighting the critical role played by timing of pregnancy awareness, and identifying the set of processes involved in an individual trajectory, including multiple abortion attempts. This identification suggests testable hypotheses about how abortion trajectories might be influenced by policy or practice.

Our conceptual framework can be used to assess how, why and with what consequences, women's abortion-related trajectories are shaped. Every component of our framework allows for testing hypotheses about how abortion trajectories might be influenced by modifications to, for example, the legal system, policy environment or individual behaviour. Such interventions have the potential to impact abortion-related morbidity and mortality outcomes.

## Acknowledgements

Partial funding towards the development of this paper was from ESRC/DFID (ES/I032967/1 and ES/L007827/1). With thanks to Samantha Lattof and Joe Strong, for their research assistance. For critical suggestions, we thank the two anonymous reviewers of this paper. With thanks to the funders and organisers of the IUSSP Special Seminar on Abortion Decision-Making, at which this paper was originally conceived.

## Appendix A. Supplementary data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.socscimed.2018.01.035>.

## References

- Aiken, A.R.A., Potter, J.E., 2013. Are latina women ambivalent about pregnancies they are trying to Prevent? Evidence from the border contraceptive access study. *Perspect. Sex. Reprod. Health* 45 (4), 196–203.
- Ajzen, I., Fishbein, M., 1980. *Understanding Attitudes and Predicting Social Behaviour*. Prentice-Hall, London.
- Ajzen, I., Madden, T., 1986. Prediction of goal directed behaviour: attitudes, intentions and perceived behavioural control. *J. Exp. Soc. Psychol.* 22 (5), 453–474.
- Al-Matary, A., Ali, J., 2014. Controversies and considerations regarding the termination of pregnancy for Foetal Anomalies in Islam. *BMC Med. Ethics* 15 (1), 10.
- Allen, R.H., Fortin, J., Bartz, D., Goldberg, A.B., Clark, M.A., 2012. Women's preferences for pain control during first-trimester surgical abortion: a qualitative study. *Contraception* 85 (4), 413–418.
- Andersen, K.L., Khanal, R.C., Teixeira, A., Neupane, S., Sharma, S., Acre, V.N., et al., 2015. Marital status and abortion among young women in Rupandehi, Nepal. *BMC Wom. Health* 15 (1), 17.
- Andersen, R.M., 1995. Revisiting the behavioral model and access to medical care: does it matter? *J. Health Soc. Behav.* 1–10.
- Andersson, I.M., Christensson, K., Gemzell-Danielsson, K., 2014. Experiences, feelings and thoughts of women undergoing second trimester medical termination of pregnancy. *PLoS One* 9 (12), e115957.
- Aniteye, P., Mayhew, S.H., 2013. Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation. *Health Res. Pol. Syst.* 11.
- Arambepola, C., Rajapaksa, L.C., 2014. Decision making on unsafe abortions in Sri Lanka: a case-control study. *BMC Reproductive Health* 11 (91), 1–8.
- Asplin, N., Wessel, H., Marions, L., Öhman, S.G., 2013. Pregnant women's perspectives on decision-making when a fetal malformation is detected by ultrasound examination. *Sexual & Reproductive Healthcare* 4 (2), 79–84.
- Azmat, S.K., Shaikh, B.T., Mustafa, G., Hameed, W., Bilgrami, M., 2012. Delivering post-abortion care through a community-based reproductive health volunteer programme in Pakistan. *J. Biosoc. Sci.* 44 (6), 719–731.
- Babitsch, B., Gohl, D., von Lengerke, T., 2012. Re-revisiting Andersen's behavioral model of health services use: a systematic review of studies from 1998–2011. *GMS Psycho-Soc.-Med.* 9 (11), 1–15.
- Bandura, A., 1977. *Social Learning Theory* Englewood Cliffs. Prentice-Hall, NJ.
- Banerjee, S.K., Andersen, K., 2012. Exploring the pathways of unsafe abortion in Madhya Pradesh, India. *Global Publ. Health* 7 (8), 882–896.
- Bankole, A., Sedgh, G., Oye-Adeniran, B.A., Adewole, I.F., Hussain, R., Singh, S., 2008. Abortion-seeking behaviour among Nigerian women. *J. Biosoc. Sci.* 40 (2), 247–268.
- Barbosa, R.M., Pinho, A.A., Santos, N.S., Villela, W.V., 2012. Exploring the relationship between induced abortion and HIV infection in Brazil. *Reprod. Health Matters* 20 (39 Suppl.), 80–89.
- Barot, S., 2012. Governmental coercion in reproductive decision making: see it both ways. *Guttacher Policy Rev.* 15 (4), 7–12.
- Barot, S., 2017a. The benefits of investing in international family planning and the price

- of slashing funding. *Guttmacher Policy Rev.* 20, 1–4.
