

From intention to withdrawal: reasons Iranian women discontinued seeking illegal abortion—a qualitative study

Narges Norouzpour

Alborz University of Medical Sciences

Zahra Tayebi

Alborz University of Medical Sciences

Razieh Lotfi

`raziehlotfi@abzums.ac.ir`

Alborz University of Medical Sciences

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Abstract

Background

Decision-making following an unintended pregnancy is complex and may change over time. Although previous studies have primarily examined factors leading women to seek abortion, limited evidence exists regarding why some women discontinue seeking an illegal abortion and continue their pregnancies. This study aimed to explore the reasons Iranian women with unintended pregnancies discontinued seeking an illegal abortion.

Methods

This qualitative study employed a conventional content analysis design. Participants were recruited through purposive sampling from healthcare centers in Karaj, Iran, between April and November 2024. The sample comprised fifteen Iranian women who had initially intended to seek an illegal abortion but ultimately decided to continue their pregnancies. In-depth, semi-structured, face-to-face interviews were conducted, with an average duration of 57 minutes, until data saturation was achieved. Data were analyzed using the conventional content analysis approach described by Graneheim and Lundman, and MAXQDA 2024 software was used to facilitate data management.

Results

Three main categories emerged: support network, transformative levers, and perceived threats. Support networks included spousal or partner support, family and social network support, governmental and legal support, and academic and institutional support. Transformative levers comprised redefinition of maternal identity, hope and optimism for the future, religious and moral convictions, family background, and clinical reassurance. Perceived threats included physical health concerns and financial and legal vulnerabilities associated with illegal abortion.

Conclusions

Withdrawal from seeking an illegal abortion was shaped by the interaction of supportive relationships, changes in maternal and moral perceptions, clinical reassurance, and perceived physical, financial, and legal risks. Healthcare professionals should provide confidential, non-judgmental, and woman-centered counselling to women experiencing unintended pregnancies. Policies should also strengthen sustainable social, financial, academic, and family support rather than relying solely on legal restrictions.

Background

Abortion is a complex reproductive health issue shaped by medical, ethical, legal, social, cultural, and economic considerations [1]. Globally, approximately 73 million induced abortions occur each year, and an estimated 45% are performed under unsafe conditions [2]. Although abortion is very safe when provided using recommended methods appropriate to gestational age and by individuals with the necessary skills, barriers to timely, affordable, respectful, and non-discriminatory care may expose women to unsafe practices and preventable complications [2].

Unintended pregnancy is a major antecedent of induced abortion. Global estimates indicate that approximately 121 million unintended pregnancies occur annually, representing nearly half of all pregnancies worldwide; approximately 61% of unintended pregnancies end in abortion [3]. In Iran, unintended pregnancy remains an important reproductive health concern. A systematic review and meta-analysis and a recent cross-sectional study have reported a substantial burden of unintended pregnancy among Iranian women [4, 5]. The experience of an unintended pregnancy may be shaped by financial constraints, concerns about existing children, relationship difficulties, perceived health risks, and social expectations. These circumstances can create considerable uncertainty and distress while women consider whether to continue or terminate the pregnancy.

Decision-making following an unintended pregnancy is rarely straightforward or static. Women may initially consider abortion in response to economic hardship, relationship instability, concerns regarding their health or fetal health, perceived inability to care for another child, or fear of social consequences [6, 7]. However, an initial intention to seek abortion does not necessarily lead to abortion. During the decision-making process, women may reconsider their initial intention as a result of personal beliefs, emotional attachment to the pregnancy, support or opposition from partners and family members, financial changes, concerns about legal or health consequences, or evolving perceptions of their circumstances. Despite the importance of this transition, most available studies have focused on factors that lead women to seek abortion rather than the reasons some women subsequently discontinue seeking it.

This issue is particularly salient in Iran, where abortion is legally restricted and the broader reproductive-health policy environment has become increasingly restrictive in recent years [8]. The legal, sociocultural, and religious sensitivity surrounding abortion may intensify women's uncertainty, limit open discussion of their options, and shape how they navigate an unintended pregnancy. Recent qualitative evidence from Iran has documented that economic difficulties, marital instability, reproductive-health concerns, and cultural factors may contribute to women's consideration of unsafe abortion [7]. Nevertheless, evidence remains limited regarding why women who initially intend to seek an illegal abortion subsequently withdraw from that decision and continue the pregnancy.

