A framework for considering women’s abortion decision-making

Transcript of discussion

Every year 43.8 million women have an induced abortion. Of these, 21.6 million women experience an unsafe abortion and 47 000 die as a result. Understanding women’s decision-making regarding abortion is necessary for policies and services to meet the needs of girls and women obtaining abortions, whether safe or unsafe, illegal or legal. But abortion research is challenging. Abortion is complex. Researchers and practitioners have typically aimed to understand this complexity by considering specific aspects of abortion decision-making.

Take a look at our conceptual framework.

Is a conceptual framework to organise evidence and visually demonstrate the effects of different influences on women’s abortion care decision-making useful?

If it is, what else should be included?

(74 comments)

Malvern Chiweshe
The framework is very useful in providing a clear and concise way of understanding abortion decision-making. It is also the first one that focuses on all aspects of abortion decision-making. Another useful application is in African settings where abortion is illegal. The framework fits well with the reproductive justice framework where abortion decision-making is not only a matter of a woman choosing whether to have an abortion or not. Abortion decision-making does not happen in a vacuum and the framework is important as it touches on the different context of social, economic, gender, and colonial inequalities that abortion decision-making occurs. My main worry, however is that there is a risk of losing the individual woman in the abortion decision. My research in Zimbabwe is showing that, despite what might appear to be similar circumstances and conditions between two women, the way they narrate and carry out their abortion decision-making is different. This then means that we need to be careful about not placing women in categories and forgetting about the individual.

Heini Vaisanen
Many thanks for your comment Malvern. Indeed, it is important not to forget the individual. It would be interesting to hear an example of your research, where women who appeared similar had different thoughts about their abortion decision, if you are comfortable sharing an example.

Ernestina Coast
Malvern, thanks. You are absolutely right, to highlight that the individual experience should not be overlooked when we try to make sense of complexity using a framework. Two women
with exactly “the same” trajectories, when talking about or discussing their experiences or decision-making, will have very different narratives or stories. Do you have a link to your work in Zimbabwe that you could share with conference participants? It’s always good to hear about new research.

**Malvern Chiweshe**
Heini and Ernestina. I will share an example of my work later today. I have attached a link to a colleagues masters thesis, [http://hdl.handle.net/10962/d1017885](http://hdl.handle.net/10962/d1017885). She used a reproductive framework in South Africa and you can start seeing some of the things from the framework.

**Ernestina Coast**
Thanks – really helpful to have such links circulated. Brings emergent work to people’s notice!

**Ann Moore**
Dear Malvern,
This framework was inspired by our IUSSP Conference last year; your work presented at that conference helped us get here. Thanks for your comment—we will be sure to think about that as we try to describe all possible scenarios in the paper.

**Alice Evans**
I think this is really brilliant, very comprehensive. I particularly like that you do not say ‘social norms’ in abstract but instead focus on an individual’s beliefs about how they will be perceived and treated by others. E.g. ‘Anticipated social treatment due to having an abortion’. As others have commented above, two women in the same town may have different beliefs about how they be treated by others.

One implication of this is that it is not enough to address an individual’s limited knowledge or internalised beliefs about abortion, it is also cardinal that they should believe they will be supported by others. They need to think norms are changing, i.e. that other people will be supportive and tolerant.

I think Government can play a big role here, in signalling wider social acceptance.

**Heini Vaisanen**
Many thanks for your comment Alice, good points! What do you (or anyone) think are the best ways government should go about signalling wider social acceptance?

**Alice Evans**
Well, obviously the most important move is for clinics and hospitals to provide these services.

And be open about such services. This is often perceived as external validation, especially in more authoritarian cultures.

**Alison Norris**
This is an important idea — that in more authoritarian governmental contexts, simply having services available signals social acceptance. I wonder how the push to make post abortion
care available in many different contexts (eg even where abortion is illegal) begins to change the sense of social acceptability of abortion itself. We have some literature about the (slow) change of social acceptance in places where abortion becomes legalized; is there evidence about whether the social acceptance changes differentially if the govt is able to place abortion services widely?

Martha Silva
In Uruguay, pre and post abortion counseling became MOH norm in 2005 to reduce the risk of improper use of Misoprostol, and then abortion became decriminalized up to 12 weeks in 2012. What we’ve seen is that even before decriminalization, there was a sense among women of accessing a legitimate service that lessened the burden to some extent of the clandestine act. After decriminalization, with abortion services made available in a very wide range of public and private health services our perception is that the right to abortion has permeated extremely quickly the social discourse, despite the stigma. This is a country with a very strong “right to health” stance compared to others in the region.