- Barot, S., 2017b. When antiabortion ideology turns into foreign policy: how the Global Gag Rule erodes health, ethics and democracy. *Guttmacher Policy Rev.* 20, 73–77.
- Beaumont, Z., Bond-Theriault, C., 2017. *Queering Reproductive Justice: a Toolkit*. National LGBTQ Task Force, Washington DC, pp. 67.
- Becker, D., Diaz-Olavarrieta, C., Juarez, C., Garcia, S.G., Sanhueza Smith, P., Harper, C.C., 2011. Sociodemographic factors associated with obstacles to abortion care: findings from a survey of abortion patients in Mexico city. *Wom. Health Issues* 21 (3), S16–S20.
- Becker, M.H., 1974. The health belief model and personal health behavior. *Health Educ. Monogr.* 2, 324–473.
- Benson, J., 2005. Evaluating abortion-care programs: old challenges, new directions. *Stud. Fam. Plann.* 36 (3), 189–202.
- Berer, M., 2009. Provision of abortion by mid-level providers: international policy, practice and perspectives. *Bull. World Health Organ.* 87 (1), 58–63.
- Berer, M., 2013. Termination of pregnancy as emergency obstetric care: the interpretation of Catholic health policy and the consequences for pregnant women: an analysis of the death of Savita Halappanavar in Ireland and similar cases. *Reprod. Health Matters* 21 (41), 9–17.
- Berer, M., 2017. Abortion law and policy around the world: in search of decriminalization. *Health. Human Rights* 19 (1), 13–27.
- Bergallo, P., Ramón Michel, A., 2016. Constitutional developments in Latin American abortion law. *Int. J. Gynecol. Obstet.* 135 (2), 228–231.
- Biggs, M., Gould, H., Foster, D., 2013. Understanding why women seek abortions in the US. *BMC Wom. Health* 13 (1), 1–29.
- Birdsey, G., Crankshaw, T.L., Mould, S., Ramklass, S.S., 2016. Unmet counselling need amongst women accessing an induced abortion service in KwaZulu-Natal, South Africa. *Contraception* 94 (5), 473–477.
- Blofield, M., 2008. Women's choices in comparative perspective: abortion policies in late-developing Catholic countries. *Comp. Polit.* 49 (4), 399–419.
- Boland, R., 2010. Second trimester abortion laws globally: actuality, trends and recommendations. *Reprod. Health Matters* 18 (36), 67–89.
- Bongaarts, J., Guilamoto, C.Z., 2015. How many more missing women? Excess female mortality and prenatal sex selection, 1970–2050. *Popul. Dev. Rev.* 41 (2), 241–269.
- Bowes, T., Macleod, C., 2006. The characteristics of women seeking termination of pregnancy at an urban-based government hospital in the Eastern Cape. *Curatiosis* 29 (4), 12–18.
- Calvès, A.-E., 2002. Abortion risk and decisionmaking among young people in urban Cameroon. *Stud. Fam. Plann.* 33 (3), 249–260.
- Cameron, S.T., Glasier, A., 2013. Identifying women in need of further discussion about the decision to have an abortion and eventual outcome. *Contraception* 88 (1), 128–132.
- Carlsson, T., Bergman, G., Karlsson, A.-M., Wadensten, B., Mattsson, E., 2016. Experiences of termination of pregnancy for a fetal anomaly: a qualitative study of virtual community messages. *Midwifery* 41, 54–60.
- Castle, M.A., 2011. Abortion in the United States' Bible Belt: organizing for power and empowerment. *BMC Reproductive Health* 8 (1), 1–11.
- Chibber, K.S., Biggs, M.A., Roberts, S.C., Foster, D.G., 2014. The role of intimate partners in women's reasons for seeking abortion. *Wom. Health Issues* 24 (1), e131–138.
- Chiweshe, M., Mavuso, J., Macleod, C., 2017. Reproductive justice in context: south African and Zimbabwean women's narratives of their abortion decision. *Fem. Psychol.* 27 (2), 203–224.
- Clapton, J., Rutter, D., Sharif, N., 2009. *SCIE Systematic Mapping Guidance*. Social Care Institute for Excellence, London, pp. 151.
- Cleeve, A., Fixelid, E., Nalwadda, G., Klingberg-Allvin, M., 2017. Abortion as agentive action: reproductive agency among young women seeking post-abortion care in Uganda. *Cult. Health Sex.* 19 (11), 1–15.
- Clyde, J., Bain, J., Castagnaro, K., Rueda, M., Tatum, C., Watson, K., 2013. Evolving capacity and decision-making in practice: adolescents' access to legal abortion services in Mexico City. *Reprod. Health Matters* 21 (41), 167–175.
- Coast, E., Murray, S.F., 2016. "These things are dangerous": understanding induced abortion trajectories in urban Zambia. *Soc. Sci. Med.* 153, 201–209.