Exploring this transition may provide a more nuanced understanding of women's reproductive decision-making and identify personal, relational, and contextual factors that support or constrain their choices. Such evidence may help healthcare professionals provide non-judgmental, woman-centred, and contextually appropriate support to women experiencing unintended pregnancy. Therefore, this

qualitative study aimed to explore the reasons Iranian women with unintended pregnancies discontinue seeking illegal abortion.

Methods

Research design

A qualitative research design using a conventional content analysis approach was employed to explore the subjective experiences and perspectives of women who withdrew from the decision to seek an illegal abortion. This methodological framework is well-suited for investigations where existing literature is limited and researchers aim to minimize preconceived conceptual categories [9].

The study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) [10].

Research setting and context

The study was conducted in healthcare centers in Karaj, Iran, from April, 2024, to November 2024. These centers provide comprehensive reproductive health services, and clients are registered in the Iranian Integrated Health System (SIB), which allows for the tracking of reproductive health indicators. The Iranian context is characterized by recent legislative shifts (e.g., the “Family Protection and Youth Population Law”) that have further restricted access to reproductive services, thereby increasing the complexity of abortion-related decision-making for women.

Researcher characteristics and reflexivity

To ensure rigor and minimize bias, the research team adopted a reflexive approach. The first author (a Master of Midwifery student) conducted the interviews. Two senior researchers (Ph.D. in Reproductive Health and Nursing) served as academic advisors. All authors were female, which facilitated an environment conducive to discussing sensitive reproductive topics with participants. To address reflexivity, the research team held regular debriefing sessions to discuss potential biases, personal assumptions, and the interview process. The first author practiced “bracketing”—setting aside personal viewpoints—to ensure that findings reflected participants’ perspectives rather than the researcher’s thoughts. Participants and the first author had no prior relationship, which helped maintain a professional and neutral researcher-participant dynamic.

Participants and sampling strategy

Participants were Iranian women who had experienced an unintended pregnancy and had initially decided to seek an illegal abortion, but subsequently reversed their decision. Inclusion criteria were: (1)

Iranian nationality, (2) age 18 years or older, (3) unintended pregnancy, (4) documented or self-reported history of initial intent to abort followed by a conscious decision to continue the pregnancy, and (5) ability to communicate in Persian. Women who were unable to provide informed consent or who had severe psychological conditions hindering communication were excluded.

Participants were recruited using purposive sampling. We identified potential candidates through the electronic health records of the Integrated Health System (SIB) at the selected centers and contacted them by phone to screen for eligibility. In total, 15 women were interviewed; this sample size was determined by data saturation—the point at which no new themes or subcategories emerged during data collection and analysis.

Data collection

Data were collected through in-depth, semi-structured, face-to-face interviews. Before starting, the study's purpose and the confidentiality of the data were explained, and written informed consent was obtained. Interviews were conducted in a private room within the healthcare centers to ensure privacy and comfort. With the participants' consent, all interviews were audio-recorded. The average interview length was 57 minutes.

The interview guide included open-ended questions: "Could you please describe the situation that led you to consider an abortion?" and "What prompted your decision to discontinue the pursuit of an abortion?" Probing questions such as, "Could you explain more about that?" or "What did you mean by...?" were used to encourage depth and clarity.

Data analysis

The recorded interviews were transcribed verbatim immediately after each session. Data analysis followed the conventional content analysis method outlined by Graneheim and Lundman [11]. The entire interview transcripts were treated as the unit of analysis. The analysis process involved: (1) reading transcripts repeatedly to achieve immersion, (2) identifying units of meaning (words, sentences, or paragraphs), (3) assigning initial codes, (4) grouping codes into subcategories based on similarities, and (5) abstracting these into broader categories. MAXQDA 2024 software was utilized to manage data coding and organization. To ensure the reliability of the analysis, the research team performed peer checking; the first author's coding was reviewed by the co-authors to ensure consistency and prevent researcher bias.

