# Safe abortion and social norms

## An annotated bibliography

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## Acknowledgements

## Disclaimer

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# Abbreviations

| | |
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| BCC | Behaviour change communication |
| COPUA | Coalition for Prevention of Unsafe Abortion (Malawi) |
| CSE | Comprehensive sexuality education |
| CUSS | Contraceptive Use Stigma Scale |
| DHS | Demographic and Health Survey |
| FGD | Focus group discussion |
| ICPD | International Conference on Population and Development |
| IDI | In-depth interview |
| ILASS | Individual Level Abortion Stigma Scale |
| LMIC | Low- and middle-income country |
| M&E | Monitoring and evaluation |
| MENA | Middle East and North Africa |
| MVA | Manual vacuum aspiration |
| NGO | Non-government organisation |
| PAC | Post-abortion care |
| SABAS | Stigmatising Attitudes, Beliefs and Actions Scale |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| STI | Sexually transmitted illness |
| UDHR | Universal Declaration of Human Rights |
| UN | United Nations |
| VC | Values clarification |
| VCAT | Values clarification and attitude transformation |
| WHO | World Health Organization |

# Glossary

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| Abortion | Any termination of pregnancy induced using medical or surgical methods, legal or illegal. Spontaneous abortion is referred to as 'miscarriage'. Abortion is 'restricted' when it is legal only in certain circumstances specified by the law. | Bradford (2018) |
| Conscientious objection | The refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs.<br><br>In medical care, health care professionals' refusal to provide certain services because they are contrary to their personal convictions or linked to faith or moral standards. | International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966)<br><br>IMAP (2016) |
| Harm reduction | An approach that seeks to reduce harms associated with an activity without requiring prohibition of the activity itself. It was widely used in HIV/AIDS prevention programmes and has also been adopted within a safe abortion approach. Harm reduction follows three core principles:<br>1. The *neutrality* principle refers to the health-related risks and harms of unsafe abortion, rather than its legal or normative status, by recognising that maternal mortality and morbidity rather than abortion per se are the problems to be solved.<br>2. The *humanistic* principle refers to the entitlement of all women, regardless of their decision-making about pregnancy, to be treated with respect, dignity and worth and to be given appropriate information in acceptable (confidential, stigma-free) settings, even if their activity is deemed illegal.<br>3. The *pragmatic* principle accepts the inevitable reality that women have unsafe abortions for many reasons, and thus emphasises the importance of meeting the needs of women where they are, which may include self-inducing abortion outside the health system. | Bradford (2018)<br><br>Erdman (2012) |
| Manual vacuum aspiration | The recommended surgical technique for abortion with gestational age less than 15 weeks. It involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. | WHO (2012) |
| Medical abortion (misoprostol, mifepristone) | Use of pharmacological drugs (mifepristone and misoprostol) to terminate pregnancy. The recommended method for medical abortion is mifepristone, followed 1–2 days later by misoprostol. | WHO (2012) |
| Menstrual regulation | Uterine evacuation without laboratory or ultrasound confirmation of pregnancy for women who report recent delayed menses. | WHO (2012) |
| Mexico City policy (sometimes referred to as the 'global gag rule') | A foreign aid funding policy that limits what organisations can do with any funding if they wish to also accept United States (US) global health funding. It stipulates that foreign organisations cannot receive US global health assistance if they continue to:<br>provide abortion as a method of family planning;<br>provide counselling and referrals for abortion as a method of family planning;<br>conduct public information campaigns on the availability of abortion advocate for the liberalisation of abortion laws or lobbying for the continued legality of abortion.<br><br>For the wording of the policy, see:<br>www.whitehouse.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/ | Columbia University Mailman School of Public Health www.mailman.columbia.edu/assessing-impact-expanded-mexico-city-policy |

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| Post-abortion care (PAC) | Emergency treatment for complications related to spontaneous or induced abortions, family planning and birth spacing, and provision of family planning methods for the prevention of further mistimed or unplanned pregnancies that may result in repeat induced abortions. PAC includes services such as testinh for sexually transmitted illnesses (STIs), including HIV. It also includes community empowerment activities to increase community awareness and mobilisation on abortion issues. | Postabortion Care Consortium (n.d.)<br><br>USAID and FIGO (2007) |
| Task shifting/ task sharing | Under World Health Organization (WHO) guidelines, task-shifting is used to optimise health care providers' roles and responsibilities by delegating certain tasks, including provision of abortion care, from physicians to nurses and midwives. | WHO (2008) |
| Values clarification and attitude transformation (VCAT) | An approach and toolkit developed by the international organisation Ipas to move participants toward support, acceptance and advocacy for comprehensive abortion care and related SRH care and rights. The VCAT approach recognises that attitudes and beliefs about abortion and related issues can change over time in response to new experiences and a deeper understanding of the issues and context. | Ipas (2014) |

# Introduction

Around the world, abortion is an inevitable occurrence. Globally, an estimated 56.3 million abortions have taken place each year (covering the period 2010 to 2014) (Sedgh et al., 2016). Rates of unsafe abortion have declined significantly since the early 1990s, with progress made in Eastern Europe and Central Asia thanks to improved abortion legislation and increased availability of family planning methods (Singh, 2017). However, unsafe abortion remains prevalent in developing regions, where 93% of countries maintain highly restrictive legislation (ibid.). Also, 42% of women of reproductive age live in the 125 countries where abortion is highly restricted (ibid.). Women aged 20–24 have the highest abortion rate globally, but data on adolescents in developing countries who have had an abortion – especially those who are unmarried or in an informal relationship – is scant (ibid.). The evidence also shows that urban and wealthier women may have better access to safer clandestine abortion services compared to rural, poorer women, and that higher education may also be linked to higher incidence of abortion (Sedgh, 2015; Chae, 2017).

The majority of abortions, including sex-selective abortions, occur because of unwanted pregnancy. As age at first sexual intercourse is declining globally, adolescent girls remain at high risk of unsafe abortion, especially where legal restrictions or policy provisions hinder access to contraception and safe abortion services. In these contexts, women resort to unsafe, illegal abortion methods, which are often fatal or result in complications.

The relationship between pregnancy and access to safe abortion services is influenced by a number of structural and relational factors – including gender and social norms – that regulate female sexuality and pregnancy decisions. Thus, for example, legal and policy environments limit the availability of services and commodities, whereas women may wish to limit family size and delay childbearing (McCleary-Sills et al., 2012). Girls' poor knowledge of how to protect themselves during sex, their inability to negotiate safe sex with partners and, in some cases, experiences of gender-based violence may affect their ability to control their reproductive life and choices (ibid.).

Religious prescriptions also influence the construction of gender roles for women and men as well as sexual behaviour within and outside marital life. One crucial aspect is how social and gender norms position women and girls as pure and immature if unmarried, and wives and mothers when adult. In this context and this web of actors and negotiations, premarital sex and pregnancy are deeply condemned, and abortion represents a deviation from and therefore defiance of these norms. For this reason, it is a highly stigmatised practice.

This annotated bibliography considers a subset of studies on the social and gender norms that influence access to safe abortion, focusing on adolescent girls. It collates academic resources exploring evidence from low- and middle-income countries (LMICs). A detailed search protocol was developed to draw resources from primarily English-language open access literature dating from the past 10 years, with a few exceptions, and from global academic databases and internet search engines.[1] Articles were selected that could provide a general overview of the issues as well as experience from specific countries, covering different regions and legal frameworks, while maintaining a strong focus on social and gender norms. Where possible, and in line with ALIGN's mandate, articles focus specifically on adolescent girls and young

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1 Databases include the following: PubMed, Social Science Research Network (SSRN), Cochrane Database of Systematic Reviews, 3ie – Systematic Reviews, EPPI Centre – Systematic Review, Google Scholar

women, but many include the larger cohort of married and unmarried women of reproductive age (15–49 years).

The bibliography covers the following themes:

- Section 2: conceptualisation of 'abortion stigma' as a manifestation of the social and gender norms that affect access to safe abortion within the environment in which women live;
- Section 3: exploration of social and gender norms and intersectional issues that influence women and adolescent girls' decision-making on abortion;
- Section 4: norms driving abortion stigma, as manifested within the family, in male partners and in the community;
- Section 5: norms driving stigma in service provision (including through 'conscientious objection') and how they affect women's experiences of abortion;
- Section 6: linkages between social and gender norms, gender-based violence, reproductive coercion and abortion decision-making;
- Section 7: impact of initiatives addressing social norms that influence abortion rights, stigma and access to safe abortion, particularly behaviour change communication (BCC), abortion hotlines and values clarification and attitude transformation (VCAT) training;
- Section 8: influence of conservative ideologies and religion on the legal and policy environments for abortion service provision, including how international policy frameworks (e.g.: the Mexico City policy) affect local access to safe abortion.

It is pertinent to provide some context to explain the choice of literature. Historically, much of the literature on safe abortion in LMICs has been framed from a public health and women's rights viewpoint rather than from a social norms perspective. Thus, many studies include safe abortion as part of addressing demand- and supply-side barriers to accessing wider SRH services and rights, including family planning and contraception uptake and post-abortion care (PAC). In this sense, they focus on lack of access to sexual and reproductive health and rights (SRHR) in different (generally restrictive) legal settings, and the consequences in terms of unwanted pregnancies, unsafe abortion, maternal mortality and morbidity. For reasons of space, we include a list of some of these studies in the additional bibliography at the end of this document, as they did not explicitly tackle norms. We also did not include public health approaches to safe abortion – particularly harm reduction and task sharing/task shifting – as none of the studies reviewed analysed them from a social norms and gender perspective.

Thus, as the focus of this annotated bibliography is on social and gender norms, we start with an exploration of the literature on stigma, defined as 'a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood' (Kumar et al., 2009: 628). The concepts of abortion stigma, as well as 'disgust' (Kumar, 2018), are particularly important, as they help us situate abortion within contextualised understandings of – and as deviation from – notions of femininity and motherhood. For this reason, the literature reviewed deals with issues such as individual guilt and shame, and the reasons why abortion evokes feelings of physical and moral 'disgust' among its detractors. It also explores women's experiences of stigmatisation within their family and community and by service providers, including 'conscientious objectors'. The literature includes tools such as stigma scales, safe abortion indicators and guidance notes on appropriate, youth-friendly terminology on abortion (see annexes).

We also aimed to understand how the effects of social norms on access to safe abortion varies in different legal and religious environments, to show how social and gender norms are framed across these different settings. We reflect on intersectional issues, or how dimensions of age, marital status, HIV status and even urban–rural location can affect access to safe abortion services.

The bibliography deals briefly with sex-selective abortion and the hotly contested

debates that surround it, as both an expression of women's agency and a gender-discriminatory practice, linked to social norms, practices and traditions that grant lower social status to women. It was also important to consider linkages between gender, social norms and gender-based violence (especially intimate partner violence) and vulnerability to repeat abortion – albeit the literature on such linkages proved scant. Here, articles reveal how women in abusive relationships may suffer reproductive coercion, defined as 'male partners controlling behaviour on contraception and pregnancy decision making' (Miller and Silverman, 2010). In these situations, women may lack the ability to decide when to have sex with their partner and use a contraceptive method, may risk repeat unwanted pregnancies, and may struggle to have – or alternatively be forced to undergo – an abortion.

Finally, the bibliography looks at the impact of initiatives to address norms around safe abortion. The literature from this perspective is scant, apart from a few examples on radical feminist abortion hotlines, VCAT training to tackle stigma, and research to inform a behaviour change communication initiative.

The review identified several gaps in the literature on safe abortion. First, the abortion literature has not been explicitly framed from a gender and social norm perspective, although stigma approaches point in that direction. Second, most of the literature focuses on single-country case studies, generally from the same countries in sub-Saharan Africa, Latin America and, to a lesser extent, South Asia; there are very few from the Middle East and North Africa (MENA) or Southeast Asia region. There is also a literature gap on abortion provision in humanitarian/conflict settings, especially for adolescent girls, mirroring a lack of this type of programming in such contexts. Overall, there are few rigorous evaluations of abortion programming that targets adolescent girls, with the exception of a few studies led by Ipas on VCAT and exploring the development of stigma measurement scales. These latter can be important tools for monitoring and evaluation (M&E) specialists as they aim to measure stigma – an important proxy for social and gender norm change.

# Stigma as a proxy for social and gender norms on abortion

## Summary

The literature on stigma in health care has been instrumental for understanding abortion stigma, which, in turn, provides an opportunity to understand social and gender norms that hinder access to abortion services. The articles in this section review the conceptualisation of stigma in abortion care and how to measure it. Thus, the seminal article by Kumar et al. (2009) provides an operational definition of abortion stigma and how it manifests itself in individual women, in society, in the wider community and the media, and in the legal and policy environment that regulates access to abortion. The White Paper by Cockrill et al. (2013) provides a comprehensive review of the literature on abortion stigma and measurement, and reviews abortion stigma interventions and evaluations. It also provides recommendations for increasing and expanding programmes to address abortion stigma at individual, community, institutional, legal, and policy and media levels.

This section also includes a very recent article on disgust and abortion stigma (Kumar, 2018). This is a new approach encouraging pro-choice advocates to engage with a very contentious moral notion that is used by anti-abortion advocates and is critically affecting the legal and policy environment for safe abortion services.

1. **Kumar, A., Hessini, L. and Mitchell, E.M.H. (2009) 'Conceptualising abortion stigma'** *Culture, Health & Sexuality* **11(6): 625–639.**
   Available at: www.tandfonline.com/doi/full/10.1080/13691050902842741?scroll=top&needAccess=true

This seminal article from Ipas develops, for the first time, an operational definition of abortion stigma and outlines some of the ways in which it is perpetuated and normalised. The authors define abortion stigma as 'a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood' (p 628). Thus, a woman having an abortion transgresses feminine traits believed to be the 'essential nature' of women: female sexuality exclusively for procreation, the inevitability of motherhood and instinctual nurturing. Women who seek an abortion defy prescribed notions of subordination to community needs and challenge the 'moral order' whereby women show moral capacity to make a life or death judgement. The authors also stress that abortion stigma is fuelled and perpetuated by unequal power dynamics, access to resources and 'systemic control of women's sexuality'. Women's sexuality and sexual activity are central to abortion stigma, as they represent transgressions of accepted localised norms about women's ability to exercise sexual choice.