- Cockrill, K., Nack, A., 2013. "I'm not that type of person": managing the stigma of having an abortion. *Deviant Behav.* 34 (12), 973–990.
- Cockrill, K., Upadhyay, U.D., Turan, J., Greene Foster, D., 2013. The stigma of having an abortion: development of a scale and characteristics of women experiencing abortion stigma. *Perspect. Sex. Reprod. Health* 45 (2), 79–88.
- Coelho, H.L.L., Teixeira, A.C., Santos, A.P., Forte, E.B., Morais, S.M., LaVecchia, C., et al., 1993. Misoprostol and illegal abortion in Fortaleza, Brazil. *Lancet* 341 (8855), 1261–1263.
- Coeytaux, F., Hessini, L., Ejano, N., Obbuyi, A., Oguttu, M., Osur, J., et al., 2014. Facilitating women's access to misoprostol through community-based advocacy in Kenya and Tanzania. *Int. J. Gynecol. Obstet.* 125 (1), 53–55.
- Conkling, K., Karki, C., Tuladhar, H., Bracken, H., Winikoff, B., 2015. A prospective open-label study of home use of mifepristone for medical abortion in Nepal. *Int. J. Gynaecol. Obstet.* 128 (3), 220–223.
- Constant, D., de Tolly, K., Harries, J., Myer, L., 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.
- Cowan, S.K., 2013. Cohort abortion measures for the United States. *Popul. Dev. Rev.* 39 (2), 289–307.
- Daly, B., 2011. Access to abortion services: the impact of the European convention on human rights in Ireland. *Med. Law* 30 (2), 267–278.
- Davanzo, J., Rahman, M., 2014. Pregnancy termination in Matlab, Bangladesh: trends & correlates of use of safer & less-safe methods. *Int. Perspect. Sex. Reprod. Health* 40 (3), 119–126.
- Dehlendorf, C., Weitz, T., 2011. Access to abortion services: a neglected health disparity. *J. Health Care Poor Underserved* 22 (2), 415–421.
- Dennis, A., Blanchard, K., Bessenaar, T., 2016. Identifying indicators for quality abortion care: a systematic literature review. *BMJ Sex. Reprod. Health* 43 (1), 1–10.
- DePíñeres, T., Raifman, S., Mora, M., Villarreal, C., Foster, D.G., Gerds, C., 2017. 'I felt the world crash down on me': women's experiences being denied legal abortion in Colombia. *Reprod. Health* 14, 133.
- Diniz, S.G., d'Oliveira, A.F.P.L., Lansky, S., 2012. Equity and women's health services for contraception, abortion and childbirth in Brazil. *Reprod. Health Matters* 20 (40), 94–101.
- Domingos, S.R., Merighi, M.A., de Jesus, M.C., de Oliveira, D.M., 2013. The experience of women with abortion during adolescence as demanded by their mothers. *Rev. Latino-Am. Enferm.* 21 (4), 899–905.
- Edmeades, J., Lee-Rife, S.M., Malhotra, A., 2010. Women and reproductive control: the nexus between abortion and contraceptive use in Madhya Pradesh, India. *Stud. Fam. Plann.* 41, 75–88.
- Eisenberg, D.L., Leslie, V.C., 2017. Threats to reproductive health care: time for obstetrician-gynecologists to get involved. *Am. J. Obstet. Gynecol.* 216 (3), 256 e251.
- Fatúndes, A., Duarte, G.A., Osís, M.J.D., 2013. Conscientious objection or fear of social stigma and unawareness of ethical obligations. *Int. J. Gynecol. Obstet.* 123 (Suppl. 3), S57–S59.
- Fernandez, M.M., Coeytaux, F., de Leon, R.G., Harrison, D.L., 2009. Assessing the global availability of misoprostol. *Int. J. Gynecol. Obstet.* 105 (2), 180–186.
- Fordyce, L., 2012. Responsible choices: situating pregnancy intention among Haitians in South Florida. *MAQ (Med. Anthropol. Q.)* 26 (1), 116–135.
- Foster, D.G., Gould, H., Taylor, J., Weitz, T.A., 2012. Attitudes and decision making among women seeking abortions at one U.S. clinic. *Perspect. Sex. Reprod. Health* 44 (2), 117–124.
- Foster, D.G., Jackson, R.A., Cosby, K., Weitz, T.A., Darney, P.D., Drey, E.A., 2008. Predictors of delay in each step leading to an abortion. *Contraception* 77 (4), 289–293.
- Foster, D.G., Kimport, K., 2013. Who seeks abortions at or after 20 weeks? *Perspect. Sex. Reprod. Health* 45 (4), 210–218.
- Freeman, E., Coast, E., Murray, S.F., 2017. Men's roles in abortion trajectories in urban Zambia. *Int. Perspect. Sex. Reprod. Health* 43.