Techniques to enhance trustworthiness

The trustworthiness of the findings was assessed according to the criteria of credibility, dependability, confirmability, and transferability [12, 13]. Credibility was enhanced through in-depth semi-structured interviews conducted by a researcher trained in qualitative interviewing, repeated reading of the

transcripts, and the use of illustrative quotations in the Results section. All researchers read the transcripts and participated in the coding and interpretation process. They independently reviewed the data, compared their interpretations, discussed discrepancies, and reached agreement through discussion. Dependability was supported by documenting the procedures used for recruitment, data collection, transcription, coding, and category development. Confirmability was enhanced by repeatedly referring to the original transcripts during analysis and discussing researchers' interpretations and potential preconceptions. Transferability was supported by providing detailed descriptions of the study context, participants, data-collection procedures, and analytical process. Participant characteristics and quotations were reported to allow readers to assess the applicability of the findings to other contexts.

Ethical considerations

Ethical approval

for this study was obtained from the Research Ethics Committee of Alborz University of Medical Sciences, Iran (IR.ABZUMS.REC.1402.365). Before the interviews, the researcher explained the study objectives, procedures, voluntary nature of participation, and confidentiality measures to each eligible participant. Written informed consent was obtained from all participants before data collection, including consent for audio-recording the interviews. Participants were informed that they could decline to answer any question or withdraw from the study at any time without consequences for their healthcare or access to services. No identifying information was included in the transcripts or reports, and the interview recordings and transcripts were stored securely and accessed only by the research team.

Use of artificial intelligence-assisted tools

During manuscript preparation, the authors used ChatGPT (OpenAI) to assist with English-language editing, structural organization, and reference formatting. The authors critically reviewed and verified all generated content, revised the manuscript as necessary, and take full responsibility for the accuracy, integrity, and final content of the manuscript.

Results

A total of 15 Iranian women who had experienced an unintended pregnancy and initially intended to seek an illegal abortion were interviewed. All participants had subsequently withdrawn from that decision and chosen to continue their pregnancies. The sociodemographic and obstetric characteristics of the participants are presented in Table 1.

The participants were 25–44 years old. Most were aged 35–44 years (n = 10, 66.7%), whereas five participants (33.3%) were aged 25–34 years. Ten participants (66.7%) were interviewed after 20 weeks of gestation, and five (33.3%) were interviewed at or before 20 weeks. Eight participants (53.3%)

reported one or two pregnancies, while seven (46.7%) reported three or four pregnancies. Thirteen participants (86.7%) had at least one living child; two participants (13.3%) had no living children.

Educational attainment ranged from primary school to a master's degree. Eight participants (53.3%) had completed an associate, bachelor's, or master's degree. Most participants were homemakers (n = 11, 73.3%), and eight (53.3%) lived in rented housing. Regarding perceived household income, seven participants (46.7%) reported moderate income, five (33.3%) reported low income, and three (20.0%) reported high income.

Table 1
Sociodemographic and obstetric characteristics of participants (N = 15)

Variable	Category	n (%)
Age (years)	25–34	5 (33.3)
	35–44	10 (66.7)
Gestational age (weeks)	≤ 20	5 (33.3)
	> 20	10 (66.7)
Gravidity	1–2	8 (53.3)
	3–4	7 (46.7)
Number of living children	0	2 (13.3)
	1	6 (40.0)
	2–3	7 (46.7)
Educational level	Primary school	1 (6.7)
	Middle school	3 (20.0)
	High school diploma	3 (20.0)
	Associate degree	1 (6.7)
	Bachelor's degree	4 (26.7)
	Master's degree	3 (20.0)
Occupational status	Homemaker	11 (73.3)
	Public-sector employee	2 (13.3)
	Self-employed	1 (6.7)
	Student	1 (6.7)
Perceived household income	Low	5 (33.3)
	Moderate	7 (46.7)
	High	3 (20.0)
Housing tenure	Homeowner	7 (46.7)
	Tenant	8 (53.3)

Percentages are based on the total sample of 15 participants and may not sum to 100.0% because of rounding.

The qualitative content analysis resulted in three main categories: **support network**, **transformative levers**, and **perceived threats**. These main categories comprised 11 subcategories and 37 initial codes derived from the participants’ meaning units. The support network category included spousal/partner support, family and social network support, governmental and legal support, and academic and institutional support. Transformative levers encompassed redefinition of maternal identity, hope and optimism for the future, religious and moral convictions, family background, and clinical reassurance. Perceived threats comprised physical health concerns and financial and legal vulnerabilities. Table 2 presents the main categories, corresponding subcategories, and initial codes identified through the qualitative content analysis.