The authors apply Link and Phelan's (2001) conceptualisation of stigma to the abortion issue. Link and Phelan posited that stigma is produced and reproduced through four steps: distinguishing and labelling human differences; identifying negative stereotypes attached to those labelled differences; placing labelled persons in separate categories that determine alterity; and status loss and discrimination experienced by labelled persons (p 626). Kumar et al. then show how under-reporting of abortion

– for fear of repercussion and social rejection – leads to an over-simplification of the profoundly individual, and often complex, reasons why women choose an abortion. This leads to the creation of the negative 'women who abort' category or stereotype, as different from the 'normal woman', who respects socially defined notions of femininity and motherhood. Fear of social exclusion prevents women and others from supporting those who do opt for an abortion, perpetuating such negative stereotypes, which in turn leads to overt discrimination across a range of settings: in medical care, at home from partners or other family members, from society and the community as a whole.

The authors then delve into an in-depth analysis of where abortion stigma discourse is created and localised and the effects this discourse has on women. Stigma is present in mass media and discourse-framing through the use of words and images that discredit the abortion experience and 'women who abort'. Stigma is also present in laws and government structures that shape societies (from national restrictive laws to the global gag rule, which affects women and organisations everywhere) as well as in organisations and institutions through their policies and architecture (e.g. separation of abortion from other women's health care services, lack of training for abortion providers, etc.). Finally, community and individual stigma factors are associated with discrimination, fear of reprisals and even death, shame and guilt, and the need for secrecy, as internalised notions of abortion stigma. These are the factors at the heart of social norms that define women who have abortions as 'deviant' and 'non-normative', limiting their agency to decide. That lack of decision-making power often leads to a lack of medical care, mental health issues, and at times even death and injury for women globally.

The authors conclude by advocating for a three-pronged approach to understanding and addressing stigma: (1) developing a research agenda that understands how stigma (as linked to other forms of discrimination and structural injustices) can be measured empirically, especially how it manifests itself at community level, in relation to the law and to public discourse formation; (2) promoting multi-country programming that addresses stigma; and (3) evaluating such programmes to learn lessons that advance abortion care.

## 2. Kumar, A. (2018) 'Disgust, stigma, and the politics of abortion' *Feminism & Psychology* 28(4): 530–538.
Available at: http://journals.sagepub.com/doi/pdf/10.1177/0959353518765572

This study, also by Kumar, argues that pro-choice activists should move beyond articulating abortion solely as the right of a woman to choose what to do about an unwanted pregnancy, to fully engage with the notions and feelings of 'disgust' and associated stigma that abortion raises. Her analysis stems from a review of the literature on disgust and draws from examples in the debate in the United States (US) around abortion. It shows how disgust manifests itself at three levels: in anti-abortion advocacy; in the abortion procedure itself; and in the stigma associated with abortion. Ultimately, Kumar argues, analysing and engaging with disgust at these levels would provide pro-choice advocates with stronger arguments to counter the way that anti-abortion advocates use the notion of disgust in the legal, political and social spheres to describe the procedure and the women who have an abortion.

The article starts with a brief review of the literature on disgust across different disciplines and as a predictor of conservative views on sex, sexuality and abortion. While there is no empirical research that connects disgust to abortion or abortion stigma, this literature helps to make those connections. Disgust operates at three levels: (1) a 'core' level, linked to reaction

to rotten food as an evolutionary protection mechanism; (2) an 'animal reaction' level, linked to reaction towards inappropriate body processes or actions (such as sex, death, bodily fluids, etc.) that link humans to animals; and (3) 'socio-moral disgust' as a reaction against taboos that break the social and moral order, such as in the case of homosexuality or abortion (p 2). Thus, abortion may provoke disgust because it is associated with blood and the impurity of menstruation (which in many cultures associates women with animals), because of the association of the procedure itself with death and blood (and, for surgical abortion, with penetration), and because it is ultimately linked to non-procreational sex and challenges socio-moral notions of femininity and motherhood.

Disgust towards abortion evokes a connection between a moral and a physical stain, and the judgement associated with the act is an expression of moral policing (Nussbaum, 2010, cited in Kumar, 2018: 532). The author uses examples from the US to describe how disgust has entered the language of the abortion debate in order to influence public opinion. For example, anti-abortion activists are now concentrating their efforts on introducing legislation that symbolically links abortion with harm and foetal pain (thus aiming to prevent abortion before 20 weeks' gestation), showing graphic images of foetal parts, focusing on sex selection and ultrasound, or fighting against abortion self-medication as a 'do-it-yourself' procedure.

The author then introduces her most contentious argument: by framing abortion as the right of the woman to take her own decision about an unwanted pregnancy – and by excluding from the conversation any discussion of pregnancy, what happens to the embryo/foetus, and of life and death or loss – abortion rights activists have given moral ground to anti-choice activists to depict women as 'aggressors' and the embryo/foetus as the 'victim' (p 534). As discussions of life and death are increasingly becoming relevant and complex in the medical world, largely due to a rapidly ageing population, Kumar suggests that pro-choice activists need to consider engaging in discussions about death or loss and the embryo/foetus. Doing so would allow the abortion conversation to shift from a dichotomy of victim/aggressor or murderer, to a fuller, demystified conversation about the abortion procedure as well as women's and providers' feelings, which might include sadness and loss but also relief, powerfulness and optimism. Kumar (p 534) stresses that this would mean that 'we could finally, unequivocally, state that women are fully autonomous humans with the moral ability to make life and death decisions'. She asks whether disgust and fear (of disruption of the social order) are what abortion stigmatisers feel, just as guilt and shame are often the feelings of those who are stigmatised. Thus, she concludes, understanding the empirical relationship between disgust, stigma and abortion, and mapping the ways in which emotions linked to abortion and stigma are produced and reproduced, is crucial for abortion advocates to understand and counter the harmful language of abortion stigma.

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3. **Cockrill, K., Herold, S., Blanchard, K., Grossman, D., Upadhyay, U. and Baum, S. (2013)** *Addressing abortion stigma through service delivery: a white paper.*
   Available at: https://ibisreproductivehealth.org/publications/addressing-abortion-stig-ma-through-service-delivery-white-paper

This extensive white paper aims to support organisations to develop programmes to address abortion stigma through service delivery interventions. It is based on a systematic review and meta-analyses of interventions and strategies used in a variety of settings across different stigma areas (drug use, HIV/AIDS, mental illness, and sexual prejudice against minority sexual orientation), as well as on 12

interviews with abortion service providers from five organisations.

The study starts with a brief exploration of the literature on stigma and prejudice from social psychology and sociology, and then delves into the description of the socio-ecological model of abortion stigma as conceptualised by Kumar et al. (2009). It also details the dimensions of individual-level stigma and stigma management as conceptualised by Herek (2009). The dimensions include 'internalised' (negative feelings such as blame and guilt), 'felt or perceived' (perceptions of stigmatising attitudes from others), and 'enacted stigma' or 'actual discriminatory behaviours or negative interactions related to the abortion experience' (p 7). Women then need to adopt specific behaviours to manage that stigma within each dimension – for example, by hiding the pregnancy to 'pass as normal' during personal interactions and manage their reputation (ibid.)

Just as women can be affected by stigma, so can service providers, whose work can be defined as 'dirty', thus associated with physical dirtiness, social dirtiness (interaction with stigmatised individuals) or moral dirtiness (having to do with sin, duplicity or deception) (p 8). For the same reasons, providers may feel or enact stigma, and need to manage it by (for example) reframing the meaning of their work into a more positive light. The study uses qualitative interviews with providers to further explore the feelings of loneliness, preoccupation with their reputation, and condemnation from the community and the media, which they constantly experience.

To tackle stigma, it must first be measured. Thus, the authors detail a number of stigma scales used in health sector research (for example, on HIV, obesity or sexual orientation) and in media and target audience research. They mention two abortion-related stigma scales: the Individual Level Abortion Stigma Scale (ILASS) and the Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) (Shellenberg et al., 2014) (see annexe). It then discusses six types of interventions to tackle abortion stigma as they emerged from the literature and interviews with providers. These include: (1) training and workshops (e.g. VCAT, service provider training); (2) coalition-building (e.g. provider support networks or coalitions to instigate legal and policy reform); (3) service provision (e.g. to increase access to the drug misoprostol, to economic support for women and to safe legal abortion); (4) accompaniment for women seeking to terminate a pregnancy; (5) dialogue (e.g. peer-to-peer, testimonies, social media campaigns); and (6) education (e.g. peer education, online medical information, campaigns).

The authors conclude with recommendations for organisations aiming to work on the under-researched area of abortion stigma. They should incorporate abortion stigma in their goals, ensure there is an organisational definition of stigma, and identify specific objectives to tackle it. They need to clearly define their target group to make it easier to measure and evaluate changing attitudes, beliefs, and behaviours among that group. They also need to define the contextualised manifestations and dimensions of stigma they seek to change, ensuring that interventions derive from local knowledge and practice. They should strengthen their M&E tools to measure change and the success of interventions, and join coalitions and groups to share experiences and successful strategies.

# Intersectionality, social norms, and girls' and women's decision-making on abortion

## Summary

The literature included in this section discusses how a range of issues intersect with social and gender norms affect women's and girls' ability to exercise abortion decision-making and the trajectories they take to seek abortion. The articles show how individual choices are often driven by a plethora of factors, including poverty and economic dependency on men, lack of knowledge about and access to family planning services, and poor service availability, alongside gendered social norms that limit women's ability (especially young and unmarried women) to exercise body control and autonomy in relation to sex, contraceptive use and family formation.

As all articles in this section reveal, abortion is a deeply contested, highly stigmatised practice, because it is deemed to fundamentally contradict and refute localised, socially acceptable gendered notions of femininity, motherhood and reproduction. Such views are perpetuated by strong religious and moral arguments, often reinforced by families, service providers and policy-makers – and sometimes by women who have had an abortion, who often stigmatise others (Cardenas et al., 2018). However, for some women, abortion can also mean a way to regain control of their lives (Cleeve et al., 2017; Cárdenas et al., 2018; Hohmann et al., 2014). In this complex, dynamic web of power and familial and social relationships, Coast et al. (2018) provide a framework for understanding women's decision-making processes and trajectories to seek an abortion as affected by changing circumstances and experiences in a woman's life.

Despite some commonality across women's experiences in LMICs, this section highlights how those experiences may be determined by factors such as age, marital status, HIV status, and rural–urban location. For example, some studies (Cleeve et al., 2017; Frederico et al., 2018; Andersen et al., 2015) highlight how young, unmarried adolescent girls, especially from rural areas (Jejeebhoy et al., 2010), are particularly at risk of unsafe abortion as families, communities and service providers strongly stigmatise premarital sexual activity and pregnancy, rendering access to safe abortion services particularly difficult for this age cohort. Moreover, children and adolescents are historically construed as innocent, pure, vulnerable and at risk of violence. Thus, families, communities and service providers, as well as international agencies working on SRH, often fail to recognise, accept and address adolescents' evolving capacities and their ability to understand and exercise choice, including on safe abortion (Clyde et al., 2013). Orner et al. (2011) explored the stigma facing HIV-positive South African women seeking an abortion, and provided recommendations on how to strengthen and integrate health service provision for this particularly vulnerable cohort.

Two articles in this section also deal with female sex-selective abortion – a particularly contested and debated issue among feminists, who portray it as either a symbol of women's agency over their own bodies or as gender discrimination against the female foetus. Against this backdrop, Eklund and Purewal (2017), for example, describe state-led, criminalising bio-politics of population control in China and India. Ultimately, sex selection in both countries was based on patriarchal notions of son preference, but Eklund and Purewal explain that neither India nor China

dealt with these underlying issues when attempting to reverse skewed sex ratios.

Hohmann et al. (2014), on the other hand, argue that sex-selective abortion in three countries in the South Caucasus between the 1990s and the early 2000s may have been the result of economic choices, rather than discriminatory cultural and patriarchal notions, as sex ratios reversed in parallel with economic development. Thus, families, and women especially, considered the higher economic benefits of having male offspring for work and defence, at a time when the region was emerging from Communism, men were migrating abroad, and conflict was rife.

## 4. Coast, E., Norris, A., Moore, A. and Freeman, E. (2018) 'Trajectories of women's abortion-related care: a conceptual framework' *Social Science & Medicine* 200: 199–210.

Available at: https://reader.elsevier.com/reader/sd/pii/S0277953618300352?token=E-18676B676826A72A94E6D2CBF4996EBF3E0E022ECDB1B2FADF6A4FDD8200CF01941D-318446E3DB2721377D984086717

This study proposes a conceptual framework for understanding the complexity and non-linear trajectories taken by women (including adolescent girls), adults and transgender men[2] to seek abortion-related care. It looks at safe and unsafe abortion and post-abortion care trajectories. Trajectories, in time and space, are understood as 'the processes and transitions occurring over time for a pregnancy that ends in abortion'. The framework is grounded in an understanding that abortion-seeking behaviour is a dynamic process, affected by changing circumstances and experiences in a woman's life, including in three distinct domains (p 201):

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

The author provides a very detailed analysis for each domain of influence, giving examples that describe the multiple events women may experience in obtaining an abortion. For each domain, alongside recognition of the women's specific socioeconomic circumstances and the family and community networks they live in, the role and influence of gendered social norms in the abortion trajectory emerges. In the domain 'abortion experience', these include (for example): fear around disclosure of the abortion; ability to exercise agency linked to social risks of the pregnancy, stigma and negotiation with others (relatives, partners, etc.); and the quality of pre-abortion counselling. In the 'individual context' domain, these include: a woman's knowledge and beliefs about abortion (which may change over time); her socioeconomic position at the time of the pregnancy; and degree of self-efficacy, autonomy and power. In the '(inter)national and sub-national context' domain, these include: structural and institutional environments such as the legality (or illegality) of abortion; punishment of those who violate laws; accessibility of safe abortion; and normative constructs of abortion and fertility. The authors conclude by stating that this framework can be useful to analyse the factors that influence women's trajectories to abortion care and their consequences.