- French, V., Anthony, R., Souder, C., Geistkemper, C., Drey, E., Steinauer, J., 2016. Influence of clinician referral on Nebraska women's decision-to-abortion time. *Contraception* 93 (3), 236–243.
- Ganatra, B., Gerds, C., Rossier, C., Johnson, B.R., Tunçalp, Ö., Assifi, A., et al., 2017. Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model. *Lancet* 390, 2372–2381.
- Gawron, L.M., Cameron, K.A., Phisuthikul, A., Simon, M.A., 2013. An exploration of women's reasons for termination timing in the setting of fetal abnormalities. *Contraception* 88 (1), 109–115.
- Gbagbo, F.Y., Amo-Adjei, J., Laar, A., 2015. Decision-making for induced abortion in the accra metropolis, Ghana. *Afr. J. Reprod. Health* 19 (2), 34–42.
- GCJ, 2011. *The Right to an Abortion for Girls and Women Raped in Armed Conflict States' Positive Obligations to Provide Non-discriminatory Medical Care under the Geneva Conventions*. Global Justice Center, New York, pp. 36.
- Gerds, C., DePíñeres, T., Hajri, S., Harries, J., Hossain, A., Puri, M., et al., 2014. Denial of abortion in legal settings. *BMJ Sexual and Reproductive Health* 41 (3), 1–4.
- Gerds, C., Hudaya, I., 2016. Quality of care in a safe-abortion hotline in Indonesia: beyond harm reduction. *Am. J. Publ. Health* 106 (11), 2071–2075.
- Gerds, C., Raifman, S., Daskilewicz, K., Momberg, M., Roberts, S., Harries, J., 2017. Women's experiences seeking informal sector abortion services in Cape Town, South Africa: a descriptive study. *BMC Wom. Health* 17 (95), 1–10.
- Gerds, C., Tunçalp, Ö., Johnston, H., Ganatra, B., 2015. Measuring abortion-related mortality: challenges and opportunities. *BMC Reproductive Health* 12 (87), 1–3.
- Gipson, J.D., Hindin, M.J., 2008. "Having another child would be a life or death situation for her": understanding pregnancy termination among couples in rural Bangladesh. *Am. J. Publ. Health* 98 (10), 1827–1832.
- Gipson, J.D., Hirz, A.E., Avila, J.L., 2011. Perceptions and practices of illegal abortion among urban young adults in the Philippines: a qualitative study. *Stud. Fam. Plann.* 42 (4), 261–272.
- Gipson, J.D., Koenig, M.A., Hindin, M.J., 2008. The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. *Stud. Fam. Plann.* 39 (1), 18–38.
- Gomez-Scott, J., Cooney, T.M., 2014. Young women's education and behavioural risk trajectories: clarifying their association with unintended-pregnancy resolution. *Cult. Health Sex.* 16 (6), 648–665.
- Grindlay, K., Yanow, S., Jelinska, K., Gomperts, R., Grossman, D., 2011. Abortion restrictions in the U.S. military: voices from women deployed overseas. *Wom. Health Issues* 21 (4), 259–264.
- Hanschmidt, F., Linde, K., Hilbert, A., Riedel-Heller, S.G., Kersting, A., 2016. Abortion stigma: a systematic review. *Perspect. Sex. Reprod. Health* 48 (4), 169–177.
- Harries, J., Gerds, C., Momberg, M., Foster, D.G., 2015. An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa. *Reprod. Health* 12 (21), 1–6.
- Harries, J., Stinson, K., Orner, P., 2009. Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa. *BMC Publ. Health* 9 (1), 296–296.
- Hedqvist, M., Brodin, L., Tydén, T., Larsson, M., 2016. Women's experiences of having an early medical abortion at home. *Sexual & Reproductive Healthcare* 9, 48–54.
- Hodes, R., 2013. The medical history of abortion in South Africa, c.1970–2000. *J. South Afr. Stud.* 39 (3), 527–542.
- Hohmann, S.A., Lefèvre, C.A., Garenne, M.L., 2014. A framework for analyzing sex-

- selective abortion: the example of changing sex ratios in Southern Caucasus. *Int. J. Wom. Health* 6, 889–897.
- Holcombe, S.J., Berhe, A., Cherie, A., 2015. Personal beliefs and professional responsibilities: Ethiopian midwives' attitudes toward providing abortion services after legal reform. *Stud. Fam. Plann.* 46 (1), 73–95.
- Hyman, A., Blanchard, K., Coeytaux, F., Grossman, D., Teixeira, A., 2013. Misoprostol in women's hands: a harm reduction strategy for unsafe abortion. *Contraception* 87 (2), 128–130.
- Ipas, 2009. *Misoprostol and Medical Abortion in Africa*. Ipas, Chapel Hill, USA.