Table 2
Categories, subcategories, and initial codes

Main Categories	Subcategories	Initial Codes (Meaning Units)
Support network	Spousal/Partner support	Assistance with childcare
		Providing leisure time for the mother
		Physical and emotional presence
		Supporting the mother's social interactions
	Family and social network support	Understanding the pregnancy situation
		Helping with childcare and household tasks
		Fostering a positive and hopeful atmosphere
		Sharing positive experiences of large families
		Facilitating access to psychological counseling
		Financial assistance from paternal and maternal families
	Governmental and legal support	Distribution of maternity subsidy coupons (Kala-barg)
		Childbearing loans and financial incentives
		Expansion of supportive insurance for childbirth
		Increased maternity and paternity leave
		Implementation of the "Family Protection and Youth Population Law"
		Counseling services provided by the "NAFAS" center
	Academic and institutional support	Providing virtual classes for pregnant students
		Priority in married student dormitory housing
		Specific academic quotas/facilities for pregnant and lactating students and their supervisors
Transformative levers	Redefinition of maternal identity	Recalling the pleasure of having a child
		Maternal excitement triggered by hearing the fetal heartbeat
	Hope and optimism for the future	Creating a playmate for the older sibling
		Avoiding loneliness for the older child

Main Categories	Subcategories	Initial Codes (Meaning Units)
	Religious and moral convictions	Future companionship and support from children
		General hope for a better future through children
		Fear of sin and maternal guilt associated with abortion (perceived as “infanticide”)
		Trust in God (Tavakkul) for resolving pregnancy-related challenges
		Recognizing the dignity and rights of the fetus
	Family background	Positive personal experience of growing up in a large family
		Desire for a multi-child family structure
	Clinical reassurance	Favorable results from prenatal screening tests
		Medical assurance regarding uterine health and absence of adhesions
	Perceived threats	Warnings from health centers regarding abortion complications
		Awareness of irreversible physical damage from illegal abortion
		Physicians’ refusal to perform or facilitate the abortion
		Media influence (TV programs) on raising awareness about abortion crises
	Financial and legal vulnerabilities	High costs and financial difficulties in accessing/affording clandestine abortion services

Support network

The support network category referred to the emotional, practical, social, financial, and institutional resources that enhanced women’s perceived ability to manage pregnancy and childcare responsibilities. Analysis of the data yielded four subcategories: **spousal/partner support, family and social network support, governmental and legal support, and academic and institutional support**. These forms of support reduced the psychological and practical pressures associated with unintended pregnancy and contributed to women’s reconsideration of their initial intention to seek abortion.

Spousal/partner support

Spousal support emerged as one of the most prominent factors influencing women’s decision to continue their pregnancies. Participants emphasized that their partners’ attention to their emotional and psychological well-being, empathy toward their concerns, respect for their autonomy in decision-making,

and practical involvement in household and childcare responsibilities created a sense of security and emotional reassurance. Such support transformed pregnancy from an experience marked by pressure and isolation into a more manageable situation, thereby strengthening women's motivation to continue the pregnancy.

Some participants described their partners' positive attitudes toward continuing the pregnancy and toward the spacing of children as important in reducing their uncertainty. As participant 2 explained:

"My husband supported me emotionally. He believed that this age gap would be good and sensible for our children. He thought that the next child should be born before our first child starts school so that they could be better playmates." (Participant 2)

Respect for women's autonomy and the absence of coercion to terminate the pregnancy were also identified as important dimensions of partner support. Participant 4 stated:

"From the beginning, my husband left the decision to me and respected whatever I decided. If he had firmly insisted that I should have an abortion, I would not have been able to prevent it." (Participant 4)

In addition to emotional support and shared decision-making, practical participation in household tasks, caring for the first child, and accompanying women to prenatal appointments contributed to participants' sense of partnership and reassurance. Participant 15 noted:

"My husband believes that the child belongs to both of us, and that he has a responsibility to help me even during pregnancy. He not only helped with household tasks, but also made time to accompany me for ultrasounds and pregnancy tests." (Participant 15)

For some women, their partners' affirmation of the value of childbearing and commitment to assist with caring for the first child reduced concerns about balancing pregnancy with education and other personal roles. Participant 14 explained:

"When my test result was positive, my husband was happy. He said that having a child was even more valuable than my academic degree, and he promised to help care for our first child so that I could have more time to rest." (Participant 14)

Overall, spousal support—expressed through emotional empathy, respect for women's decisions, positive attitudes toward childbearing, and tangible participation in family responsibilities—reduced women's sense of helplessness in facing an unintended pregnancy and facilitated reconsideration of their decision to seek abortion.