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2    This refers to people who were born female, now identify as male, but may still have female reproductive organs and thus can get pregnant.

5. **Cárdenas, R., Labandera, A., Baum, S., Chiribao, F., Leus, I., Avondet, S. and Friedman, J. (2018) '"It's something that marks you": abortion stigma after decriminalization in Uruguay'** *Reproductive Health* **15: 150.**
Available at: https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-018-0597-1

The Latin American region has the highest percentage of unsafe abortions in the world, despite many countries having partially decriminalised the procedure. This is because, notwithstanding legal improvements, abortion remains highly stigmatised. Evidence shows that where abortion is legal, the risks of unsafe abortion and the stigma suffered by women are reduced. In Uruguay, abortion up to 12 weeks' gestation was decriminalised in 2012. Thus, this study explores the extent to which legal changes have affected the opinions and attitudes of abortion clients and health professionals approximately two years after decriminalisation, to assess if and how stigma still manifests within institutions that provide abortion services. This paper is based on analysis of 10 interviews with abortion clients aged 22–38 years at a major hospital in Montevideo, and 10 health professionals (doctors, midwives, social workers and a psychiatrist).

Results show that women did not regret having an abortion; they agreed with the new legal provisions and saw abortion as their right, but would not want to have to experience it again, as they expressed feeling of sadness, loneliness and depression. They also harshly judged other women who have repeat abortions, describing them as selfish and immature. Women felt shame and guilt when visiting the facilities but felt well-treated by the providers.

Providers supported women's right to choose, did not have specific moral positioning towards the procedure (perceiving it as a regular SRH service), and felt that repeat abortions were more a result of the failure to provide contraceptives and moral taboos about sexuality than individual women's fault. Some providers expressed a preference for medical over surgical abortion, because it permits them to detach themselves from the actual procedure. Providers and clients alike felt that the five-day reflection period following pre-abortion counselling (introduced with the new law) was unnecessary, as it introduced stress and doubts after a decision had already been taken. Finally, providers and clients expressed the urgent need to sensitise non-clinicians and administrative staff, as they may act as gatekeepers who can actively obstruct women from obtaining abortion services. The same was expressed for potential conscientious objectors.

The authors suggest that Uruguay is somewhat unusual in Latin America: providers are strongly pro-choice; the Catholic church does not influence SRH issues; and decriminalisation follows on from a period of experimentation with a harm-reduction model. However, they conclude, abortion stigma persists – both for women seeking an abortion and health professionals providing the service. This is manifested in the introduction of the five-day reflection period, which implicitly signifies distrust in women's ability to decide and ascribes some level of superficiality to their actions. Also, providers' preference for medical abortion speaks to the notion that surgical abortion is 'dirty work' (see article by Cockrill et al.: 2013 in section 2) and to their desire to disassociate from the procedure. Finally, non-clinical gatekeepers may reproduce stigma and treat abortion clients differently from others who seek other services, so may require training and sensitisation.

## 6. Cleeve, A., Faxelid, E., Nalwadda, G. and Klingberg-Allvin, M. (2017) 'Abortion as agentive action: reproductive agency among young women seeking post-abortion care in Uganda' *Culture, Health & Sexuality* 19(11): 1286–1300.

Available at: www.tandfonline.com/doi/pdf/10.1080/13691058.2017.1310297?needAccess=true

In Uganda, abortion is legally permitted to save the life and health of the pregnant woman; however, the decision to have an abortion is highly stigmatised. Lack of harmonisation of the Penal Code with the Constitution and the Reproductive Health Policy often leads to ambiguity in the interpretation of the law. Numerous factors – including high fertility rates, barriers to and misconceptions around contraceptive uptake, gender and social norms around female sexuality, and health care barriers – combine to make women (and especially adolescent girls) particularly at risk of unsafe abortions. Against this backdrop, the authors explore young Ugandan women's experiences and decision-making pathways to seeking an (often unsafe) abortion. The study is purely qualitative, comprising semi-structured interviews with 17 women aged 15–24 years, who were thought to have had an induced, unsafe abortion and were admitted to Kampala's Mulago Hospital emergency gynaecology ward, in which post-abortion care is provided.

The authors situate Ugandan young women's choice and reproductive agency within contextual meanings of 'femininity' linked to fertility, motherhood and timing of pregnancies, whereby abortion challenges the very notion of 'real womanhood', as well as women's role as child-bearers and men's influence on women's reproductive choices. The authors identify interrelated areas in which gender and social norms, power imbalances (in relation to male partners), family expectations and secrecy influence women's pathways to choose induced abortion. Women's economic dependency limits their ability to negotiate safe sex and contraceptive use with male partners, and to protect themselves from gender-based violence. Community shame and negative social sanctions, parental rejection, disagreement around family size and male partners' neglect of their children influence women's choices around safe abortion. Social sanctioning and providers' stigma push women to have an abortion in secret, at high cost to their mental and physical health. Yet while still describing abortion as an immoral and unwanted act, the women interviewed deemed it inevitable in order to avoid social exclusion and regain control over their education or work aspirations. To avoid being in the same situation in future, they expressed a desire (and believed it was their right) to use contraception, regardless of their partner's wishes.

The authors conclude that women's narratives reveal how abortion was a 'non-choice' as it was their only perceived choice, negotiated within and influenced by powerful gender norms and relational dynamics. Women have to navigate a complex web of power structures – including economic support, notions of family and femininity, social acceptance and stigma, and negotiating the costs of secrecy of pregnancy and abortion – to exert agency. However, the authors argue, this non-choice also granted women 'agentive power', enabling them to regain some form of control over their bodies and their futures. The authors maintain that abortion should be seen as a form of female empowerment and thus crucial for female emancipation in Uganda. They also call for changes in the discourse around social norms and stigma, and increased access to SRH care and the preventive component of post-abortion care through contraceptive counselling.

**7.** **Frederico, M., Michielsen, K., Arnaldo, C. and Decat, P. (2018) 'Factors influencing abortion decision-making processes among young women'** *International Journal of Environmental Research and Public Health* 15: 329.
Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5858398/pdf/ijerph-15-00329.pdf

Despite a very progressive abortion law instituted in Mozambique in the 1980s and further expanded in 2014, unsafe abortion remains one of the main causes of maternal death. Data from the 2011 Demographic and Health Survey (DHS) and the Mozambican Association for Family Development (AMODEFA) clinics' surveys show high demand for (safe) abortion among young women aged 15–24 years. This exploratory study uncovers the individual, interpersonal and environmental factors behind the abortion decision-making process among 14 young Mozambican women aged 17–25, from suburban slum areas in Maputo (the capital) and Quelimane.

Analysis of women's individual stories show that young women lack power, agency and economic independence to decide whether to terminate a pregnancy, with the decision ultimately made by family members or male partners. Women also generally lack knowledge about legal provision of abortion, their sexual rights, and where they can access relevant services. Overall, poor availability of local abortion services at tertiary facilities means that abortion is, in practice, only available for those who are wealthy and educated. Finally, providers often decide which procedure to use without consulting the woman and at times do not refer them to the appropriate health facility.

The authors stress that these factors are linked with gender inequalities and power dynamics between young women and adults (for example, parents and providers or even male adult partners), and that young women's lack of knowledge puts them at risk of obtaining unsafe abortions. The authors conclude by suggesting measures to address these barriers: (1) increase women's autonomy in decision-making; (2) improve information about legal provisions on abortion; (3) increase the number of health facilities in remote areas; and (4) improve providers' communication skills in client-centred service provision.

**8.** **Clyde, J., Bain, J., Castagnaro, K., Rueda, M., Tatum, C. and Watson, K. (2013) 'Evolving capacity and decision-making in practice: adolescents' access to legal abortion services in Mexico City'** *Reproductive Health Matters* 21(41): 167–175.
Available at: www.sciencedirect.com/science/article/pii/S0968808013417081

This article highlights an important aspect that has historically been poorly addressed in development policy and practice: recognising children's and adolescents' evolving capacities and their ability to make independent choices around sexuality. Often, adolescence and sexuality issues in LMICs have been framed within a discourse of violence, exploitation and abuse, or through a public health lens, focusing on demand/supply gaps. Children and adolescents have also been historically and socially construed as non-sexual innocent beings, with girls especially portrayed as vulnerable and lacking knowledge (and services) to protect themselves from unwanted sex or pregnancy (Pincock, 2018). However, understanding and being able to take decisions about their own sexuality is crucial for adolescents' development. For example, age-appropriate comprehensive sexuality education (CSE) is centred on recognising adolescents' sexuality needs, reducing misinformation, and supporting adolescents' decision-making and negotiation around sex and contraception (Santhya and Jejeebhoy, 2015; Cornwall et al., 2008).

This article looks at whether service providers understand and recognise the capacity of adolescents in Mexico to take decisions about abortion. It starts with an overview of how international policy on children and adolescents has progressively recognised young people's 'evolving capacities' and ability to make decisions that concern their lives. This includes young people's ability to decide on aspects of their SRH (including safe abortion) when offered proper support and information with privacy and confidentiality and without mandatory parental notification or involvement – a strong deterrent for adolescent girls.

The article describes Mexico's process of legalising abortion (in 2007) without restriction up to 12 weeks' gestation. The legal and policy framework also introduced a series of (at times contrasting) policy requirements for adult accompaniment of minors seeking abortion at both private and public health care providers. Given this context, the study looked at whether, by 2009, service providers' regulations and clinician attitudes and practice were supporting or hindering access to information on abortion among adolescent girls aged 12–17. The study involved several research methods: focus group discussions (FGDs) with 23 adolescents with unwanted pregnancies; 38 'mystery' client visits to private clinics and those managed by non-

government organisations (NGOs); a quantitative survey with 47 senior managers and staff at NGO and public sector clinics providing abortion services; and a quantitative survey with 61 adolescents (aged 13–17 years) leaving public hospitals after seeking information for, or having had, an abortion.

Findings show that overall, service providers (clinic staff and managers) recognised adolescents' evolving capacities and abilities to understand and decide about abortion, and supported counselling provision to meet adolescents' needs. They also believed that older adolescents had greater decision-making capacity than younger ones. Mystery client visits demonstrated that often, adolescents who were accompanied by adults received more complete and accurate 'basic' information (e.g. on access, methods and costs) than those that attended alone. For accompanied minors, no option to talk alone was offered. Several exit interviews showed that adolescents received good information, but clear breaches of privacy took place. The study concludes that, while there are good signs of progress two years after the introduction of the new law, providers need to offer quality information while at the same time supporting adolescents' autonomy and protection. It offers a series of practical recommendations on how to improve services.

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9.  Jejeebhoy, S., Kalyanwala, S., Francis Zavier, A.J., Kumar, R. and Jha, N. (2010) 'Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages' *Reproductive Health Matters* 18(35): 163–174.
    Available at: www.sciencedirect.com/science/article/pii/S0968808010355042#

Despite abortion being legally available in India, unsafe abortion remains a significant driver of maternal mortality and most abortions take place in uncertified settings. Age and marital status are important determinants in accessing safe abortion services; due to prevailing gendered social norms, young, unmarried pregnant adolescents are often stigmatised for having had premarital sex and seeking an abortion. Studies

show that this group are, in fact, more at risk of delaying abortion-seeking or using unqualified providers than their married counterparts, but data on their experiences is scant. The authors aim to fill this gap through a quantitative survey of 795 young women aged 15–24 years (549 unmarried and 246 married) and in-depth interviews (IDIs) with 26 randomly selected unmarried respondents.

Findings confirm that due to marital status, lack of SRH knowledge (and thus late realisation of the pregnancy) and lack of accompaniment and support from male partners, unmarried young women had more second trimester abortions than their married counterparts. All these factors were exacerbated if girls came from a rural location. For unmarried girls, choice of facility was driven by fear of disclosure and the need for confidentiality, rather than safety considerations. The authors highlight that 'the fact that married young women had comparatively few second trimester abortions highlights that it was being unmarried, not being young, that inhibited access to timely abortion' (p 172). Thus, they conclude, it is important to strengthen adolescent girls' access to SRH knowledge and information on contraceptives, as well as to sensitise young male partners on their roles and responsibilities so that both can protect themselves from (or support each other in case of) unwanted pregnancies.

## 10. Andersen, K.L., Chandra Khanal, R., Teixeira, A., Neupane, S., Sharma, S., Acre, V. and Gallo, M.F. (2015) 'Marital status and abortion among young women in Rupandehi, Nepal' BMC Women's Health 15: 17

Available at: https://bmcwomenshealth.biomedcentral.com/track/pdf/10.1186/s12905-015-0175-4

In Nepal, since liberal abortion legislation was enacted in 2002, the government has sought to implement comprehensive abortion care services across the country. However, unsafe abortion remains a key driver of maternal mortality. Barriers to safe abortion include: lack of knowledge of available services; stigma and fear of repercussions; lack of access to CSE; poor service provision; and costs associated with obtaining an abortion. These factors are compounded by age and marital status. For example, young Nepalese women report high unmet need for contraceptives, receive second trimester abortion, or delay seeking help in case of complications – all of which may be attributable to stigma around adolescent sexuality. On the contrary, married women may be pressured by families into repeat, unsafe and illegal abortions in case of sex selection linked to son preference.

This study aims to fill a gap in research on the gender and social norm drivers of premarital sexual activity and the links between marital status and abortion in Nepal. It is based on a cross-sectional survey using a probability-based household sample of 600 women aged 16–24 years in Rupandehi district – an accessible but diverse area (in terms of religion, ethnicity and caste). About 54% of participants were never married, while the remainder were either currently married (45%) or separated, divorced or widowed (1%).

Findings show that surveyed women had good access to SRH information, with 88% able to identify one abortion method (medical abortion). Overall, women had little knowledge of abortion legislation and while they denied having had romantic relationships outside of marriage (potentially due to social desirability bias), they mentioned that this was common among their friends.