Ernestina Coast
Martha, a really interesting example – you mention it as a perception that the “right to abortion” has rapidly become part of social discourse – are you (or others) following any sources of evidence or lines of enquiry to track this? Media reports? Social media? It could be a very interesting way of understanding how changes in law are socially diffused?

Ann Moore
Thanks so much for your feedback, Alice! I love getting your health sector perspective on this.

You would be an excellent reviewer for this paper once we get it submitted to a journal. I hope you won’t mind us recommending you as a reviewer.

Best of luck with your work in Zambia.

Salma Ahmed
This is a very comprehensive framework. I think one should not overlook costs of abortion, such as medical risks from unsafe abortion.

Ernestina Coast
Salma, you are right that the medical consequences of unsafe abortion are an important factor – both in influencing an individual’s perceptions and decisions about different methods, and also for the consequences they experience. In our framework we try to include these (briefly) in the final box on the bottom row “Sequelae from (attempted) abortion: • Physical, • Psychological, • Socioeconomic (for individual and others)”

Amos Mwale
I love the framework it is very useful in providing a clear and concise way of understanding abortion decision-making for women. I am not just sure how women make they decision and what information is used. In most cases a number of things and information is always missing before a woman can make a decision. Maybe the question we should ask is what information
do women have on safe abortion services. We also need to ask what influences women to make the decision they make.

**Ernestina Coast**
Amos, yes, many women cannot access information, or the information is not available. In terms of research – there is some information that shows us (from women who have had an abortion) what they did / did not know. However, we know a lot less about women who self-induce, or about women who continued with a pregnancy because of a lack of information, for example.

**Valentina Fusari**
I think the framework is useful and well designed, although thinking about my research experience on unsafe abortion in Eritrea I should consider, for example, that women’s (or couple’s) decision about abortion can only be oriented to unsafe abortion because the law is very strict. Furthermore, looking through data about family planning and discussing with health workers, it seems clear that knowledge, use and availability of modern contraceptive methods do not show the same trends. In fact, family planning is more used to guarantee safe motherhood and avoid infant and maternal mortality, not to control fertility. As a result, this attitude impact on the demand of illegal and highly unsafe abortion practices. So, what about the responsibility of governments in pushing women towards unsafe practices although women are aware about other opportunities to avoid risks but they can not access them?

**Ernestina Coast**
Valentina, Yes, our framework has been developed so that it can be used in any legal setting – so in the case of Eritrea this structural factor – constrains the options that are open to people. It would be great to hear more about your work in Eritrea – do you have links to any presentations or papers that you could share with e-conference participants?

**Valentina Fusari**
Dear Ernestina, unfortunately at the moment I have no presentations or papers to share with all the participants. I’m working on my notes and data for next events, then I’ll be able to share everything.

**Wellington Moyo**
Very good framework. What would just be required probably is the availability of these services in all areas so that they can be accessed by all those who need them. One of the reasons why some people have resorted to dumping babies on the streets, toilets among other cases which we come across in the media, is not having easy access to abortion services. They fear the process and steps one has to go through before the procedure is carried on.

**Roger Ingham**
Just a couple of comments triggered by what I have read so far:

1 – the framework is indeed very helpful and comprehensive but, like all such frameworks, has to over-simplify to fit on one page! Each ‘box’ can be expanded to incorporate further factors of crucial importance. For example, my own work (with Ellie Lee) on second trimester abortions in the UK revealed a variety of factors why the ‘awareness of pregnancy’ occurred sooner or later, and, in some cases – especially involving younger women – how ‘awareness’ was confounded with ‘acceptance’, denial, etc. These wider issues were not
necessarily abortion related but were also influenced by societal views on pre-marital sex, young people, etc. These wider issues could profitably be added into a couple of the boxes in the top row.

2 – the implications of the timing of awareness for the type of procedure that is feasible are very important, of course (for finding suitable providers, for health risk, for possible reactions after the event, etc.). In some cases, delays to past the first semester may make a safe abortion non-viable.

3 – another issue on the framework is the order of events – we found some coming and going between stages that makes the seemingly simple time line problematic (this is NOT a criticism!).

4 – attitudes of providers appeared, in some cases, to delay steps along the way such that women were given fewer options for method. These are not out and out objectors, but act in more subtle (and seemingly nasty) ways. These comments are based on the reports of the women we have interviewed, not on objective data from providers.

5 – the final box in the red line could add in provision of contraception as part of the abortion process (only if carried out legally, presumably).

6 – Finally (for now) I note that most users are using the term ‘abortion’ but a few are using ‘termination’. Is there a preferred terminology in different countries; does one have less stigma than another (for either provider or the women involved)?