Family and close friends' support

Support from family members and close friends has historically been considered an important factor in strengthening motivation for childbearing. According to several participants in the present study, access to supportive resources—particularly assistance with childcare—and the presence of a supportive

network of family members or close friends reduced their uncertainty about continuing the pregnancy. Encouragement from significant others to maintain the pregnancy and their support for the couple's decision increased their motivation and intention to continue the pregnancy and have a child.

Some participants described the emotional support and ongoing concern expressed by family members, particularly sisters, as influential in moving away from their initial intention to seek abortion. Participant 3 stated:

"I received a great deal of support from my own family, especially my sisters. They constantly made sure that I would not regret my decision or think about abortion." (Participant 3)

In addition, advice from friends who had previously experienced abortion influenced some women's reconsideration of their decisions. Participant 12 explained:

"When I told my friends that I intended to have an abortion, two of them who had previously experienced abortion told me that I would definitely regret it and that guilt would not leave me alone. Because they insisted, I changed my mind." (Participant 12)

Governmental and organizational support

Governmental and organizational support, including childbearing-related financial benefits and employment-related support for mothers, was identified as a factor that strengthened some participants' decisions to continue their pregnancies. Participants reported that access to benefits such as childbearing loans, extended maternity leave, and workplace accommodations for mothers reduced some of their financial and occupational concerns and made pregnancy continuation more feasible.

Some women referred to financial benefits received after childbirth and their role in alleviating economic pressures. However, they considered these forms of support helpful but insufficient. Participant 11 stated:

"Some of my husband's colleagues received benefits from the government, such as car loans, after having their third or fourth child. Their maternity leave had also been extended. After the birth of my third child, I also received a childbearing loan. In my opinion, government support in this area is good, but it is not sufficient." (Participant 11)

In addition to financial support, employment-related and legal accommodations for mothers were perceived as influential in strengthening women's motivation to continue their pregnancies. Participant 12 explained:

"Because, under the new law, maternity leave had been extended to nine months, and hourly leave for mothers of children under six years of age was implemented in my workplace, I became more motivated to keep the baby." (Participant 12)

Overall, governmental and organizational support contributed to some women's decisions to continue pregnancy and withdraw from seeking abortion by partially reducing financial concerns and facilitating the reconciliation of motherhood with employment responsibilities.

Support from academic institutions

Support from academic institutions, particularly encouragement from faculty members and flexibility in educational arrangements, was another factor that reduced some participants' concerns about continuing their pregnancies. For students who experienced pregnancy while studying, concerns about academic progress, class attendance, and completion of practical requirements could influence their decision-making. In this context, faculty support and flexible participation in educational activities made it more feasible for them to continue the pregnancy.

Participant 14 explained that after learning about her pregnancy during her studies, she was concerned about the potential impact on her academic progress. However, her supervisor's support and coordination with other faculty members reduced her concerns and helped her continue the pregnancy:

"When I found out that I was pregnant during my studies, I became very anxious and worried about my academic progress. Therefore, I consulted my supervisor. She strongly encouraged me to continue the pregnancy and told me not to worry about my studies or university. She even spoke with my other professors, and I attended many of the in-person classes virtually. As a result, I was able to spend more time with my first child and only attended the internship and practical sessions held at health centers and hospitals. Many of my concerns were reduced." (Participant 14)

Overall, faculty members' emotional and educational support, coordination with other instructors, and flexibility in class attendance helped reduce academic concerns among pregnant students and strengthened their decision to continue the pregnancy.

Transformative Levers

During the data analysis, several conceptual triggers emerged that functioned as psychological and cognitive turning points, prompting participants to reconsider and ultimately withdraw from seeking an illegal abortion. These factors encouraged participants to pause, reflect, and re-evaluate their decisions. This main category comprises five subcategories:

Strengthening Maternal Attachment

Direct sensory awareness of fetal life and the re-activation of maternal affection served as strong emotional deterrents against finalizing the abortion decision. Concrete indicators of fetal vitality (such as hearing the embryonic heartbeat) or reflections on past positive parenting experiences fostered feelings of moral responsibility and emotional attachment.