Marital status determined sources of information on SRH and contraception: friends and the media were an important source of information for unmarried women, whereas married women obtained information from a female community health volunteer, health care provider or their husband. Overall, all women were embarrassed to talk about sex, sexuality and human anatomy. Unmarried women were more supportive of abortion, more likely to talk about it with a friend or to support a friend who needed an abortion than married women. Both married and unmarried women reported that abortion among unmarried women is socially unacceptable and difficult to obtain.

Given the early age at first childbearing among young women in Nepal, the study highlights the importance of providing accurate SRH information, including on safe abortion, to all young women regardless of their marital status.

### 11. Orner, P., de Bruyn, M. and 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' *Culture, Health & Sexuality* 13(7): 781–795

Available at: www.researchgate.net/publication/51204437_%27It_hurts_but_I_don%27t_have_a_choice_I%27m_not_working_and_I%27m_sick%27_Decisions_and_experiences_regarding_abortion_of_women_living_with_HIV_in_Cape_Town_South_Africa

In 2010, an estimated 5.6 million South Africans were living with HIV. Most were women in their early reproductive years (with a peak of 33% of women aged 25–29 years, compared to a peak of 25.8% of men aged 30–34 years). Gender and social norms affect the reproductive choices, behaviour and childbearing wishes of women living with HIV. Unplanned or unwanted pregnancies and abortion – even under South Africa's relatively liberal abortion law – remain major issues for women living with HIV. This study explores the experiences of 36 married/cohabiting and unmarried HIV-positive women (aged 20–49 years) in three public health sector facilities in Cape Town.

Results show that a complex web of factors hinder or facilitate decision-making about pregnancy and access to safe abortion in public hospitals, and that these are profoundly influenced by social norms and stigma against pregnant HIV-positive women. Pregnancy often resulted from contraceptive failure, male refusal to wear a condom, or limited contraceptive choice and availability. Overall, communities view HIV-positive pregnant women as a problem because, due to their health status, people mistakenly believe such women will experience complications during pregnancy and that the child will automatically be HIV-positive too. Women's disclosure of their pregnancy status to family and friends was deemed difficult. Again, because of their HIV-positive status, women anticipated feelings of disappointment from their families but also disapproval, refusal of support from partners or being reprimanded by partners if they chose to have an abortion.

Among women who were able to access abortion, there were mixed experiences: due to expectations of substandard services, women were positively impressed by the professional attitude of providers and the fact that they were not shouted or sworn at. However, some reported experiencing more judgemental attitudes from clerks when registering for the abortion, while others were turned away by providers who falsely invoked that the law prohibited a repeat abortion or because of a high number of patients on the day.

Overall, the authors conclude, the experience of seeking abortion in South Africa can be more stigmatising than being HIV-positive. Normative views of abortion associate women with images of sin, disgrace and murder, and this was reflected in the ways in which some gatekeepers treated women seeking abortion services. For policies to be more supportive of HIV-positive women needing an abortion, more research is needed to uncover their experiences with health services, alongside improved access to information on the provisions of South African law.

## 12. Eklund, L. and Purewal, N. (2017) 'The bio-politics of population control and sex-selective abortion in China and India' *Feminism & Psychology* 27(1): 34–55

Available at: http://journals.sagepub.com/doi/pdf/10.1177/0959353516682262

Drawing on secondary sources and census data, this article explores how China and India are attempting to reverse historical high sex ratio imbalances towards males. In both countries, reproductive behaviour is grounded in deep cultural roots that discriminate against women. The respective governments have recognised the risks of this imbalance to their economic development, peace and stability, and have adopted policies to support the birth of girl children and (eventually) to criminalise sex selection. The authors argue that the approach adopted in both countries has followed similar lines and has adopted punitive rather than gender transformative effects. The article also engages with the hotly contested and polarised feminist debate that views sex-selective abortion as either gender discrimination against the girl child or the reproductive right of women to body autonomy.

The authors start with an in-depth theoretical discussion of what they call 'disciplining sex-selective abortion' practices (p 37), which criminalise women who seek female sex-selective abortion without challenging the underlying cultural male bias that leads to son preference. They then give a very detailed account of the policies adopted by India and China to combat sex-selective abortion and the outcomes they achieved. In both countries, skewed sex ratios were due to a combination of cultural factors (such as the one-child policy in China), which were incentivised through wider state-led population control policies. As both countries grappled with the potential economic and social risks of skewed sex ratios, they introduced policies to reverse the situation, including a ban on prenatal diagnosis but also public campaigns to promote the value of the girl-child. As results lagged, both countries also adopted a criminalising approach, which punished women who practised illegal sex-selective abortion and encouraged the public to report or stigmatise them and their families.

The authors argue that none of these approaches addressed the profoundly patriarchal underpinnings of sex-selective abortion – son preference – in which daughters are regarded as diminishing women's status in the family and society, and detrimental to family-building relations. Nor have they dealt with the psychological consequences of sex-selective abortion: the intimate partner violence associated with the birth of an unwanted female daughter (which is what drives women to practice sex-selective abortion); the shame and guilt associated with public stigmatisation; and the impact of sex-screening technologies that have contributed to reproducing 'the family as the site of violence' (p 49). The authors conclude that more research is needed to fully understand how sex-selective abortion and criminalisation affect societies and normalise violence, and their consequences for women and families.

## 13. Hohmann, S.A., Lefèvre, C.A. and Garenne, M.L. (2014) 'A framework for analyzing sex-selective abortion: the example of changing sex ratios in Southern Caucasus' *International Journal of Women's Health* 6: 889–897

Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4208631/pdf/ijwh-6-889.pdf

This article challenges the predominant view that patriarchal society, son preference and gender discrimination underpin female sex-selective abortion. It explains why female sex-selection has been recorded in countries in the Southern Caucasus (specifically Armenia, Georgia and Azerbaijan) in the 1990s and has then stabilised in the 2000s. It uses a broad socioeconomic approach that looks at: (1) demand (the perceived economic value of children, population pressures, costs of children, migration issues, family size and composition, patronymic transmission, and prestige and inheritance issues); (2) supply (sex screening and abortion methods); and (3) regulation of abortion (laws, social norms and ethical issues). Data draws on interviews with physicians, gynaecologists, lay persons, lawyers, and activists involved in women's rights in the three countries.

In the South Caucasus, DHS data shows an increase in the sex ratio at birth after 1990 due to sex-selective abortion, particularly after two or three girls have been born to the family, and then a decline or stabilisation more recently. The authors argue that sex-selective abortion cannot be ascribed exclusively to what they define as a 'vague patriarchal framework' (p 894), as societies with strong patriarchal and religious values exist all over the world, yet not all practice sex-selective abortion. Rather, the demand for sex-selective abortion started to

increase in the 1990s due to various factors linked to the dismantling of the Soviet Union, the end of the social welfare system, an increase of male migration to Western Russia and Siberia, and the need for male soldiers to fight in ongoing regional conflicts. This in turn increased the perceived economic value of having sons. State engagement was also limited, as it considered the issue a private matter, in the midst of a period of political instability, wars and preoccupation with economic development after the fall of the Soviet Union. Medical providers and the general population in all three countries were deemed more tolerant towards abortion (including late abortion) as a method of contraception, in a context of lower desired family size and a low fertility rate.

The authors also argue that in the early 2000s, sex-selective abortion started to stabilise as economic conditions in all three countries improved. This, perhaps, was a sign that economic rather than cultural factors and patriarchal forces were responsible for what South Caucasians may have considered a form of birth control at a challenging time. The authors conclude by advocating for more research to uncover the patterns of decision-making around sex-selective abortion among couples but also among service providers and the political establishment.

# Family and community stigma

## Summary

The articles in this section explore the manifestation of family and community stigma towards abortion-seeking women, especially young sexually active unmarried women, and the risks they run because of an unwanted pregnancy. Studies explain how stigma is produced and reproduced in society and within the family, the sense of guilt and shame that women experience, and male partners' ambivalent attitudes (from support to rejection).

Marlow et al. (2014) show how, in western Kenya, the community perceives abortion-seeking women not just as unfaithful or unmarriageable but also as criminals and a bad influence on other women. This mirrors findings on perceptions of abortion among male opinion-leaders in Uganda (Moore et al., 2014) and among male partners in Uganda (Moore et al., 2011) and the Philippines (Hirtz et al., 2017). All the articles refer to how male gatekeepers, family members and partners follow predominant religious views and social norms that frame abortion as a sin and women abortion-seekers as wrongdoers and therefore morally reprehensible.

Moore et al. (2011) and Blodgett et al. (2018) focus on exploring male partners' ambivalent attitudes towards contraceptive use and abortion decision-making, and how these manifest themselves through stigmatising behaviours. For example, Blodgett et al. show that simply communicating with male partners about family planning and contraception to avoid an unwanted pregnancy is not sufficient to reduce abortion stigma, whereas gaining the male partner's active support in and agreement with contraceptive uptake may act as a proxy for reducing abortion stigma. Moore et al. (2011) show that, despite recognising the risks that an unsafe abortion poses to the woman's life, male partners would actively support a woman's decision to have a safe abortion only if they agreed with it, thus demonstrating more preoccupation with controlling women's reproduction than protecting their health. The articles also explain women's views on the importance of keeping secret about a shameful pregnancy and abortion to avoid family stigma and intimate partner violence (in cases where the male partner did not agree to the abortion).

14. **Marlow, H.M., Wamugi, S., Yegon, E., Fetters, T., Wanaswa, L. and Msipa-Ndebeleet, S. (2014) 'Women's perceptions about abortion in their communities: perspectives from western Kenya'** *Reproductive Health Matters* **22(43): 149–158.**
Available at: www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2814%2943758-3?needAccess=true

This qualitative study analyses social, economic and cultural norms that influence induced abortion among married women aged 24–49 and young, unmarried women (aged below 20 years) in Bungoma and Trans Nzoia counties, western Kenya. It is based on five FGDs with young unmarried women and five with married women in rural and urban communities in each county. The study aimed to increase understanding about women's knowledge about safe and unsafe methods of abortion as well as to explore community perceptions about abortion.

Findings show that most of the women thought that abortion was illegal in all circumstances and also unsafe. Respondents described various unsafe and life-threatening abortion methods, reflecting not just the perceived impossibility of accessing women-friendly and youth-friendly health providers but also the high costs of health services. The study also found that some providers mistreat women, especially if they are young and sexually active. They wilfully misdirect women as to legal provisions for abortion so that they can overcharge them for private services on

the basis of the woman's perceived wealth, the length of the pregnancy and the level of secrecy requested. Finally, community perceptions of women who have had an abortion are profoundly stigmatising; such women are considered unfaithful (if married) or unmarriageable, viewed as murderers or as a bad influence on others, and are thus ostracised.

The findings from this study were used to develop an educational outreach programme that trained women in women's groups, churches and their homes, reaching young women through school as well as peer educators and service providers. The programme also adopted a community-based approach, sensitising traditional and religious leaders and other community members about the dangers of unsafe abortion. It involved VCAT training and technical training in manual vacuum aspiration (MVA) and medical abortion, and upgrading of services to create an enabling environment for women requesting abortion services.

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## 15. Blodgett, M., Weiderta, K., Nieto-Andradeb, B. and Prata, N. (2018) 'Do perceived contraception attitudes influence abortion stigma? Evidence from Luanda, Angola' *Population Health* 5: 38–47.
Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5993162/pdf/main.pdf

Abortion is legally restricted in Angola. Its codification originated during colonisation through the Portugal Criminal Code and is reinforced by strong religious traditions (Christian and Roman Catholic). Pope Benedict XVI, during a visit in 2009 and addressing nearly a million Angolan Catholics, called abortion 'a strain on the traditional African family' (p 39). His speech reinvigorated Angolan bishops, who have since called for stronger legal restrictions. Very little is known about incidence of abortion due to lack of data, but several national and international organisations and the Ministry of Health have started working on post-abortion care (PAC) to address maternal mortality arising from unsafe abortion.

Grounding this study in the concept of abortion stigma, the authors explain that in Angola, abortion is considered to contravene the very fundamental notion of procreation, separating it from essentialist notions of female sexuality and womanhood. Albeit less vehemently attacked, contraception also separates female sexuality and procreation and is equally stigmatised. Thus, this study explores the relationship between perceived attitudes to contraception (rooted in social norms) and abortion stigma in the capital, Luanda.

The study used data from the 2012 Angolan Community Family Planning Survey, alongside other data from Angola's Malaria Indicator Survey. Demographic, social and reproductive information from a representative sample of 1,469 Luandan women aged 15–49 was collected, with most respondents younger than 30. Women were asked how they thought their partners, friends and communities felt about contraception. Bivariate and multivariate analysis was used to identify a number of social factors linked to abortion stigma at individual, partner and community levels as well as to assess the level of abortion stigma, measured through: willingness to help someone get an abortion; willingness to help someone who was sick after an abortion; and desire to not talk about abortion experiences.

The results show various social factors that may influence abortion stigma, but that abortion in itself is not as shameful as unintended pregnancy; rather, it is tainted by association with the unintended pregnancy that leads to the abortion. Also, the ways in which partners are communicating about contraceptive use or effectively engaged in joint decision making about contraceptive use seems to be an important predictor of support or denial of abortion. Thus, on contraception, the study shows that partner engagement in family planning (measured by involvement

and frequency of communication) reduces the likelihood of helping a friend or family member seek an abortion, as well as of discussing an abortion experience. Conversely, partner encouragement for family planning (measured as encouragement and approval of family planning) has exactly the opposite result: it increases communication about abortion or the

likelihood of supporting someone who is seeking an abortion. The study concludes that working to increase partner support in family planning and contraception may act as a proxy to reduce abortion stigma, but overall, any intervention should go beyond abortion to focus on beliefs about 'shameful pregnancies'.

## 16. Moore, A., Kibombo, R. and Cats-Baril, D. (2014) 'Ugandan opinion-leaders' knowledge and perceptions of unsafe abortion' *Health Policy and Planning* 29(7): 893–901.