**Ernestina Coast**

Roger, thanks for really helpful comments on the framework. Yes, how to incorporate the iterative nature of many women’s trajectories in a 2-dimensional visual. You are right to point out that our framework gives the impression of a strict ordering or events on the bottom row, when in fact there’s often a lot of iteration and to-ing and fro-ing. The issue of “unofficial” conscientious objection as you describe it is an important one – and one that’s probably really under-researched. I suspect that practitioners who are clearly and obviously conscientiously objecting are more likely to “stand up and be counted” as it were than those who – as you describe – do this in more insidious ways.

For others in this econference, here’s the citation to Roger’s work – we’ll be taking a look to see how the framework fits (or needs adjusting) to it: Ingham, Roger, et al. “Reasons for second trimester abortions in England and Wales.” Reproductive health matters 16.31 (2008): 18-29.

**Ernestina Coast**

Interesting how often (already) issues of language have come up in this e-conference. I’d be really interested to hear others’ perspectives on this issue – abortion or termination? In Zambia – where the legal framework is the “Termination of Pregnancy Act”, we have found termination to be a more “acceptable” terminology to use in our work because it uses the same word as the law. But when presenting out research at international conference etc., have used the word abortion. So elision of language depending upon context?
Fiona Bloomer
On the issue of language Termination of Pregnancy is often regarded as a loaded term in Northern Ireland where I conduct research. The Department of Health here were forced by the courts to issue guidance for medical professionals on the vague law (which dates from 1861 and case law in 1990s). The guidance is entitled Termination of Pregnancy. The language used in the last version of the guidance in 2013 was widely criticised with terms such as mother / unborn used extensively whilst woman/ foetus was not. The term abortion is regarded as more acceptable then termination, particularly by non-government bodies and activist groups.

Martha Silva
The red arrow at the bottom does accentuate the apparent linearity of events at the bottom, and I also had the same feeling that something may be missed when the process is considered linear. In Uruguay all legal abortions are pharmaceutical and women take the pills at home. Women are deciding even after they’ve accessed the service and in that way are managing their time in a different way than if the abortion was surgical and in-clinic.

Participant 9
I’d like to add to the discussion on post-abortion care within this framework. My research on post-abortion care in [African country], where abortion is prohibited under any circumstance, suggests that post-abortion care may in fact increase the stigma of abortion. Without a doubt, the Ministry of Health has done an excellent job of integrating PAC into routine obstetric care in public hospitals. At the same time, PAC is overwhelmingly portrayed as a service for treating complications of miscarriage rather than complications of induced abortion. Women suspected of having attempted to terminate pregnancy may be subjected to repeated questioning, threats to withhold treatment, or threats to call the police. Yet, even women suspected of induced abortion may be recorded in PAC registers as having had a miscarriage. Indeed, most PAC cases are recorded as miscarriages. By recording most cases of PAC as miscarriage, the very act of recordkeeping reproduces the notion that most PAC patients have had a miscarriage and therefore that induced abortion is rare. The discriminatory treatment of suspected women represents the local production of abortion stigma within the hospital. I’ve written about the production of abortion stigma through PAC recordkeeping and am happy to share the article. More recently, I’ve written about how the management of manual vacuum aspiration technology reflects continuing anxieties about the line between abortion and PAC in [African country]. Efforts to keep MVA ‘safe’ from inappropriate use within hospitals may limit women’s access to this technology for the purpose of PAC, even when it is available. Formal and informal policies designed to regulate MVA suggest that even in a context where PAC has been routinized into obstetric care, the stigma of abortion continues to shape the provision of care for health professionals and women patients. I’m also happy to share this article.

I’m really glad that we’re talking about post-abortion care. In contexts such as [African country] where abortion is highly restricted, the organization, delivery and experience of PAC are profoundly reflective of social, legal and professional meanings of abortion.

Fiona Bloomer
I would concur with others that the framework is constructed well and manages to summarise
so many factors/ issues on one page, that is no easy feat. I would like time to digest it further but my initial view is that I could see it applying to the Northern Ireland. Fiona

Peg Johnston
Abortion Decisions are Life Decisions: One of the guiding principles when I created the Pregnancy Options Workbooks (http://www.pregnancyoptions.info) was that decisions were really about the entirety of women’s lives, specifically whether they could, in good conscience, have a child or another child, depending on their economic and social position, strength of relationships with partner, family or other support, beliefs, needs of other children, self concept, perceived stigma, religion, and many many other factors. As Charlotte Taft has formulated this (recently here http://www.salon.com/2015/06/05/i_wish_that_we_talked_about_choices_instead_of_choice—a_texas_abortion_counselor_on_how_to_change_the_conversation_about_abortion/) Abortion is the Hole in the Doughnut, but the Doughnut itself is her Life. This seems important because we can get distracted by the controversy of abortion and miss how complex the decision is regardless of the eventual choice, and how a woman can hold several beliefs about it at the same time, as in, “I know this is the right choice” and “I may go to hell for it.” (or lesser forms of that dichotomy.)