- IUSSP, 2014. International Seminar on Decision-making regarding abortion-determinants and consequences. In: I.S.P.o.A. Research (Ed.), *International Seminar on Decision-making Regarding Abortion-determinants and Consequences*. IUSSP, Nanyuki, Kenya.
- Izugbara, C.O., Egesa, C., Okelo, R., 2015. 'High profile health facilities can add to your trouble': women, stigma and un/safe abortion in Kenya. *Soc. Sci. Med.* 141, 9–18.
- Janiak, E., Kawachi, I., Goldberg, A., Gottlieb, B., 2014. Abortion barriers and perceptions of gestational age among women seeking abortion care in the latter half of the second trimester. *Contraception* 89 (4), 322–327.
- Jejeebhoy, S.J., Kalyanwala, S., Zavier, A.J.F., Kumar, R., Jha, N., 2010. Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages. *Reprod. Health Matters* 18 (35), 163–174.
- Johnson-Hanks, J., 2002. The lesser shame: abortion among educated women in southern Cameroon. *Soc. Sci. Med.* 55 (8), 1337–1349.
- Jones, R.K., Jerman, J., 2013. How far did US women travel for abortion services in 2008? *J. Wom. Health* 22 (8), 706–713.
- Kapp, N., Blanchard, K., Coast, E., Ganatra, B., Harries, J., Footman, K., et al., 2017. Developing a forward-looking agenda and methodologies for research of self-use of medical abortion. *Contraception*.
- Katz, J., 2017. Advocacy above the fray? Limitations of the pro-voice approach to supporting abortion patients. *Fem. Psychol.* 27 (2), 243–250.
- Kavanagh, E.K., Hasselbacher, L.A., Betham, B., Tristan, S., Gilliam, M.L., 2012. Abortion-seeking minors' views on the Illinois parental notification law: a qualitative study. *Perspect. Sex. Reprod. Health* 44 (3), 159–166.
- Kebede, M.T., Hilden, P.K., Middelton, A.L., 2012. The tale of the hearts: deciding on abortion in Ethiopia. *Cult. Health Sex.* 14 (4), 393–405.
- Kimport, K., Cockrill, K., Weitz, T.A., 2012a. Analyzing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experience of abortion clinics. *Contraception* 85 (2), 204–210.
- Kimport, K., Perrucci, A., Weitz, T.A., 2012b. Addressing the silence in the noise: how abortion support talklines meet some women's needs for non-political discussion of their experiences. *Women's Health* 52 (1), 88–100.
- Labandera, A., Gorgoroso, M., Briozzo, L., 2016. Implementation of the risk and harm reduction strategy against unsafe abortion in Uruguay: from a university hospital to the entire country. *Int. J. Gynecol. Obstet.* 134 (Suppl. 1), S7–S11.
- Lafarge, C., Mitchell, K., Fox, P., 2013. Women's experiences of coping with pregnancy termination for fetal abnormality. *Qual. Health Res.* 23 (7), 924–936.
- Lara, D., Garcia, S.G., Wilson, K.S., Paz, F., 2011. How often and under which circumstances do Mexican pharmacy vendors recommend misoprostol to induce an abortion? *Int. Perspect. Sex. Reprod. Health* 37 (2), 75–83.
- Leone, T., Coast, E., Parmar, D., Vwalika, B., 2016. The individual level cost of pregnancy termination in Zambia: a comparison of safe and unsafe abortion. *Health Pol. Plann.* 31 (7), 825–833.
- Liang, K., Meyers, K., Zeng, W., Gui, X., 2013. Predictors of elective pregnancy termination among women diagnosed with HIV during pregnancy in two regions of China, 2004–2010. *Bjog* 120 (10), 1207–1214.
- Lipp, A., 2011. Stigma in abortion care: application to a grounded theory study. *Contemp. Nurse* 37 (2), 115–123.
- Lubinga, S.J., Levine, G.A., Jenny, A.M., Ngonzi, J., Mukasa-Kivunike, P., Stergachis, A., et al., 2013. Health-related quality of life and social support among women treated for abortion complications in western Uganda. *Health Qual. Life Outcome* 11 (118), 1–8.
- MacFarlane, K.A., O'Neil, M.L., Tekdemir, D., Foster, A.M., 2017. "It was as if society didn't want a woman to get an abortion": a qualitative study in Istanbul, Turkey. *Contraception* 95 (2), 154–160.
- Mackian, S., Bedri, N., Lovel, H., 2004. Up the garden path and over the edge: where might health-seeking behaviour take us? *Health Pol. Plann.* 19 (3), 137–146.
- Macleod, C., Sigcau, N., Luwaca, P., 2011. Culture as a discursive resource opposing legal abortion. *Crit. Publ. Health* 21 (2), 237–245.