Available at: www.ncbi.nlm.nih.gov/pubmed/24064047

The focus of this article is the effect of public works schemes and cash transfers on adolescent girls' roles and responsibilities. Increasing participation in social protection is intended to enhance the development of girls in participating households, but evidence on their school participation and workloads suggests that the reverse may be happening. Combining a review of other papers addressing the effects of social protection on children's work with analysis of quantitative and qualitative data, Camfield explores what happens to girls' roles and responsibilities when households participate in social protection schemes in rural Ethiopia and Andhra Pradesh, India. She argues that effects are complex and often context-specific; however, the assumption that 'beneficiaries' benefit from programming means that negative impacts are rarely acknowledged.

The article's conceptual framing engages directly with the normative frameworks that underpin girls' work. It uses Power's (2004) concept of 'social provisioning' to highlight the exclusion of girls' caring and unpaid labour from evaluations of the outcomes of social protection schemes. Camfield also draws on Donath's (2000) characterisation of the 'other economy' to emphasise that the behaviour of individuals is shaped not by economic rationality but norms and expectations – both their own and those imposed by external forces.

The article reviews two social protection schemes: the MGNREGS in rural India, which has been successful in both recruiting women and increasing agricultural wage rates for non-participating women, and the PSNP in Ethiopia.

Camfield finds that, at present, targeted social protection schemes 'may "work" somewhat perversely as...they risk "improving" the short-term lives of vulnerable families at the expense of girls' schooling and workloads, with negative implications' for girls' medium- and long-term prospects. While girls' contributions are not valued or taken into account by development policymakers, it is in fact their care of younger and older household members that frees up the labour of adult women to engage in new economic opportunities, including public works programmes. Indeed, in many cases these schemes unintentionally increase girls' workloads and significantly reduce their time for study and leisure. Social protection schemes can also sharpen tensions between individual and collective (family) interests to the detriment of adolescent girls' school attendance, achievement and, in some cases, health – for example, where the costs of schooling for some siblings are covered, but not others, or where increases in workload are reported for non-beneficiary children in households receiving conditional cash transfers. Further, where CTs do not adequately protect against household shocks such as illness,

this can leave girls acting as 'shock absorbers' for persistent crises.

Camfield concludes by emphasising the need for social protection policy to recognise, firstly, girls' role in 'social reproduction' (e.g., in responding to household shocks or when women are engaged in other activities) and, secondly, that girls are embedded in social relationships that shape their motivations and constrain their agency.

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## 17. Moore, A., Jagwe-Wadda, G. and Bankole, A. (2011) 'Men's attitudes about abortion in Uganda' *Journal of Biosocial Science* 43(1): 31–45.

Available at: www.cambridge.org/core/journals/journal-of-biosocial-science/article/mens-atti-tudes-about-abortion-in-uganda/528130956B1744DB566AF5FA070B95C0

In Uganda, abortion is legally restricted except to save a woman's life; however, there are an estimated 300,000 induced abortions annually among women aged 15–49. This study originally aimed at understanding women's access to abortion and, complications, to post-abortion care (PAC). The analysis of the data, however, shed light on men's perceptions on abortion, revealing how they are ultimately the gatekeepers for safe abortion and PAC. The study draws on in-depth interviews carried out in 2003 with 61 women aged 18–60 and 21 men aged 20–50 from Kampala (the capital) and Mbarara.

In line with predominant religious views and social norms around female sexuality and abortion, results show that men view abortion as 'abominable' and 'evil' (p 18). They do not agree with the practice, and think that a woman who has an abortion may want to hide an extra-marital relationship, especially if the pregnancy had not been disclosed. They are concerned that a woman may die as a result of the procedure and that they may be arrested for having supported an illegal act. Interestingly, men were not in disagreement with school-going adolescent girls having an abortion; rather, they feared that the man could be arrested for violating the age of consent (18 years) (defilement of an under-age girl), and were not concerned that the girl should be given the opportunity to continue with school.

Women's narratives, on the other hand, linked abortion to the realities of repeat childbearing and caring, the loss of education opportunities, or marital problems. They stressed the importance of maintaining secrecy for fear of intimate partner violence and of being stigmatised in their community, as well as preoccupations about complications resulting from an abortion, as these would have to be endured at considerable cost (both physical and mental health costs, and economic costs). Yet, a woman's economic dependency on her husband meant that, in case of complications, the abortion would have to be revealed, which could result in abandonment and further stigmatisation. Overall, men explained that if a woman revealed the pregnancy and they made a joint decision to seek an abortion, they would support their wife; but not if they disagreed with seeking an abortion.

Findings confirm Uganda's strong patriarchal views towards women and abortion: men's responses show that women are primarily considered mothers, and that abortion violates and deviates from this view. Thus, men's strong objection to abortion has more to do with their desire to control women's reproduction than to protect women's health, and to ensure that women do not undermine tradition – men perceiving themselves as the bearers of cultural norms and values. Men in the sample seemed oblivious to women's reasons about childbearing and having an abortion and their vulnerability due to economic dependency on men. Men's reaction to women's silence, an agentive action, is the threat of abandonment or, in case of abortion disclosure, even violence. The authors conclude by advocating for the need to include men in reproductive health programmes, but also to engage in further research to unpack what influences Ugandan men's attitudes towards gender roles and norms around abortion.

## 18. Hirtz, A.E., Avila, J.L. and Gipson, J.D. (2017) 'The role of men in induced abortion decision making in an urban area of the Philippines' *International Journal of Gynaecology and Obstetrics* 138(3): 267–271.

Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5748335/pdf/nihms876594.pdf

Access to safe abortion is a serious health concern in the Philippines, where there were about 100,000 hospitalisations due to abortion-related complications in 2012, and where there are 1,000 maternal deaths due to unsafe abortion each year. SRH and rights, including abortion, are severely restricted in this Catholic country, reflecting social and gender norms that stigmatise adolescent sexuality and premarital sex, and promote chastity until marriage. However, adolescents are having sex at an earlier age and outside of wedlock: data from the latest national DHS shows that the proportion of adolescent mothers (aged 15–19 years) has doubled, from 6.3% in 2002 to 13.6% in 2013. Rates of unwanted pregnancies and induced abortions have also increased.

Against this backdrop, this study explores young Filipino men's attitudes towards, and their roles in, abortion decision-making through IDIs and FGDs with 58 men (aged 20–29 years) in an undisclosed urban area. Interviewees were selected among those that had reported being 'afraid or troubled' or 'afraid and planned to terminate' when asked about a partner's past pregnancy in a local survey. FGDs were held with married or co-habiting men.

The study shows that a complex web of norms influence men's role in their partner's induced abortion. In FGDs, men associated women who have premarital sex and induced abortions with notions of irresponsibility, looseness or belonging to gangs, but admitted having premarital sex themselves without contraception. If a pregnancy occurred, they viewed it as 'the will of God', for which they would feel financially and morally responsible; thus abortion would be a sinful act against God.

IDIs revealed more nuanced perspectives on abortion and men's role. On the one hand, religiosity, fear of stigma from the family and community, and their own individual economic circumstances influenced men's willingness and ability to support their partners, though they recognised that women suffer heavier consequences if they fell pregnant out of wedlock. However, men also expressed feelings of powerlessness in the face of families' arbitrary decisions to terminate their partner's pregnancy or when excluded from the abortion decision-making process. Men also felt resentful of being excluded from reproductive choices more widely, as they felt they were more rational decision-makers than women.

The article concludes that the idea of abortion as a sin pervades men's views. It pushes them to distance themselves from women for fear of being associated with a sinful act – something the author links to Kumar's notion of abortion stigma (see section 5); thus men can also experience abortion stigma. This religious position may be perpetuated at community level by the ubiquitous influence of the Catholic church, with its strict interpretations of womanhood and notions of sexual purity and nurturing motherhood.

# Service providers' stigma and 'conscientious objection'

## Summary

There are safe and effective evidence-based interventions to prevent unsafe abortion; however, one of the crucial barriers is a lack of trained providers who can perform various counselling and interventions for safe abortion and PAC (WHO: 2015). Service providers are crucial to women's access to safe abortion services, yet stigma among health services towards women presenting for abortion (or with complications from an unsafe abortion) often compromise the quality of those services.

The articles in this section deal with the spectrum of attitudes about abortion service providers, from those who stigmatise women and girls presenting for an abortion to those who endure being portrayed as 'abortionists' by their communities. These attitudes are influenced by the contexts in which providers operate and the social norms that produce and perpetuate stigma. Thus, Izugbara et al. (2017), Rehnström Loi et al. (2015) and Håkansson et al. (2018) show how contextualised perceptions of unmarried young women as pure, innocent and chaste negatively influence providers' ability to treat girls with respect. Overall, the articles clearly show how social norms and religious views influence providers' attitudes. But these are compounded by a lack of appropriate training to treat abortion-seeking women and girls, as well as a general sense of unpreparedness to deal with one's own contrasting professional versus personal views on adolescent sexuality and abortion.

Finally, two articles deal with the contentious practice of conscientious objection to abortion provision, and the social norms and legal boundaries that allow providers to refuse to offer abortion services in Zambia (Freeman et al., 2017) and Tunisia (Raifman et al., 2018).

19. **Izugbara, C., Egesa, C., Kabiru, C. and Sizdu, E. (2017) 'Providers, unmarried young women, and post-abortion care in Kenya'** *Studies in Family Planning* **48(4): 343–358.**
   Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1111/sifp.12035

In Kenya, there are widespread reports of abuse, mistreatment, wilful misinformation and stigma facing young patients when they seek post-abortion care (PAC). A poor legal framework and policy clarity is compounded by popular opinion, which views abortion as immoral and criminal. This leads many girls to seek unsafe abortion and leads to harassment and stigmatisation of providers who offer safe abortion. This article explores PAC providers' understanding of the challenges facing unmarried young women and girls (under the age of 25) when seeking abortion and PAC. It is based on interviews with 152 PAC providers drawn from a sample of purposely selected public and private facilities.

The study uses stigma theory, whereby abortion stigma and understandings of adolescence derive from locally constructed social and gender roles, produced in the context in which people and communities operate (Kumar et al., 2009; Link and Phelan, 2001). Thus, adolescence is viewed as a time of sexual abstinence, innocence and restraint; there are popular beliefs that attribute personhood to the foetus; and there is a growing public discourse that condemns young people's sexual activity.

The authors hypothesise that this context influences providers' conceptions of 'proper' femininity and adolescence, encouraging a belief that adolescents cannot make conscientious choices about termination of a pregnancy and, in turn, compromising providers' ability to offer non-judgemental PAC services.

The article highlights two clear levels of interconnected stigma that affect both providers and young patients. On one side, providers have to deal with structural and personal challenges: from working in a context of inadequate health infrastructure and staffing, poor training on youth-focused abortion care, and legal and policy ambiguity, to being stigmatised by the public, colleagues and the media. This undermines their ability to offer quality care and to treat those seeking PAC with respect, for fear of being labelled 'abortionists'. On the other,

they specifically blame young abortion care-seekers for their own difficulties in reaching and using PAC. They view them as having violated socially accepted notions of femininity, chastity (especially for the unmarried), innocence and purity for having initiated sex before marriage. Ultimately, a young woman's ordeal when seeking PAC is grounded in perceptions of her 'immorality' and personal failures for having premarital sex.

The authors call for providers to change attitudes and practices towards adolescent girls seeking abortion, seeing their predicament as a consequence of systematic denial of women's human rights rather than of girls' moral failure. They also advocate for Kenyan institutions to fully implement guidelines on comprehensive abortion care, so as to offer better services and reduce stigma directed towards providers.

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## 20. Rehnström Loi, U., Gemzell-Danielsson, K., Faxelid, E. and Klingberg-Allvin, M. (2015) 'Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data' *BMC Public Health* 15: 139–152.

Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4335425/

Poor and young adolescent women are often victims of unsafe abortion because they lack knowledge about safe services, but may also lack money and decision-making power or be discouraged by providers' attitudes, lack of confidentiality and privacy. In fact, while induced abortions are legal on specific grounds in most countries in sub-Saharan Africa and Southeast Asia, health care providers often represent a major obstacle to service provision, viewing it as an immoral act (on grounds of personal beliefs) or being discouraged from providing the service due to community stigma and discrimination.

This systematic review provides data on health care providers' perceptions of and attitudes to induced abortion based on 36 quantitative, qualitative and mixed-methods studies conducted in 15 countries in sub-Saharan Africa and Southeast Asia. Results show that providers hold strong conservative views on induced

abortion. While they accepted specific instances in which abortion could be provided (e.g. in cases of incest, rape or foetal malformation), overall, providers' (especially Christians) viewed abortion as a mortal sin and a denial of motherhood. However, many providers considered menstrual regulation as acceptable. Some studies from South Africa show that medical abortion was more accepted as a method, as it put the decision in the hands of women and did not contrast with providers' personal beliefs. In some instances, some nurses and midwives involved in abortion services raised feelings of guilt and uneasiness, which they viewed as contrasting with their code of ethics and, overall, they felt unprepared to deal with women with unwanted pregnancies.

The authors conclude that, despite task shifting as a widely recommended practice to provide safe abortion services, it will not be practical if nurses and midwives are reluctant to

provide abortion care. For this reason, there is a need for VCAT training and a clear understanding of the legal and policy frameworks to support providers to be able to commit fully to delivering comprehensive abortion care.

## 21. Håkansson, M., Oguttu, M., Gemzell-Danielsson, K. and Makenzius, M. (2018) 'Human rights versus societal norms: a mixed methods study among healthcare providers on social stigma related to adolescent abortion and contraceptive use in Kisumu, Kenya' *BMJ Global Health* 3: e000608

Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5841529/pdf/bmjgh-2017-000608.pdf

The study aims to contribute to the global evidence on health care providers' stigma towards adolescents' use of abortion and contraceptive services by analysing attitudes among professionals at 86 PAC centres in Kisumu slum, a poor setting in Kenya. It uses two quantitative scale surveys: the 18-item Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS) and the 7-item Contraceptive Use Stigma Scale (CUSS) as well as FGDs with 12 PAC providers.