I think pregnancy decisions, as I prefer to call them, are made more complex by having to manage the stigma associated with abortion, and also with adoption. In the US (and my remarks are perhaps US centric) I see this in choosing the abortion pill over the procedure: many patients feel that it is not an abortion, or not as much of an abortion. Women seem aware that they are creating an illusion about this: they say, “I know it’s silly, but somehow I can believe that it isn’t really an abortion if I bleed at home.”

Ernestina Coast
Peg, thanks – you raise a useful point about the framing of “pregnancy decisions” as opposed to “abortion decisions”. Our framework is focusing explicitly on a woman’s individual abortion – but as you point out, this is part of a broader set of decisions about a pregnancy.

Heini Vaisanen
Thanks Peg. I found the point about medical abortion being “not as much of an abortion” in some women’s opinion quite interesting. I saw a presentation in PAA where it was shown that in some areas of Texas women travel long distances to get a medical abortion although they could get a surgical one more easily. It created discussion on why this may be the case. Perhaps the reasons you outlined explain part of the association? Here’s a link to the abstract http://paa2015.princeton.edu/abstracts/153738

Alison Norris
In terms of ‘not as much of an abortion’ from medication abortion — less stigma, less going to hell — I think there is less worry about resultant future infertility, which, in east Africa at least (and I think US too?) is a central concern among women having abortions. Is concern for preserving future fertility part of our framework in any way? Often women conceive unwanted pregnancies because they are afraid hormonal methods of contraception will interfere with future fertility, so thoughts about future fertility are a part of abortion decisions in multiple ways.
Ernestina Coast
Yes – role of perceived infertility as a result of abortion was definitely a theme that emerged in our conversations with youth parliamentarians in Zambia. (The first ever Youth Parliament in Zambia (held earlier this year) debated the topic of abortion). I “think” concerns about future infertility are in the framework, but we should revisit.

Participant 8
Also fear of infertility (or wanting to make sure she was not infertile) – not the desire to have a child at the present time – was a concern of many of the young women who presented for pregnancy testing/care in an urban clinic in USA where I worked.

Flavia Bulegon Pilecco
Congratulations for the framework! It synthesizes pretty well the abortion decision-making process.

A suggestion would be to include study or work trajectory. There is already a topic “Material/physical resources (transport, money, childcare, ability to miss school or work)”, but it does not give the idea of interposition between pregnancy and personal projects. I am studying induced abortion among immigrants now and this seems to be a considerable issue (at least among this population).

Ernestina Coast
Flavia, thanks for this suggestion. Do you have any links to your work that you can share with participants? It’s always good to hear about new research!

Emily Freeman
Hi Flavia, I think this is a really good point we should consider including. It certainly chimes with our work in Zambia where continuing with education was a key reason young women gave for having sought an abortion. While to an extent it comes into material resources (I can’t afford a child now and I won’t be able to in future if I don’t finish school), I think you’re right that deviation from personal projects and goals might be a wider influence. Where is your study based? Do you have any presentations or papers you could share? It would be great to hear more.

Navtej Purewal
The framework is very comprehensive and I support it overall. In particular, I like the three themes and how they categorically address women’s agency in decision-making in context.

However, as it stands, there may be need for more clarity to be made across the three tiers on sex selective abortion. My worries are, having been through the hype around the sex selection amendment reading and vote in the Houses of parliament earlier this year in February, that sex selection can get picked up again. So, in this framework, I would like to see it ‘mainstreamed’ into the individual context and decision-making and accessing abortion tiers too, and not just at the international/sub-national context. Could we have a discussion on this?

Ernestina Coast
Navtej, we wanted to make sure that the issue of sex selective abortion was included in the framework, and your comments have revealed the internal debates we had about how and
where to include it in the framework. Because, as you rightly point out, it (like so many other issues) cuts across layers – from the institutional to the individual. We have included it explicitly in “(Inter)national and sub-national contexts – social and cultural position on fertility and abortion”, but would then expect it to also manifest at “Individual” and “Decision-making context”, for example, as a result of “partner/family/community context” or “emotions”. The example you use above – the recent reading and vote in the UK parliament – is an excellent one of the ways in which an issue (perceived or real), in this case sex selective abortion amongst South Asian socio-cultural groups in the UK, can be used to effect another group’s means. For members of the econference not familiar with this – here is some information on the issue:

http://services.parliament.uk/bills/2014-15/abortionsexselection.html
http://www.bbc.co.uk/news/uk-politics-31596968

Navtej Purewal
Ernestina, I was pleased to see sex selection mentioned explicitly in the framework. The threatened UK abortion amendment was, I believe, being driven by the US context where state-by-state (Indiana being the most recent example with two women, Indian (Purvi Patel) and Chinese (Bei Bei Shuai, who attempted suicide while pregnant) being convicted for ‘feticide and neglect of a dependent’).