- MacQuarrie, K.L., Edmeades, J., 2015. Whose fertility preferences matter? Women, husbands, in-laws, and abortion in Madhya Pradesh, India. *Popul. Res. Pol. Rev.* 34 (4), 615–639.
- Madkour, A.S., Xie, Y., Harville, E.W., 2013. The association between prepregnancy parental support and control and adolescent girls' pregnancy resolution decisions. *J. Adolesc. Health* 53 (3), 413–419.
- Marecek, J., Macleod, C., Hoggart, A., 2017. Abortion in legal, social, and healthcare contexts. *Fem. Psychol.* 27 (1), 4–14.
- Marlow, H.M., Wamugi, S., Yegon, E., Fetters, T., Wanaswa, L., Msipa-Ndebele, S., 2014. Women's perceptions about abortion in their communities: perspectives from western Kenya. *Reprod. Health Matters* 22 (43), 149–158.
- McGinn, T., Casey, S.E., 2016. Why don't humanitarian organizations provide safe abortion services? *BMC Confl. and Health* 10 (8), 1–7.
- McLemore, M.R., Kools, S., Levi, A.J., 2015. Calculus formation: nurses' decision-making in abortion-related care. *Res. Nurs. Health* 38 (3), 222–231.
- McLeroy, K.R., Bibeau, D., Steckler, A., Glanz, K., 1988. An ecological perspective on health promotion programs. *Health Educ. Q.* 15 (4), 351–377.
- Miake-Lye, I.M., Hempel, S., Shanman, R., Shekelle, P.G., 2016. What is an evidence map? A systematic review of published evidence maps and their definitions, methods, and products. *Syst. Rev.* 5 (28), 1–21.
- Miles, M.B., Huberman, A.M., 1994. *Qualitative Data Analysis: an Expanded Sourcebook*. Sage, Thousand Oaks, Calif.; London.
- Mitchell, E.M., Kwizera, A., Usta, M., Gebreselassie, H., 2010. Choosing early pregnancy termination methods in Urban Mozambique. *Soc. Sci. Med.* 71 (1), 62–70.
- Moore, A.M., Frohvir, L., Blades, N., 2011a. What women want from abortion counseling in the United States: a qualitative study of abortion patients in 2008. *Soc. Work. Health Care* 50 (6), 424–442.
- Moore, A.M., Jagwe-Wadda, G., Bankole, A., 2011b. Men's attitudes about abortion in Uganda. *J. Biosoc. Sci.* 43 (1), 1–15.
- Moore, A.M., Kibombo, R., Cats-Baril, D., 2014. Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion. *Health Pol. Plann.* 29 (7), 893–901.
- Moore, A.M., Singh, S., Bankole, A., 2011c. Do women and men consider abortion as an alternative to contraception in the United States? An exploratory study. *Global Publ. Health* 6 (Suppl. 1), S25–S37.
- Ngoc, N.T., Bracken, H., Blum, J., Nga, N.T., Minh, N.H., van Nhang, N., et al., 2014. Acceptability and feasibility of phone follow-up after early medical abortion in Vietnam: a randomized controlled trial. *Obstet. Gynecol.* 123 (1), 88–95.
- Nguyen, M.H., Gammeltoft, T., Rasch, V., 2007. Situation analysis of quality of abortion care in the main maternity hospital in hải phòng, Viet Nam. *Reprod. Health Matters* 15 (29), 172–182.
- Nguyen, P.H., Nguyen, S.V., Nguyen, M.Q., Nguyen, N.T., Keithly, S.C., Mai, L.T., et al., 2012. The association and a potential pathway between gender-based violence and induced abortion in Thai Nguyen province, Vietnam. *Glob. Health Action* 5, 1–11.
- Norris, A., Harrington, B.J., Grossman, D., Hemed, M., Hindin, M.J., 2016. Abortion experiences among Zanzibari women: a chain-referral sampling study. *Reprod. Health* 13 (23), 1–9.
- Nyanzi, S., Nyanzi, B., Bessie, K., 2005. "Abortion? That's for women!" Narratives and experiences of commercial motorbike riders in south-western Uganda. *Afr. J. Reprod. Health* 9 (1), 142–161.
- Oduro, G.Y., Otsin, M.N.A., 2014. "Abortion—it is my own body": women's narratives about influences on their abortion decisions in Ghana. *Health Care Women Int.* 35 (7–9), 918–936.
- Orner, P., de Bruyn, M., Cooper, D., 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. *Cult. Health Sex.* 13 (7), 781.
- Ostrach, B., Cheyney, M., 2014. Navigating social and institutional obstacles: low-income women seeking abortion. *Qual. Health Res.* 24 (7), 1006–1017.
- Osur, J., Orago, A., Mwanzo, I., Bukusi, E., 2015. Social networks & decision making for clandestine unsafe abortions: evidence from Kenya. *Afr. J. Reprod. Health* 19 (1), 34–43.