Findings from the quantitative surveys showed that providers hold strong stigmatising attitudes towards adolescent sexuality and decision-making. This includes perceiving adolescents who use contraceptives as too young and promiscuous, those who have abortions as having a bad influence on others, and generally perceiving abortion as a sin. Findings from FGDs confirmed these beliefs and were categorised under two themes: human rights and societal norms. Under the human rights theme, discussions focused on 'acceptance' of a girl's choice, understanding of the 'economic aspects' leading to that choice, the importance of providing 'youth-friendly counselling services'

and CSE, and the importance of addressing gender inequality and including men as they often control women's reproductive choices. Under the social norms theme, discussions focused on morality and religious beliefs that view girls' premarital sexual activity as immoral and indecent, leading them to committing sins, including abortion. Other issues included dealing with society's misconceptions about contraceptives and fertility problems, but also that contraception equates with unhealthy lifestyles. There was also general societal and religious resistance to provision of information on abortion and PAC and inconsistencies in policy regulations. A final theme under social norms was women's lack of autonomy, especially economic autonomy, which leaves them dependent on men to access contraception.

The authors conclude there is clear evidence that PAC providers are unprepared to deal with their own contrasting professional versus personal views on adolescent sexuality and service provision; they need training and support to provide quality, non-judgemental contraception, abortion and PAC services

## 22. Freeman, E., Coast, E. and Vwalika, B. (2017) *Understanding conscientious objection to abortion in Zambia*. Poster at 2017 International Population Conference.

Available at: https://iussp.confex.com/iussp/ipc2017/mediafile/Presentation/Paper4458/CO_Paper_4458.pdf

Despite Zambia's legal provisions on abortion being less restrictive than those of other countries, 70% of abortions remain unsafe. The authors' own research showed that access to safe abortion is prevented by providers' misrepresentation of (or reluctance to respect) legal provisions on the grounds of their own moral judgement. The study sheds light on how providers exercise conscientious objection and the reasons behind it, how they interpret the law, and negotiate their refusal as individuals with their role as service providers. According to Fink et al. (2015), conscientious objection in health care refers to individuals whose '... moral, ethical, or religious beliefs precluded her or him from being willing to perform or assist abortions in some or all situations'. The authors include in this definition a health worker's willingness to refer a girl or woman to another safe abortion provider (something generally not included in the definition of conscientious objection). The study is based on 55 interviews with abortion providers, who accept or refuse to provide and/or refer women to abortion services, in rural and urban settings and at all levels of the Zambian health system.

The study finds that only specialised obstetrician gynaecologists were aware that they are allowed to perform abortion as per the legal regulations, but all study participants were unaware of the legal restrictions on conscientious objection, stressing that their own personal beliefs informed the advice and counselling they gave to patients, including referral. Providers who claim conscientious objection stated that they provided abortion only in the case of evident risk to the pregnant woman's life.

Christian values (all participants belonged to different Christian denominations) informed views on abortion provision. Some service providers distinguished their Christian values from their role as service providers, while others changed their mind after witnessing cases of unsafe abortion. Despite recognising the limited choice certain women have (pregnancy as a result of violence, poverty, risk of school dropout, etc.), conscientious objectors believed that abortion mostly takes place among school-aged adolescent girls or adulterous women; thus they did not empathise with their situation and judged abortion as a sinful choice to get out of a problem.

Stigma from within the medical community, especially from senior doctors who would hold back junior doctors' careers, as well as from the general public (especially in rural areas) strongly discouraged service provision. Conscientious objectors' decision to refer women elsewhere required them to reach an accommodation with their own personal beliefs: some providers (especially doctors in large hospitals) would not attend meetings with women who sought a termination, while others would counsel them to convince them to continue with the pregnancy and respect Christian values. Others would personally engage with the woman's situation, trying to find a resolution. There was little understanding that women seeking abortions or colleagues who perform abortions would also hold Christian values. The authors conclude that the landscape of abortion provision is incoherent and fragmented and depends largely on who the service provider is.

## 23. Raifman, S., Hajri, S., Gerdts, C. and Foster, D. (2018) 'Dualities between Tunisian provider beliefs and actions in abortion care' *Reproductive Health Matters* 26(52): 47–57.

Available at: www.tandfonline.com/doi/pdf/10.1080/09688080.2018.1472486?needAccess=true

Tunisia has one of the most liberal abortion laws in the North Africa region. It allows for elective first trimester abortion (provided by physicians or midwives), at no cost, in public health facilities. Tunisia was the first Muslim country in the Arab world to introduce the emergency contraceptive pill, and the first African country to legalise medical abortion. Despite such progressive legislation, since the Arab Spring in 2011, a resurgence of conservatism, budget cuts and providers' invocation of conscientious objection are hindering abortion access for women. This study explores providers' attitudes around conscientious objection, drawing on 25 key informant interviews (KIIs) with health providers and gatekeepers (front-desk staff) at six facilities in and around Tunis.

The authors use Harris et al.'s (2016) conceptualisation of conscientious objection as firmly influenced by prevailing economic, social and political pressures. Conscientious objection manifests itself in three domains: (1) beliefs about abortion (morality, safety and legality); (2) actions related to conscientious objection and abortion (counselling, service provision, denial or referral); and (3) self-identification as a conscientious objector. When applied, these can limit or delay access to legal abortion or further stigmatise women that need it. For the authors, understanding how service providers negotiate conscientious objection between actions and beliefs is crucial to create a more nuanced understanding of abortion provision in Tunisia.

Results offer insights about providers with a range of views, from those who believe abortion should be legal and the law should remain as it is, to those who morally oppose it and think it should be legally restricted, and those who support it but only in certain circumstances. Overall, the first group (their beliefs notwithstanding) felt they should aim to support women who present at their service, providing them with appropriate information, counselling and compassion. The second group invoked religious beliefs that view abortion as a sin and openly claimed they had attempted to convince women, especially younger women, to change their mind when they presented at the service. Interestingly, providers and gatekeepers who are most against access to safe abortion are also those who have the most misconceptions and poor information about legality and safety of the procedure. Some providers stated that they refused to serve unmarried young women altogether. The third group believed that abortion services and counselling should be offered in specific cases, depending on marital status, number of children, husband's income and employment status, number of previous abortions, and patient's health status, although different views emerged on which circumstances would qualify. These results show that categorising providers as conscientious objectors on the basis of beliefs and actions is difficult; further research is needed on providers' perspectives and to understand why they treat certain patients differently from others.

# Linkages between gender, social norms, violence against women and abortion

## Summary

The social acceptability of gender-based violence (GBV), and especially intimate partner violence (IPV), affects norms and practices around reproductive autonomy and safe abortion. In contexts where both forms of violence are deemed socially acceptable and considered a private matter, women may suffer violation of their bodily integrity and lose control of their reproductive autonomy. Women who experience IPV may be unable to negotiate sex with a partner or resist family pressure to have children; they may also struggle to access or use contraception, and therefore have unwanted pregnancies. A woman may also experience violence from her partner and his family, who may force her to have an abortion. Gender and social norms that approve of male control over women's reproduction may lead to contraception sabotage and intimate partner sexual violence, which, in turn, may lead to a cycle of unwanted pregnancies. As a result, women may be seeking an abortion alone, without their partner's knowledge or consent, and may find it difficult to cope alone in this situation.

There is a dearth of literature on the linkages between the social and gender norms that fuel GBV, IPV and unsafe abortion in LMICs. While studies exist that show both forms of violence as a predictor of unsafe abortion, there is little empirical data on how violence, social norms and unsafe abortion are connected and mutually reinforcing. Two of the studies selected for this review (Hall et al., 2014; Pearson et al., 2017) highlight this paucity of data, as they use quantitative methods to analyse linkages between and the effects of violence on women's fertility choices. The article by Nguyen et al. (2012) on GBV and induced abortion in Vietnam does the same, but grounds its results in an analysis of gender roles in Confucianism that grant women lower status in Vietnamese society and sanction gender-based violence as a private matter. Thus, while these articles do not seem to explicitly address social norms around the acceptability of violence and access to safe abortion, they show how violence and abortion are deeply connected, and how women's reproductive autonomy is influenced by powerful agents (families, religious prescriptions, partners, etc.), including through violence.

24. **Nguyen, P.H., Nguyen, S.V., Nguyen, M.Q., Nguyen, N.T., Keithly, S.C., Mai, L.T., Luong, L.T.T. and Pham, H.Q. (2012) 'The association and a potential pathway between gender-based violence and induced abortion in Thai Nguyen province, Vietnam'** *Global Health Action* 5: 19006.
Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3511781/pdf/GHA-5-19006.pdf

When this study was published, Vietnam was witnessing high rates of GBV: a 2010 nationally representative study on domestic violence showed that 58% of Vietnamese women had experienced some form of violence in their lifetime. The literature also showed high induced abortion rates (2.5% during a woman's reproductive life). This study sheds light on GBV as a predictor of induced abortion. Specifically, it analyses the prevalence of GBV among married women of reproductive age in Thai Nguyen province, and examines the pathways linking GBV and unintended pregnancy

to induced abortions, by analysing associations between GBV, contraceptive use and first and repeat induced abortion. The study uses logistic regression to analyse data from a cross-sectional household survey with a representative sample of married or partnered women aged 18–49, as part of a project entitled 'Primary Health Improvement Initiative in Thai Nguyen Province, Vietnam'. Variables analysed include sociodemographic data, sexuality and obstetric history, knowledge, attitudes and practices related to contraception, fertility preferences, history of GBV, attitudes towards and access to family planning and reproductive health services, history of abortion, and experience with abortion services.

Results show that women who experience GBV (defined as physical, sexual and emotional violence) are at greater risk of induced abortion and repeat induced abortion. The study also found that GBV was positively associated with female-only contraceptive use (rather than couple contraceptive use) and unintended pregnancy, and, in turn, that these factors were positively associated with induced abortion. The authors argue that this may be explained by the fact that women who are victims of abuse may be reluctant to have a child in those circumstances and make individual decisions about contraception,

but partners may sabotage contraception and react violently if they find out. This may explain the link between GBV and contraceptive use and, eventually, with abortion and repeat abortion: abused women may struggle to control reproductive choice and contraceptive as and their ability to use family planning methods can be affected by fear of violence, which can lead to contraceptive failure, unintended pregnancy and induced abortion. Yet the latter represents a way for women to regain some level of control of their reproductive health and life.

The study explains that Vietnam's culture is rooted in Confucianism, which grants women lower status than men and instructs obedience towards the husband. Gender norms also hold that women are responsible for maintaining family harmony and reputation, whereby GBV issues should not be discussed in public as they are a private family matter. This culture of silence aggravates public awareness of GBV issues and women's ability to report GBV. Although Vietnam has made strides in addressing GBV and family planning, contraception can be difficult to access for women who are subjected to GBV. Thus, future programmes and policies should clearly consider the linkages between GBV, family planning and induced abortion.

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### 25. Hall, M., Chappell, L.C., Parnell, B.L., Seed, P.T. and Bewley, S. (2014) 'Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis' *PLoS Medicine* 11(1): e1001581.
Available at: https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001581&type=printable

IPV is prevalent across continents, but its linkages with pregnancy, and termination of pregnancy, have not been fully and systematically explored. This systematic review attempts to understand this connection for the first time and includes studies with no restriction on location, time and language. The review process included a final list of 74 studies from 1985 to 2013, covering North America (35 studies), Asia (12), Europe (10), Africa (8), Australasia (6) and South America (2).

One study included data from several continents. Studies included a variety of samples and quality.

The article does not provide specific evidence on findings by continent. Authors found that rates of IPV against women seeking a termination of pregnancy were high across all continents. Overall, women who had experienced IPV were less likely to report control over contraceptive choices and more likely to report contraceptive sabotage and sexual violence perpetrated by a husband or boyfriend. They were also less likely

to inform partners of the termination for fear of further violence. The analysis of data also led to an understanding that IPV may lead to a pregnancy and to a subsequent termination, and then to a cycle of subsequent pregnancies and terminations as women do not have control over their bodies. In some studies, women reported having been coerced into the termination by the partner. Multiple studies reported on the mental health consequences of termination of pregnancy among women involved in abusive relationships, with symptoms including depression, anxiety and suicidal tendencies.

The study calls on health professionals to give more attention to the risk factors that seem to associate IPV with terminations: repeat terminations, lack of contraception, initially planned pregnancy, and the partner being absent for the termination (or not supporting it). The authors also highlight that IPV may be associated with young age, marital status, ethnicity, and low household income. They argue that services should do more to ensure women's safety and confidentiality, and provide information and referral pathways for those who disclose IPV.

### 26. Pearson, E., Andersen, K., Biswas, K., Chowdhury, R. Sherman, S. and Decker, M. (2017) 'Intimate partner violence and constraints to reproductive autonomy and reproductive health among women seeking abortion services in Bangladesh' *International Journal of Gynaecology and Obstetrics* 136: 290–297.
Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC5324615/pdf/IJGO-136-290.pdf

IPV is a severe public health concern in Bangladesh, where an estimated 50%–60% of women have experienced IPV in their lifetime, and 30% had experienced IPV in the year prior to the study. IPV is also associated with a 50%–60% increase in unwanted pregnancy and also an increased likelihood of induced abortion. Abortion is illegal in Bangladesh, except to save the woman's life, but menstrual regulation within 10 weeks from the last period is accepted and post-abortion care (PAC) is widely practised. The linkages between IPV and induced abortion may suggest that women who have experienced IPV have no control over their reproductive autonomy: male partners may force their reproductive preferences on women, sabotage contraception or put pressure on women to follow the wishes of the family (especially in-laws) when it comes to childbearing. This study analyses IPV experiences and constraints to reproductive autonomy among women who had accessed abortion services. It used data from a survey of 457 women aged 18–49 years who received abortion services and selected a short-acting contraceptive method or no contraception, in 16 public sector facilities.

The findings showed that 25% of abortion care-seekers reported IPV in the preceding year and this was associated with other constraints on their reproductive choice. These include: reporting that contraception was too difficult to obtain and to use; being more likely to disagree with their partners and in-laws on fertility intentions; disagreeing with in-laws about contraceptive use; and reporting religious prohibitions to contraceptive use and use of PAC for induced abortion rather than menstrual regulation. Findings thus suggest that powerful players – such as family members or partners and religious leaders and traditions – determine the reproductive choices of women who have experienced IPV, as well as their ability to access contraception. But women may also be attempting to regain control over their choices by attempting abortion covertly, outside regulated settings, and without their family's knowledge. The authors conclude by calling for interventions at the household and community levels to improve women's reproductive autonomy and to promote gender equality, which will improve their reproductive health.