I think the framework’s implementation and future policy developments will need to keep on top of sex selection, not because it is an ‘abortion issue’ but because it is increasingly being targeted by religious conservative groups and anti-abortion lobbyists as a weak spot in the pro-choice movement.

In the UK context, it was cunningly introduced through the Serious Crime bill as a form of Violence against Women and Girls, which caught many otherwise pro-choice voices off guard in speaking against the sex selection bill when it was first introduced.

I had written a blog piece one year before the debate entered the political debate, which now appears very dated but shows how the media was playing a role in picking up ‘sting operations’ of doctors who would be the target of the Sex selection abortion amendment bill’s criminalisation of sex selective abortion and the kinds of ‘data’ that were used as evidence driven by a carefully selected sample of immigrants born in India. Interestingly, the composite UK South Asian population shows no evidence of sex selection, while the sample cited uses Indian-born mothers.

http://discoversociety.org/2014/03/04/painting-by-numbers-locating-missing-girls-in-the-sex-ratio/

Supporting women under duress from pressure to have sons is an issue for supporting women not criminalising them. I can see that the framework allows for this in terms of making space for mechanisms to address community-family-individual levels of support.

Navtej Purewal
My earlier comment on sex selective abortion was intended to generate an informed discussion to create safeguards against the language and tactics of the anti-abortion lobby
which picks up on South Asian patriarchal ‘culture’ and the preference towards sons, which does not necessarily result in sex selective abortion. There was a discussion around safeguarding during the November 2014-February 2015 debates in terms of ensuring that women who were accessing abortion services were not doing so under duress due to cultural pressures to have sons. My take is that it is impossible to locate the point at which this decision-making takes place.

**Peg Johnston**
I appreciate the comments about the legitimizing power of the government and of services just being available. We see that now when some US states have made it almost impossible to get an abortion, and patients must travel long distances or jump through many bureaucratic hoops. I have not seen studies that measure the level of stigma increasing, has anyone else? We could hope that it makes women angry and less stigmatized!!

The other US example that occurs to me is in the 80’s when Ronald Reagan was President, a conservative Republican politician. He always spoke at anti-abortion rallies and he never spoke out against violence against clinics. That was stigmatizing to providers.

**Ernestina Coast**
Peg, I also couldn’t think of or find any studies that look at trends in abortion stigma – those that I know of are cross-sectional. But you are right that looking at trends over time could shed light on how law/policy/service change are manifesting. But others on this forum might know of time trend data on abortion stigma (for women or service providers)?

**Participant 7**
To date, there are no published studies (or even any studies under way that I know about) looking at stigma trends (up or down) over time as it relates to law/policy changes. There are several groups/researchers that are collecting pre and post data to evaluate community level and health facility level stigma interventions (Ipas, IPPF, Ibis and Sea Change, among many, many others) so sooner than later we’ll have empirical information about how perceived or experienced stigma changes for women and providers as the result of targeted interventions. We unfortunately do know, from work that ANSIRH did several years ago as part of their “Heartland Study” that many women who were presenting for abortions SUPPORTED abortion restrictions – which is of course very disheartening.

**Ernestina Coast**
Thanks – I think it will be important to see how these pre- and post-studies (with different contexts and policy change over time) find dis/similarity in change over time. It strikes me that political economy analysis might have something to contribute (if it hasn’t already!) to this bigger picture. For others, here’s a link to the Heartland Study: [http://www.ansirh.org/research/aspects.php](http://www.ansirh.org/research/aspects.php)

**Jeannie Ludlow**
I really appreciate this framework. It packs a lot into one page, and because of this, users of the framework will want to be careful not to use it to elide differences between individuals. I think a simple statement reminding users of this would be helpful.
Like Roger Ingham, I find it to be a bit linear. I’d like to recommend that those arrows between the levels go in both directions, indicating that individual factors can also influence the national and sub-national factors (and so on). For example, two people from the same cultural background, same religion, and same legal context might have very different experiences with pregnancy decision-making because of the individuals’ different personal beliefs about morality, different motherhood goals, and different abilities to cope with anticipated stigma. In my field of study, we think about the difference between understanding an experience to be socially constructed or socially constituted. Social construction describes a one-directional vector of influence by which social forces shape our lives. By comparison (see the work of feminist bioethicist Rosalyn Diprose), social constitution describes an iterative process by which the individual responds to those social and cultural forces; she is influenced by them and, at the same time, makes decisions about how that influence operates in her life.