- Palmer, J.J., Storeng, K.T., 2016. Building the nation's body: the contested role of abortion and family planning in post-war South Sudan. *Soc. Sci. Med.* 168, 84–92.
- Palomino, N., Padilla, M.R., Talledo, B.D., Mazuelos, C.G., Carda, J., Bayer, A.M., 2011. The social constructions of unwanted pregnancy and abortion in Lima, Peru. *Global Publ. Health* 6 (Suppl. 1), S73–S89.
- Perry, R., Murphy, M., Haider, S., Harwood, B., 2015. "One problem became another": disclosure of rape-related pregnancy in the abortion care setting. *Wom. Health Issues* 25 (5), 470–475.
- Pescosolido, B.A., 1992. Beyond rational choice: the social dynamics of how people seek help. *Am. J. Sociol.* 97 (4), 1096–1138.
- Peterson, G., Azize, Y., 2005. Abortion practice in the northeast Caribbean: "Just write down stomach pain". *Reprod. Health Matters* 13 (26), 44–53.
- Powell-Jackson, T., Acharya, R., Filippi, V., Ronsmans, C., 2015. Delivering medical abortion at scale: a study of the retail market for medical abortion in Madhya Pradesh, India. *PLoS One* 10 (3), e0120637.
- Purcell, C., Hilton, S., McDaid, L., 2014. The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010. *Cult. Health Sex.* 16 (9), 1141–1155.
- Puri, S., Adams, V., Ivey, S., Nachtigall, R.D., 2011. "There is such a thing as too many daughters, but not too many sons": a qualitative study of son preference and fetal sex selection among Indian immigrants in the United States. *Soc. Sci. Med.* 72 (7), 1169–1176.
- Ralph, L., Gould, H., Baker, A., Foster, D.G., 2014. The role of parents and partners in minors' decisions to have an abortion and anticipated coping after abortion. *J. Adolesc. Health* 54 (4), 428–434.
- Ramachandar, L., Pelto, P.J., 2002. The role of village health nurses in mediating abortions in rural Tamil Nadu, India. *Reprod. Health Matters* 10 (19), 64–75.
- Ramos, S., Romero, M., Aizenberg, L., 2015. Women's experiences with the use of medical abortion in a legally restricted context: the case of Argentina. *Reprod. Health Matters* 22 (44), 4–15 Suppl. 1.
- Ramos, S., Romero, M., Ramon Michel, A., 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. *Reprod. Health* 11, 72.
- Rasch, V., Sorensen, P.H., Wang, A.R., Tibazarwa, F., Jager, A.K., 2014. Unsafe abortion in rural Tanzania - the use of traditional medicine from a patient and a provider perspective. *BMC Pregnancy Childbirth* 14 (419), 1–8.
- Reichel, M., Ramey, M.A., 1987. *Conceptual Frameworks for Bibliographic Education: Theory into Practice*. Libraries Unlimited, Littleton, Colo.
- Ricketts, T.C., Goldsmith, L.J., 2005. Access in health services research: the battle of the frameworks. *Nurs. Outlook* 53 (6), 274–280.
- Rocca, C.H., Kimport, K., Roberts, S.C., Gould, H., Neuhaus, J., Foster, D.G., 2015. Decision rightness and emotional responses to abortion in the United States: a longitudinal study. *PLoS One* 10 (7), e0128832.
- Rosen, J.D., 2012. The public health risks of crisis pregnancy centers. *Perspect. Sex. Reprod. Health* 44 (3), 201–205.

- Rosenstock, I.M., 1966. Why people use health services. *Milbank Mem. Fund. Q.* 44 (3), 94–106.
- Rossier, C., 2007. Abortion: an open secret? Abortion and social network involvement in Burkina Faso. *Reprod. 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. *Reprod. Health Matters* 22 (44), 42–51.
- Sánchez Fuentes, M.L., Paine, J., Elliott-Buettner, B., 2008. The decriminalisation of abortion in Mexico City: how did abortion rights become a political priority? *Gend. Dev.* 16 (2), 345–360.
- Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.-B., Daniels, J., et al., 2014. Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health* 2 (6), e323–e333.
- Schuster, S., 2005. Abortion in the moral world of the Cameroon grassfields. *Reprod. Health Matters* 13 (26), 130–138.
- Schuster, S., 2010. Women's experiences of the abortion law in Cameroon: "What really matters". *Reprod. Health Matters* 18 (46), 137–144.
- Schwandt, H.M., Creanga, A.A., Adanu, R.M.K., Danso, K.A., Agbenyega, T., Hindin, M.J., 2013. Pathways to unsafe abortion in Ghana: the role of male partners, women, and health care providers. *Contraception* 88 (4), 509–517.