# Impact of initiatives to change norms around abortion

## Summary

Few articles document initiatives that address social norm change around safe abortion, especially for adolescent girls, and this literature review revealed a paucity of rigorous evaluations in this field. The articles in this section provide just a few examples of these kinds of initiatives. Banerjee et al. (2012) analyse the gaps between availability of safe abortion, uptake of services, and the sources of information women use to access them, as a way to understand how to target women with BCC initiatives. Drovetta (2015) outlines the use of anonymous hotlines in Latin America – a crucial strategy used by feminist grassroots organisations to provide information and services to women in legally restrictive settings. Finally, Turner et al. (2018) report on the impact of VCAT training on abortion providers and key stakeholders in 12 countries in Africa, Latin America and South Asia. This is another key strategy devised and implemented by the NGO Ipas to shift providers' attitudes and tackle abortion stigma.

27. **Banerjee, S., Andersen, K., Buchanan, R. and Warvadekar, J. (2012) 'Woman-centred research on access to safe abortion services and implications for behavioral change communication interventions: a cross-sectional study of women in Bihar and Jharkhand, India'** *BMC Public Health* 12: 175.
Available at: https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/1471-2458-12-175

Despite improvements in the legal and policy environment in India, and the implementation of initiatives to increase the availability of safe abortion services, maternal mortality and morbidity due to unsafe abortion persist. This is primarily because of limited access to and utilisation of safe abortion services, especially in rural locations, but also lack of awareness of the legality of abortion, limited understanding of the implications of unsafe abortion, and lack of information on availability of safe providers and methods. This quantitative study uses logistic regression to analyse the gap between safe abortion availability and use of services in four rural districts in the states of Bihar and Jharkhand. It does so by examining accessibility to services from a survey with 1,411 rural, married women of reproductive age (15–49 years old). It also aims to understand women's exposure to information through mass media or other types of information services so as to devise appropriate BCC interventions.

The study finds that women in the sample belong to poor, excluded castes/classes/tribes, with limited access to mass media, electronic or print media. They rely on community-level sources of information on safe abortion services, such as Accredited Social Health Activists (ASHAs), Anganwadi workers (at rural childcare centres) and auxiliary nurse midwives, or on informal discussions among women through community groups or at markets. The study also revealed that most women were not aware of legal provisions around abortion, lacked knowledge about availability and affordability of safe abortion services, but especially had negative attitudes about abortion, and were concerned about stigmatising social norms if they had an abortion.

Two important findings from the multivariate analysis to assess knowledge, attitudes and practices about abortion show that exposure to safe abortion messages was associated with more positive attitudes towards abortion.

Also, knowledge about at least one abortion method led to an increased perception that services are available and to having positive attitudes toward abortion. The study suggests that contextual BCC programming, based on the sources of information women use and interpersonal approaches with traditional and community leaders, can (1) provide women with the information they need, (2) counter stigma and negative social norms, attitudes and practices, and (3) support an enabling environment for access to safe abortion services.

## 28. Drovetta, R.I. (2015) 'Safe abortion information hotlines: an effective strategy for increasing women's access to safe abortions in Latin America' *Reproductive Health Matters* 23(45): 47–57.

Available at: www.tandfonline.com/doi/abs/10.1016/j.rhm.2015.06.004

This study describes the implementation of five safe abortion information hotlines in Argentina, Chile, Ecuador, Peru and Venezuela, where abortion is legally restricted. Hotlines provide information on safe medical abortion using misoprostol, and are a common strategy used by feminist organisations around the world in countries where abortion has been criminalised. Hotlines provide a virtual safe space where women seeking abortions can receive appropriate information in a non-stigmatising way. At times, hotlines may send misoprostol to those seeking abortion services. The study analyses the structure, goals and experiences of the hotlines as well as decisions taken by a sample of women who received advice. The methodology included observation of how the hotlines work as well as interviews with those who provide information and with 14 women who used these hotlines and went on to induce their own abortion.

After giving an overview of the global impact of unsafe abortion and a history of the feminist movement supporting women's right to abortion, the study delves into analysis of the individual hotlines in each country. These operate outside the health sector, and are based on radical, sometimes lesbian/gay/bisexual/transgender (LGBT) feminist collectives that reject conventional biomedical/clinical structures and support women in their own 'abortion itinerary'. They provide accurate information according to WHO guidelines on the use of misoprostol to ensure women's safety and privacy. They also advise women on how to avoid being reported to the police by doctors if they need to go to a hospital. Their work includes data collection and analysis, resulting in important studies on incidence of abortion, Spanish-language feminist publications and booklets on medical abortion, social media activism, and participation in the transnational Red de Experiencias Autónomas de Aborto Seguro (REAAS, Network of Autonomous Experiences for Safe Abortion). Ultimately, hotlines provide important, friendly and confidential advice as well as follow-up for all women in need, helping women avoid judgemental and stigmatising health services or even being reported to the police.

## 29. Turner, K., Pearson, E., George A. and Andersen K.L. (2018) 'Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries' *Reproductive Health* 15: 40.

Available at: https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/s12978-018-0480-0

Values clarification and attitude transformation (VCAT) is a training workshop based on values clarification (VC) theory and practice. VC examines a person's moral reasoning toward specific topics to understand the values that underlie it. It helps a person understand how 'these core values conflict with assumptions or actions that may be informed by social norms and other external influences and examine alternate values and their consequences'. VC has been successfully used in public health to reduce HIV stigma. VCAT is used with abortion providers and policy-makers and other key stakeholders to tackle abortion stigma.

The VCAT approach is based on a series of facilitated conversations that explore deeply held assumptions and myths about abortion, clarify and affirm one's values, and potentially resolve conflicts, transform beliefs and attitudes that impact behaviours, and state intentions to act in accordance with affirmed values. [3] The hypothesis is that participants who are open to change will be able to act more consistently on the basis of their new affirmed values. There is little literature on the impact of VCAT training, and this review aims to fill this gap by analysing pre- and post-workshop surveys to assess changes in three domains: knowledge, attitudes and behavioural intentions related to abortion care. Workshops were held in Africa, Latin America and South Asia. This assessment covers results from 43 workshops from 12 countries with a total of 641 participants (providers and other stakeholders) with matched pre- and post-workshop surveys.

Results across countries on the three domains show that the main changes took place in terms of knowledge. Participants with the lowest levels of pre-workshop knowledge of abortion provision experienced the greatest gains, as indicated in mean scores in the pre- and post-workshop surveys. However, the same participants did not catch up with their more knowledgeable peers and their post-workshop scores were still lower than those of participants who had high pre-workshop scores for knowledge of abortion provision.

Results at the level of attitudes were harder to measure and more variable by question, whereby changes were visible from negative to neutral or from neutral to positive attitudes for less controversial questions, but no change was observed for more controversial issues such as second-trimester abortion. However, these are positive results, as it suggests that those with previously obstructive attitudes may develop more supportive attitudes after training. The lowest scores were achieved in the domain of behavioural intentions to change, but this may have been due to participants' selection issues (participants were selected on the basis of past work in abortion or because they met other screening criteria for abortion VCAT workshops).

Overall, the best results were achieved in the service providers' workshop (as opposed to other stakeholders such as those working in the media, policy-makers, etc.). Regional variation showed improvement across all three domains in Africa, in knowledge and attitudes in Asia, but in none of the domains in Latin America – possibly due to how the survey instrument was designed and the need for further contextualisation for that continent.

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3   For the full methodology, see: Turner, K.L. and Chapman Page, K. (2008). Abortion attitude transformation: a values clarification toolkit for global audiences. Chapel Hill, NC: Ipas

# Conservative ideologies, religious prescriptions, and the legal and policy environment for safe abortion

## Summary

The articles discussed in this section describe how conservative ideologies and religious prescriptions may influence abortion legislation, policy and practice locally and internationally and the strategies used at local level to counter these forces. Thus, the articles by Hessini (2007) and Coates et al. (2014) shed light on Islamic and Catholic provisions on abortion and how these are interpreted and used locally – in the Middle East and North Africa region (Hessini) and internationally (Coates et al.) – to regulate and influence access to safe abortion services.

Against this backdrop, pro-abortion activists and sympathetic providers have strategically adopted a public health approach, focusing on post-abortion care as an entry point to address the high rates of maternal mortality and morbidity resulting from unsafe abortion, to then initiate a conversation about women's reproductive rights (Storeng and Ouattara, 2014 Daire et al., 2018). Only recently, the conversation has expanded to exploring communities' and service providers' values and beliefs about abortion (ibid.).

Despite progress in liberalising the abortion legal framework worldwide, the policy and funding environment for reproductive health is currently witnessing a resurgence of conservative politics stimulated by the Trump administration's reinstatement of the Mexico City policy (also known as the global gag rule) (Barot, 2017; Finer and Fine, 2013). Beyond preventing funding for safe abortion programming, these forces are introducing procedural barriers in abortion legislation that dramatically hinders access to abortion services, and which especially affect very poor women. The increasingly restrictive environment for abortion in some countries reflects the growing dominance of conservative norms and ideologies. Therefore, some articles are included in the bibliography to provide a picture of the interaction between international norms, laws and policies and provision of abortion services at local level (Barot, 2017; Storeng and Ouattara, 2014; Daire et al., 2018; Coates et al., 2014).

30. **Storeng, K. and Ouattara, F. (2014) 'The politics of unsafe abortion in Burkina Faso: the interface of local norms and global public health practice'** *Global Public Health* **9(8): 946–959.**
    Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC4285657/pdf/rgph-9-946.pdf

In Burkina Faso, abortion is legally restricted (legislation is based on French colonial rule) to a few situations: to save the mother's life or health, in case of severe foetal malformation, or if the pregnancy is the result of rape or incest. Abortion is deeply morally sanctioned, and it often takes place in unsafe conditions. In 2012, 105,000 abortions were performed, most of which were unsafe, and 43% of women presented for complications that required treatment. The authors argue that in Burkinabe society, abortion is the 'object of condemnation' and is negatively

sanctioned, alongside extra-marital sexual activity, young people's sexual activity (including contraceptive use) – especially girls and particularly unmarried girls. Abortion is viewed as a particularly dangerous social phenomenon alongside homosexuality and prostitution.

The study provides a detailed account of how international practice and public health influenced the politics of abortion, post-abortion care (PAC) and women's rights in Burkina. It argues that since the 1990s, Burkina Faso's primary response to the problem of unsafe abortion has been that of adopting a public health harm-reduction approach focused on providing PAC, rather than focusing on abortion as a woman's right. This originated within Burkina from a small group of public health clinicians, who opposed induced abortion on religious grounds, but viewed it as a public health concern that needed to be

addressed. Therefore, they chose to focus on PAC as a life-saving procedure to be delivered for medical ethical reasons. This was in line with the public health approach adopted by feminist and international safe motherhood advocacy groups negotiating with conservative forces in various fora, such as the International Conference on Population and Development (ICPD).

For Burkinabe and international actors working on access to safe abortion, this was a strategic, non-confrontational approach that allowed for a progressive opening up of the provision of abortion services without having to deal with the politics of abortion rights. However, the authors argue, this approach continues to limit their ability to confront the underlying moral, gender and social norms as well as the legal politics that maintain abortion as an unsafe practice in Burkina Faso.

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### 31. Daire, J., Kloster, M.O. and Storeng, K.T. (2018) 'Political priority for abortion law reform in Malawi: transnational and national influences' *Health and Human Rights Journal* 20(1): 225–236.
Available at: https://cdn2.sph.harvard.edu/wp-content/uploads/sites/125/2018/06/Daire.pdf

This article was written in 2015, at a time when Malawi's Special Law Commission on the Review of the Law on Abortion released a draft Termination of Pregnancy Bill that, if approved by Parliament, would have liberalised Malawi's restrictive abortion law. This policy review conducted discourse analysis of media and policy documents and 56 qualitative key informant interviews to track the changing popular and political discourse and landscape on abortion. It shows how various stakeholders – from national and international NGOs, to expert medical practitioners and groups doing local public advocacy around maternal mortality due to unsafe abortion – worked together to set up the Coalition for Prevention of Unsafe Abortion (COPUA) in 2010. The coalition helped frame the abortion debate in Malawi as a public health issue – a strategy that was used elsewhere globally – and demonstrated that 18% of cases of maternal mortality in the country (at a ratio of 846 per

100,000 live births) were due to unsafe abortion.

Despite the strong work of COPUA and the support garnered among professional and civil society organisations, the Termination of Pregnancy Bill was strongly rejected by religious organisations (especially the Catholic church but also Evangelical and Muslim religious bodies). In a series of articles, representatives of the religious establishment portrayed access to abortion and reproductive rights as a Western, anti-Malawian cultural imperialism project to attack African culture and values.

The authors argue that promoting access to safe abortion care therefore requires a multi-pronged strategy. This includes value clarification activities, policy engagement, and countering misinformation that stigmatises women and providers and supports negative attitudes and obstructionist behaviours. There is also a need to strengthen the health care system and develop standards for comprehensive abortion care.

## 32. Barot, S. (2017) *When antiabortion ideology turns into foreign policy: how the global gag rule erodes health, ethics and democracy*. Guttmacher Policy Review 20.

Available at: www.guttmacher.org/gpr/2017/06/when-antiabortion-ideology-turns-foreign-policy-how-global-gag-rule-erodes-health-ethics

The global gag rule (the Mexico City policy) halts US funding towards non-US organisations implementing family planning programmes that include abortion information, counselling, referral and service provision. First enacted in 1984, it affects non-US organisations providing such services or advocating for liberalised abortion laws. Expanded under the Reagan and Bush administrations, the Trump administration has pushed it forward, renaming it as 'Protecting life in global health assistance' – de facto extending the Mexico City policy to global health assistance furnished by all US departments or agencies. It applies to all NGOs, including foreign NGOs, which receive a sub-award from a US-based NGO. This policy is affecting millions of women globally as well as important US health programmes on HIV/AIDS, Zika, maternal and child health, malaria, nutrition, and integrated health programmes that include information or services related to abortion.