If I were a practitioner using this framework to help me talk and listen more effectively with people about their pregnancy decisions, I think I would appreciate a reminder that these vectors of influence can go in multiple directions.

**Ernestina Coast**

Jennie, absolutely, two (hypothetical) women who have exactly the same context/characteristics might have two very different trajectories, and the individual is at the centre of our thinking (if not at the centre of our diagram visually). Your suggestion of social construction and social constitution is really helpful – not least because different disciplines bring different perspectives and language to a problematic. In a spirit of reflexivity, and you’ve got me reflecting on this now!, this framework was developed by a set of people with backgrounds in demography, anthropology, epidemiology, medicine and sociology – so likely reflects these perspectives in particular.

**Jeremiah Chikovore**

This is a comprehensive framework and many thanks for the great work. My comment is on something others may have touched on earlier, especially about the complex individual context and also the situation of young unmarried women. Our work in Zimbabwe revealed immense fears about having a pregnancy while unmarried and/or in school; and this was also related to unacceptability of/silence around sexual activity for unmarried young people — and hence, of use of contraceptives, and to the shame of being pregnant or making a girl pregnant while in school. The silence/muting, power dynamics, and violence woven around gender, age difference/generational relations seems a powerful dynamic in young women’s ways of having sex but also being compelled to opt for abortion. The silence on youth sexuality and denial of contraceptives seems to affect the young partners to young girls too. Even though in one sense under pressure to be sexually active and thus even forcing girls into sex, when their girlfriend becomes pregnant they panic and then deny responsibility, running away to escape or even committing suicide. I therefore suggest greater visibility of abortion dynamics within young unmarried women arising from their age and marital status, their mode and context of having sex, and the likely serious outcomes of being pregnant in the context of their family, partnerships especially with other young people, and the wider public sphere encompassing the school environment. Herewith some of our papers from the work: 1) Chikovore, J., Nyström, L., Lindmark, G. and Ahlberg, B.M. (2003). Denial and violence: paradoxes in male perspectives to premarital sex and pregnancy in rural Zimbabwe. African

Emily Freeman
Jeremiah, thanks for sharing this. We have found very similar situations in Zambia, and I can imagine it’s experienced elsewhere. Like so many items in the framework, the dynamics around demography (age, gender, marital status) in a particular setting influence access to knowledge about contraception and then access to contraceptives in the first instance, through to abortion – access to, desperation for, methods used (in our Zambian study, adolescents were much more likely to have unsafe abortions either because they are low ‘social risk’ – they don’t involve having to disappear for a day to visit a clinic in the city, or finding a significant amount of money and therefore risking exposure, or because they were desperate) , right through the sequelae and how that is then dealt with (for young women in our Zambian study – how long before they told their mum what’s really wrong etc.)

I think your point also raises an interesting issue about male involvement and how that shapes – either for better or worse – women and girls’ experiences. In our Zambian study, there were certainly cases of boys “denying” the pregnancy and fathers who would be beat their daughters for being pregnant, but for many women, men and boys – brothers and boyfriends’ friends – had strong supporting roles in getting the information about how to abort and then finding the money for it. Has anyone done work specifically on male involvement they’d like to share?

Ann Moore
I’m very glad to see Jeremiah bring in this perspective. Jeremiah and I have both done work on men’s involvement:


But as men are often gate-keepers on women’s access to health services in SSA, much more work needs to be done on men and abortion.

Jesper Kamuhuza
It is quiet detailed and rich Framework. I would also like to add my submission to the bone of contention. In Zambia culture and policies have made it very difficult for the issues of abortion to come on the surface and give women or girls considering abortion a clear path to take. Talks have been done in parliament as regards this topic and the house only went as far as allowing it to be undertaken if the lives for the mother and child are in danger. The truth is, even if we deny it or fail to recognize it, abortion is happening in the country and on a high rate. It important however in this case to consider the reasons why unmarried women, pupils and students are considering abortion every time they fall pregnant. you would discover that
there are so many genuine reasons these different groups of women have before taking abortion. School girls would consider it for fear of losing their education, being chased from home by their parents or simply the boyfriend cannot manage. How society treats those who fall pregnant before marriage has a contribution to it. And important point put in consideration is poverty. Not every woman at the time they fall pregnant is capable of taking care of a pregnancy worse still a baby in crazy economy like Zambia’s. The church, Govt and culture setup in Zambia thinks abortion is a bad omen and as such every woman found considering abortion should be punished which makes it even more worse. The victims then choose to do abortion in the silence by using illegal methods for instance use of needles pushed through the birth canal, taking a lot of panado tablets with a bottle of coke or go to unregistered private clinics to seek help by paying huge sums of money which does not go with cleaning after. The large community inn Zambia and other African countries need to change the view towards abortion and help women with information how to take proper abortion procedures when need be to avoid losing the lives of both mother and the unborn baby. More needs to be done