- Sedgh, G., Bearak, J., Singh, S., Bankole, A., Popinchalk, A., Ganatra, B., et al., 2016. Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. *Lancet* 39 (10041), 16–22.
- Sethna, C., Doull, M., 2013. Spatial disparities and travel to freestanding abortion clinics in Canada. *Wom. Stud. Int. Forum* 38, 52–62.
- Shah, I.H., Ahman, E., 2012. Unsafe abortion differentials 2008 by age & developing country region. *Reprod. Health Matters* 20 (39), 169–173.
- Singh, J.A., Karim, S.S.A., 2017. Trump's "global gag rule": implications for human rights and global health. *The Lancet Global Health* 5 (4), e387–e389.
- Singh, S., Darroch, J.E., Ashford, L.S., 2014. Adding it up: the Costs and Benefits of Investing in Sexual and Reproductive Health 2014. Guttmacher Institute, New York.
- Singh, S., Wulf, D., Hussain, R., Bankole, A., Sedgh, G., 2009. Abortion Worldwide: a Decade of Uneven Progress. Guttmacher Institute.
- Sneeringer, R.K., Billings, D.L., Ganatra, B., Baird, T.L., 2012. Roles of pharmacists in expanding access to safe and effective medical abortion in developing countries: a review of the literature. *J. Publ. Health Pol.* 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. *Reprod. Health Matters* 21 (41), 243–250.
- Stanback, J., Vance, G., Asare, G., Kasonde, P., Kafulubiti, B., Chen, M., et al., 2013. Does free pregnancy testing reduce service denial in family planning clinics? A cluster-randomized experiment in Zambia and Ghana. *Glob. HR: Sci. Park* 1 (3), 382–388.
- Stevenson, A.J., 2014. Finding the Twitter users who stood with Wendy. *Contraception* 90 (5), 502–507.
- Stokols, D., 1996. Translating social ecological theory into guidelines for community health promotion. *Am. J. Health Promot.* 10 (4), 282–298.
- Subramaney, U., Wyatt, G.E., Williams, J.K., 2015. Of ambivalence, shame and guilt: perceptions regarding termination of pregnancy among South African women. *S. Afr. Med. J.* 105 (4), 1–2.
- Suh, S., 2014. Rewriting abortion: deploying medical records in jurisdictional negotiation over a forbidden practice in Senegal. *Soc. Sci. Med.* 108, 20–33.
- Sundaram, A., Juarez, F., Bankole, A., Singh, S., 2012. Factors associated with abortion-seeking and obtaining a safe abortion in Ghana. *Stud. Fam. Plann.* 43 (4), 273–286.
- Tagoe-Darko, E., 2013. "Fear, shame & embarrassment": the stigma factor in post abortion care at komfo anokye teaching hospital, kumasi, Ghana. *Asian Soc. Sci.* 9 (10), p134.
- Tamang, A., Tuladhar, S., Tamang, J., Ganatra, B., Dulal, B., 2012. Factors associated with choice of medical or surgical abortion among women in Nepal. *Int. J. Gynecol. Obstet.* 118 (Suppl. 1), S52–S56.
- Tangmunkongvorakul, A., Kane, R., Wellings, K., 2005. Gender double standards in young people attending sexual health services in Northern Thailand. *Cult. Health Sex.* 7 (4), 361–373.
- Umuhzo, C., Oosters, B., van Reeuwijk, M., Vanwesenbeeck, I., 2013. Advocating for safe abortion in Rwanda: how young people and the personal stories of young women in prison brought about change. *Reprod. Health Matters* 21 (41), 49–56.
- Valley, L.M., Homiehombo, P., Kelly-Hanku, A., Whittaker, A., 2015. Unsafe abortion requiring hospital admission in the Eastern Highlands of Papua New Guinea—a descriptive study of women's and health care workers' experiences. *Reprod. Health* 12 (22), 1–11.
- van Ditzhuijzen, J., Ten Have, M., de Graaf, R., van Nijnatten, C.H., Vollebergh, W.A., 2015. The impact of psychiatric history on women's pre- and postabortion experiences. *Contraception* 92 (3), 246–253.
- Vasquez, D.N., Das Neves, A.V., Golubicki, J.L., Di Marco, I., Loudet, C.I., Roberti, J.E., et al., 2012. Critical care providers' opinion on unsafe abortion in Argentina. *Int. J. Gynecol. Obstet.* 116 (3), 249–252.
- Vincent, L., 2011. Shaking a hornets' nest: pitfalls of abortion counselling in a secular constitutional order – a view from South Africa. *Cult. Health Sex.* 14 (2), 125–138.
- WHO, 2017. Global Abortion Policies Database. World Health Organization, Human Reproduction Programme.
- Zamberlin, N., Romero, M., Ramos, S., 2012. Latin American women's experiences with medical abortion in settings where abortion is legally restricted. *BMC Reproductive Health* 22 (9), 11.