The author argues that, contrary to what its proponents believe, the global gag rule does not stop women from getting abortions. By banning safe and trained providers, it achieves the opposite: it affects women's ability to receive contraceptive services, which could lead to an unwanted pregnancy and an unsafe abortion. It violates fundamental principles of medical ethics by allowing providers to withhold information about a patient's reproductive health options; it also bars providers from offering abortion referrals. Similarly, it contravenes WHO technical and policy guidelines on the provision of safe abortion care as well as the World Medical Association principle that allows providers to consciously object to information and service provision, provided they refer women to a qualified colleague. It also undermines democratic values by preventing national organisations from lobbying to their own governments for more progressive abortion legislation and policies or from informing the public about safe abortion services, while allowing anti-abortion advocates to dominate the public debate. The author defines the global gag rule as 'the logical extension of an extremist, ideologically driven agenda' (p 76–77) that stigmatises women's legitimate reproductive health needs for abortion and separates it out from other 'acceptable' needs; for this reason, the author argues, it must be repealed.

## 33. Finer, L. and Fine, J.B. (2013) 'Abortion law around the world: progress and pushback' *American Journal of Public Health* 103(4): 585–589.

Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3673257/pdf/AJPH.2012.301197.pdf

This editorial article summarises recent trends in abortion legislation globally. It shows that major progress has been made, with abortion restrictions being progressively lifted in nearly all countries in the global North and central and eastern Asia (apart from Poland, Malta, and the Republic of Korea). However, countries in the global South have maintained strict or very strict legislation, criminalising abortion. The article argues that despite advocacy achievements in many countries, legal strategies have emerged to introduce new types of barriers that impede women's access to legal abortion. These are ascribed to a global, coordinated, anti-abortion movement, led by conservative, religious forces as well as domestic political diatribes used for political gains. One such approach being used in the US and in Central and Eastern European countries (e.g. Poland), for example, involves introducing procedural barriers in abortion

legislation that hinder access to abortion services: mandatory and biased counselling requirements, increased waiting periods, third-party consent and notification requirements (especially for minors), limitations on the range of abortion options (especially medical abortion, including specific bans on misoprostol), and limitations on abortion funding. Other tactics include unregulated conscientious objection of health care providers but also nationalist stances, whereby forcing women to carry pregnancies to term would reverse trends in demographic decline.

The authors detail the public health consequences of adopting legal restrictions and criminalisation of abortion, and explain how – irrespective of legal status of the practice – women who want to terminate a pregnancy will continue to do so, albeit in unsafe circumstances, which will increase maternal mortality and morbidity. They also argue that opponents of liberal abortion laws tend to refute the scientific evidence on the grounds of questionable and debunked evidence 'to motivate ideology-driven agendas' (p 587). As an example, the authors cite the US, where some states have introduced mandatory counselling on the supposed negative mental health consequences of abortion or a false link between abortion and increased risk of breast cancer. The authors conclude by calling for continued advocacy based on clear scientific evidence as well as the respect for basic human rights guarantees, and for the global SRH community to assert these strong grounds in the face of growing attack.

## 34. Hessini, L. (2007) 'Abortion and Islam: policies and practice in the Middle East and North Africa' *Reproductive Health Matters* 15(29): 75–84.
Available at: www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2806%2929279-6?needAccess=true

The Middle East and North Africa (MENA) region is extremely diverse in terms of health and human development indicators, political systems, women's rights, and interpretations of Islam. This article analyses the legal, social, religious and medical factors that inform access to safe abortion in 21 Muslim countries in the region. It uses data from academic literature, articles from national (mostly Egyptian and Moroccan) newspapers and key informant interviews with health professionals and women's rights organisations. The article provides a quick outline of the key texts and schools of thought that form Islamic jurisprudence as well as an in-depth review of abortion laws and policies across the different countries.

It finds that overall, interpretations of the scriptures on family planning and abortion have a long history in Islam, whereby abortion was allowed for a justifiable reason 'if pregnancies ended before ensoulment of the foetus, described as occurring between 40, 90 or 120 days after conception, depending on the school of thought' (p 76). Thus, Islamic scriptures explain that life begins at ensoulment and specific Qur'anic verses describe the evolution of the foetus until ensoulment. At the time the article was written, across the region, family planning was generally encouraged (within marriage). Interpretations on the permissibility of abortion were based on gestational age, risks to the life of the mother (which takes precedence to that of the foetus until ensoulment), and cases of rape. In this latter case (rape), prominent religious leaders have also issued specific fatāwa.[4] The author argues that although these opinions have stimulated important religious debates about abortion, male religious scholars are mainly concerned with protecting women's marriageability rather than their SRH rights.

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4    A fatwa (pl. fatāwa) is a non-binding religious guidance issued by a prominent Islamic scholar

The article describes the specific legal provisions in restrictive, somewhat restrictive and liberal settings, the abortion and post-abortion care service delivery environment as well as abortion in cases of foetal impairment due to consanguineous marriage. It then gives a brief analysis of women's experiences of abortion and linkages to suicide rates, especially among unmarried young women, noting that there are few studies on this. It concludes by re-stating the great diversity in Muslim religious discourse and practices around abortion across the MENA region, and advocates for challenges to conservative and restrictive religious interpretations that put women's lives at risk.

## 35. Coates, A.L., Hill, P.S., Rushton, S. and Balen, J. (2014) 'The Holy See on sexual and reproductive health rights: conservative in position, dynamic in response' *Reproductive Health Matters* 22(44): 114–124.

Available at: www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2814%2944815-8?needAccess=true

This article uses data from a meta-narrative review of the Holy See's official statements to analyse the Catholic church's discourse and political engagement at key United Nations (UN) negotiations on sexual and reproductive health and rights (SRHR), including abortion. It argues that, while maintaining a stable conservative position on SRHR for the past 20 years – from the first International Conference on Population and Development in 1994 to 2014 – the Church has adopted a dynamic approach that exploits the 'diplomatic rhetoric' (p 115) of the UN and strategic interpretations of human rights principles to justify its position. Thus, for example, it has cleverly positioned its relevance to 'the life of nations' (p 117) as a source of spirituality but also as a pragmatic force through its poverty reduction and health promotion mission worldwide. Exploiting the lack of specific definitions of what constitutes a 'family' in human rights treaties, it has used Art. 16(3) of the Universal Declaration of Human Rights (UDHR) (which states: 'we know that a man and a woman united in marriage, together with their children, form a family which is the natural and fundamental unit of society') to frame sexual life as a parental responsibility within the context of marriage and procreation.

The Holy See has adopted a similar approach when debating issues such as comprehensive sexuality education (CSE) and family planning, which should both remain firmly within the realm of the 'family' and not of the state. On family planning, the Holy See has also consistently objected to sterilisation, contraception to prevent procreation, and HIV prevention – as they limit 'the liberty and responsible behaviour of spouses but also, using scientific arguments, to counter population dynamics and fertility rate reductions' (pp 118–119). On abortion, its position is framed within the principle of the 'right to life' as expressed in the UDHR, but it stretches that definition to the unborn child, as it maintains that life begins at conception. The church has taken consistently radical positions on this subject, including against emergency contraception and abortion as a result of rape in war, and even in emergency obstetric care when abortion is needed to save the life of the mother. The authors argue that such positions are fundamentally based on the Catholic church's view on 'gender' as biological differences between men and women. But, more recently, the church has recognised that such differences exist within the social context in which women live, and has reiterated its support for women to overcome any barriers to equality but without forgetting their essential roles as 'mothers, wives and caregivers' (p 120).

The authors conclude by drawing attention to the shift in language choices the Catholic church has adopted throughout its history at the UN. Shifting from religious to secular language and

using UN terminology, it has firmly grounded its position on sexuality in the role of the traditional family, de facto excluding anything that precludes procreation (homosexuality, unwanted sex/rape, adolescent premarital sex, etc.) and denying women agency beyond their 'complementarity' to men and to their role in the family. The authors describe how, 'Skilfully, sexual and reproductive health and rights have been pitted against the rights of the family, abortion rights against the right to life, and the right to comprehensive sexuality education against the rights of parents' (p 121). They conclude that understanding this shift in rhetoric is important for organisations to pre-empt future battles in realising women's sexual and reproductive health rights.

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# Annexes

## Annex I: Stigma-related scales

This Annex outlines various scales that measure stigma at the level of the individual (Cockrill et al., 2013), provider (Håkansson et al., 2018) and community (Shellenberg et al., 2014). In particular, the Individual Level Abortion Stigma Scale (ILASS) measures three types of stigma (internalised, felt and enacted) and three types of stigma management behaviour (managing the damaged self, maintaining a good reputation, and managing a damaged reputation). Håkansson et al. (2018) used the Stigmatising Attitudes, Beliefs and Actions Scale (SABAS) and the Contraceptive Use Stigma Scale (CUSS) to measure providers' stigma towards abortion-seeking adolescents. Shellenberg et al. devised a 57-item Stigmatising Attitudes Scale which looks at stigma at the individual and community levels. These tools unpack beliefs and attitudes about abortion and contraceptive use, and can be especially useful for monitoring and evaluating stigma reduction initiatives.

### Individual Level Abortion Stigma Scale (ILASS)

Cockrill, K., Upadhyay, U., Turan, J. and Greene Foster, D. (2013) 'The stigma of having an abortion: development of a scale and characteristics of women experiencing abortion stigma' Perspectives on Sexual and Reproductive Health 45(2): 79–88 (www. guttmacher.org/journals/psrh/2013/05/stigma-having-abortion-development-scale-and-characteristics-women)

### The Stigmatising Attitudes, Beliefs and Actions Scale (SABAS) and the Contraceptive Use Stigma Scale (CUSS)

Håkansson, M., Oguttu, M., Gemzell-Danielsson, K. and Makenzius, M. (2018) 'Human rights versus societal norms: a mixed methods study among healthcare providers on social stigma related to adolescent abortion and contraceptive use in Kisumu, Kenya' BMJ Global Health 3: e000608 (www.ncbi.nlm.nih.gov/pmc/articles/PMC5841529/pdf/bmjgh-2017-000608.pdf)

### Stigmatising Attitudes Scale

Shellenberg, K.M., Hessini, L. and Levandowski, B.A. (2014) 'Developing a scale to measure stigmatizing attitudes and beliefs about women who have abortions: results from Ghana and Zambia' Women & Health 54(7): 599–616 (www.ncbi.nlm.nih.gov/pubmed/25074064)

| SABAS | |
|---|---|
| 1 | The health of a woman who has an abortion is never as good as it was before the abortion |
| 2 | A woman who has had an abortion might encourage other women to get abortions |
| 3 | Once a woman has one abortion, she will make it a habit |
| 4 | A woman who has an abortion is committing a sin |
| 5 | A woman who has an abortion brings shame to her family |
| 6 | A woman who has had an abortion brings shame to her community |
| 7 | A woman who has had an abortion cannot be trusted |
| 8 | A woman who has had an abortion is a bad mother |
| 9 | A woman who has an abortion should be treated the same as everyone else* |
| 10 | A man should not marry a woman who has had an abortion because she may not be able to bear children |
| 11 | I would tease a woman who has had an abortion so that she will be ashamed of her decision |
| 12 | I would try to disgrace a woman in my community if I found out she had had an abortion |
| 13 | I would stop being friends with someone if I found out she had had an abortion |
| 14 | A woman who has had an abortion should be prohibited from going to religious services |
| 15 | I would point my fingers at a woman who had an abortion so that other people would know what she has done |
| 16 | If a man has sex with a woman who has had an abortion, he will become infected with a disease |
| 17 | A woman who has an abortion can make other people fall ill or get sick |
| 18 | A woman who has an abortion should be isolated from other people in the community for at least 1 month after having an abortion |

| CUSS | |
|---|---|
| 19 | A young girl who uses a contraceptive method will encourage other girls to lead a promiscuous lifestyle |
| 20 | A married woman is more deserving of a contraceptive method than an unmarried woman |
| 21 | A young girl who uses a contraceptive method is promiscuous (sexually immoral, likes to have many sexual relationships) |
| 22 | A young girl cannot decide for herself whether to use a contraceptive method |
| 23 | A young girl who carries condoms is likely to have many sexual partners |
| 24 | A young girl who uses contraceptives will have problems when she decides to get pregnant |
| 25 | A young girl should not insist on using a condom; the man should decide whether to use a condom or not |

# Annex II: Indicators and tools

Dennis et al. (2017) offer an overview of key standardised indicators for quality abortion care extrapolated from an extensive review of the peer and grey literature. Ultimately, they show how quality abortion care goes beyond medical practice to include important socio-cultural indicators linked to social norms, such as non-judgemental attitudes towards patients, good communication, compassion, and emotional support provision.

Dennis, A., Blanchard, K. and Bessenaar, T. (2017) 'Identifying indicators for quality abortion care: a systematic literature review' Journal of Family Planning and Reproductive Health Care 43: 7–15 (https://srh.bmj.com/content/familyplanning/43/1/7.full.pdf)

These are two IPPF peer education tools that support educators, trainers and young people to talk about abortion and frame appropriate rights-based messages.

Gold, J., Hurley, L., Wachsmann, H. and Wilkins, R. (2015) How to talk about abortion: a guide to rights-based messaging. London: International Planned Parenthood Federation (IPPF) (www.ippf.org/sites/default/files/ippf_abortion_messaging_guide_web.pdf)

Hurley, L., Wachsmann, H. and Wilkins, R. (2016) How to educate about abortion: a guide for peer educators, teachers and trainers. London: IPPF (www.ippf.org/sites/default/files/2016-05/ippf_peereducationguide_abortion_final.pdf)

**About ALIGN**

ALIGN is a digital platform aimed at advancing understanding of gender norms by connecting a global Community of Practice committed to gender equality for adolescents and young adults. By encouraging collaboration and knowledge exchange, ALIGN aims to ensure evidence and learning on norm change informs more effective policy and practice.

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