Emily Freeman
Jesper, thank you for your comment – it’s great to get this kind of insight. I think you raise an import point here – and perhaps others have examples from elsewhere? – abortion in Zambia is legal not just if the life of the woman or any existing children are in danger, but also if there’s a risk to her or their physical or mental health – and that medical practitioners can take account of age and environment when deciding what the risk is. But as you say, there is very limited understanding of the law – even senior figures publically misquote it.

Alison Norris
A related question, for me, is how much the legal context matters in places where knowledge of the law is absent. It ties back to an earlier thread in this discussion about how abortion services need to be well advertised by govt facilities so that people will know it is legal.

Ferdousi Begum
Thanks for the comprehensive framework.

In the green area: For the health system Service providers need/rights may include support system .Either in green area( social/cultural) or in read area women’s education and empowerment may be added or more pronounced.

May we understand the coding for the colors? Why green, yellow and red. This signifies as the traffic light with the signal for safe, alert and danger. It should be clear.

Ernestina Coast
Ferdousi, you raise a really good point and one that I think (I can’t speak for my co-authors!) that we should address. You are right – looking at it – that it gives an impression of a “traffic light” colour system. But this was not our intention at all. The colours are irrelevant, and we should change them. Thanks so much for this feedback – it sometimes takes other peoples’ eyes to see things!

Participant 4
Sorry I have to come in the discussion quite late. However, I think the framework is very comprehensive and elaborate. Thanks for that. I may not have read all the discussion points but I have seen that a lot has been discussed especially on my country, Zambia. My comment relates to power relations that exist in my country and deep rooted in our culture. Am happy that it is reflected in the framework. However, we need programmes that links it to culture, education system and socio-economic situations. For Zambia it is evident even in children and adolescents who grow up in the same situations. I would be happy to learn how this is addressed in other similar cultural settings like mine.

Heini Vaisanen
Thanks for the comment. Power relations are indeed important and I think it is quite interesting how that comes up in all the discussion themes in this e-conference!

Ernestina Coast
Specifically which sorts of power relations are you including? Are there any that you think — in your context — are particularly dominant?

Participant 3
Thank you so much for the invitation to participate. To reiterate what others have said, the conceptual framework is really excellent, it is indeed very thorough. When I think about the women from all walks of life that I’ve interviewed or talked to, from the young undergraduate student at the University of Ghana to the older market woman who doesn’t want to have her sixth child, it seems to be applicable in all their situations.

However, when I think about the women who would prefer to use abortion as their form of birth control, or the women who know which herbs to use to “regulate menstruation” and use them religiously, I’m wondering how the role of “abortion as contraception” is made evident in the framework. Their individual knowledge and beliefs about abortion/social positions may capture these beliefs they have which may be derived from the health system and the sub-national social and cultural positions. However, I still think it may be something that could be considered a bit more.

Ernestina Coast
Do you have any links to your work on abortion in Ghana? I’d like to hear more about the women you interviewed who you describe as relying upon abortion (what kind? all traditional eg: herbal methods?) to control their fertility. Were these “unusual” cases in your research?

Participant 3
I didn’t really get to touch on it much in the paper but this is a link to it: [Link omitted to preserve the anonymity of the author]

I gathered this from an interview I had with a doctor, he talked about his patients relying on abortion as birth control, them being insistent on not wanting to use contraception but being quick to resort to abortion when a pregnancy happened. Also, from my interviews there was a group of women who mentioned no interest and no plans to use modern contraception (or family planning, as we tend to refer to it), so I gathered that they may also fall in this group of “abortion as contraception” users. However, it was only a few, about 5 out of the 23, who mentioned this and they used both hospital and traditional methods. Two terminated their
pregnancies at the hospital, one drank blood tonic, one purchased Egometrine from the drug store, and the last inserted cassava stick into her vagina. They didn’t really seem to be an unusual group, they just had an abhorrence of modern contraception.

Alison Norris
I agree with this insight — the (planned) use of abortion as contraception has a different set of norms/access as compared to abortion for unexpected pregnancies. Serbia might be an interesting case to consider how the framework applies in contexts where abortion is less stigmatized than contraception.

Participant 7
Congratulations to the authors on this very comprehensive framework on women’s trajectories towards an abortion. It is wonderful to read all the other participants’ comments and ideas about the framework. I have a few questions/comments:

- I am curious as to why you’re using the chosen visual approach instead of using the more typical “socio-ecological” framework that represents then many layers of influence on an individual’s health and well-being? It seems as though several people have expressed concerns about the linearity of the framework and/or challenges about each box being presented as an equal influence. I don’t have the answer to this but is there a better way in which all of this information could be presented?

- Have you considered ordering the bullets in terms of importance (even if that importance is subjective from the authors’ perspectives)? For example, in the structural and institutional environment box, the government position or religious position might hold a place of more prominence at the top of the list.

- Have you considered having “health of the woman” be its own box? – I’m not clear on how it fits into the “Individual’s & others’ social position & linked-beliefs”. There are so many aspects of woman’s health (and the fetus’) that could come into play during a decision to terminate a pregnancy, e.g., HIV status, being diabetic, exposure to drugs or alcohol during the early gestational period, fears of being too old).

- I don’t think there is anything in the framework about existing children. We know that women often terminate a pregnancy to enable them to take care of the children they already have – perhaps a consideration for inclusion? Perhaps it is encompassed by “reasons for choosing abortion” but might fit in as a standalone bullet under “partner/family/community context.”

- One of my clinical colleagues wondered about where “clinical competence of providers” fits in – is that encompassed in “type of abortion” or “treatment by provider?” (I assume the latter is about interpersonal interactions).

My apologies for throwing out so many things in one post but wanted to get it all out there before the e-conference closes on my coast!

Congrats again on wonderful progress towards a comprehensive framework and for taking this innovative approach to information sharing among colleagues across the globe. I can speak for my colleagues here at Ipas that were already thinking about how to use it in our work!
Ernestina Coast
On the contrary, thanks for “throwing out so many things”! Really thoughtful and helpful.
OK, some initial reactions (and my co-authors are free to contradict / disagree!), starting with
the format of the diagram
– Overall structure of the diagram: because of the level of detail that we wanted to include in
the framework diagram, we used this structure. However, we might now accompany it with a
broader (less detailed) socio-ecological type diagram, and then “explode” out to this greater
detail. I think we might need a graphic designer….

– The implied linearity of what is currently the bottom row is definitely something that we
need to revisit. To some extent there is a time-ordering of events (finding out about the
pregnancy – (non-)disclosure – abortion attempt(s)). However, there is obviously a lot of to-
ing and fro-ing within these broad start and end points, and we need to capture that dynamism
much better

Alison Norris
I particularly like two of your points about women’s situation: health of the woman and
existing children. Thanks!

Ernestina Coast
Re: “health of the woman” as a specific component. This is an important point and not one
that I think the framework captures well at the moment (it does make an appearance in the
paper we are drafting that accompanies the framework, but needs to be in the framework
more explicitly). Thanks for highlighting this.

Ernestina Coast
Thanks to your clinical colleague – agree that competency needs to be explicitly mentioned,
and is separate from “treatment by provider” (as an extreme – someone could be clinically
incompetent but have excellent interpersonal skills – so these need to be dealt with
separately)

Georgina Oduro
Sorry, my comment mistakenly came through though I had not completed. My argument is
that, your framework has alerted me to other useful frameworks in abortion decision making
because I used the Social ecological framework in my own study titled ‘abortion -It is my
own body’. One of the strong themes that emerged and which I find relevant for this platform
is, whose decision it is to terminate a pregnancy? What weight or value is given to the woman
carrying the pregnancy? To what extent does her voice matter in the decision to termina-
unwanted pregnancy. How does this bodily control sit side by side with the legal
requirements in the control, whether there is full legalisation, partial legalisation or no
legalisation. At least, Ghana permits abortion under certain circumstances, but how many
people are aware of these Legal requirements and are able to through safe abortions. For right
decisions to be taken in relation to abortion, there is the need for more Sensitization at the
grassroot level so that people will be familiar with the law and their right to safe abortion
services

Ernestina Coast
Georgina, do you have a link to your work that you can share?
Participant 10

I appreciate the authors’ work in designing this very useful and comprehensive framework. One question I have is whether gender norms/preference could also fit into the individual context level. Broader son preference norms (among other factors) may inform individual abortion decisions but many countries such as China specifically outlaw sex selective practices, despite being having highly liberal (or at times, coercive) abortion laws. In that case, a person may face conflicting pressures (i.e. legal prohibition and familial/community expectations for sons) on abortion decisions. Do the authors think that gender preference could also fit within partner/family/community contexts?