Participant 2 highlighted this turning point:

“When I heard the fetal heartbeat, I regretted my intention to abort and decided to continue the pregnancy.”
(Participant 2)

Likewise, witnessing the growth of existing children reinforced participants’ willingness to endure the hardships of pregnancy:

“When I look at my daughter’s laughter, I realize that enduring the difficulties of pregnancy is worth preserving it.” (Participant 9)

“My mother always said that each pregnancy is unique, which helps a person become more patient. Given that I was already a mother, whenever I thought about the fetus inside me, I loved it just like my other child and felt obligated to protect it.” (Participant 14)

Hope for the Future and Perceived Value of Children

A positive perception of a child’s long-term role in fostering family vitality, emotional well-being, and providing companionship in older age acted as a key motivator. Additionally, parents recognized the importance of sibling companionship in securing a happier and more supportive future for their existing children.

Participant 7 noted:

“People around me kept saying that as you age and the children grow up, you realize what a great blessing it is to have children. It fills your loneliness, and they become the closest and most supportive companions to their parents.” (Participant 7)

Participant 8 reflected on the meaning and fulfillment brought by children:

“When children grow up, life transforms. For instance, when I look at my daughter, I tell her that she is much better and more beautiful than anything I had ever imagined. She has made my life so much more meaningful. If someone asked me the ultimate purpose of my life, I would say my daughter. For this very reason, I wanted to maintain this pregnancy.” (Participant 8)

Religious and Spiritual Beliefs

Strong religious convictions, spiritual accountability, and perceiving the fetus as a human being endowed with the right to life played a pivotal role in discontinuing abortion attempts. Awareness of religious rulings prohibiting abortion, coupled with moral distress and fear of spiritual transgressions, decisively prevented illicit actions.

Participant 10 explained:

“At the healthcare center, I was told that abortion at any gestational age is a major sin and illegal. Therefore, out of fear of God and moral guilt, I respected divine wisdom and will, and decided to continue the pregnancy.” (Participant 10)

Family Background and Perceived Value of Siblings

Growing up in larger families and drawing on personal positive experiences of sibling support encouraged women to view the upcoming child as an essential emotional asset for their first child. This background motivated participants to prevent their current child from growing up isolated or without sibling support.

Participant 12 elaborated:

"I grew up in a family with five siblings, and my husband also has many siblings. We are both very grateful for this because we share close bonds and never feel lonely. We thought that for the sake of our first child, we should keep this pregnancy, and consequently, we abandoned the decision to abort." (Participant 12)

Clinical Reassurance and Fetal Well-being

Receiving reassuring clinical, laboratory, and sonographic results eliminated uncertainties stemming from fears of congenital anomalies or maternal health risks. Confirmation of normal fetal development and the absence of prior surgical complications (e.g., uterine rupture or adhesions after cesarean section) reinforced the decision to continue the pregnancy.

Participant 11 shared:

"When I underwent screening tests and found out the fetus was healthy, I felt relieved. I thought to myself, now that the baby is healthy, why should I risk my own health by having an abortion?" (Participant 11)

Participant 4 highlighted how normal findings justified the prior financial burden of prenatal care:

"Although I struggled to afford prenatal tests, the ultrasound, and the first-trimester screening, when all results came back completely normal, I decided against abortion so as not to risk complications or burden my family under these tough economic conditions." (Participant 4)

Participant 6 emphasized how imaging resolved anatomical concerns from previous surgeries:

"Because my previous delivery was a cesarean, I was terrified of uterine rupture and intra-abdominal adhesions in subsequent pregnancies. When the sonographer assured me that there were no adhesions, I was deeply relieved and continued the pregnancy with much greater peace of mind." (Participant 6)

Perceived threats

This category comprised codes that reflected participants' perceived risks and threats associated with abortion. Within this context, uncertainty about the consequences of abortion acted as a deterrent and led some women to abandon their initial intention to seek abortion. This main category consisted of two subcategories:

Financial concerns

High abortion costs, particularly when participants had to seek services from informal providers or unregulated settings, were an important barrier in their decision-making. For some women, the inability to pay these costs or the lack of insurance coverage prompted them to withdraw from seeking abortion.

Participant 10 stated:

"I went to several doctors to have an abortion, but they asked for very high fees. Since I did not have the money, I changed my mind about having the abortion." (Participant 10)

Participant 4 also noted the role of high costs and the absence of insurance support:

"When I realized that even health insurance would not cover the cost of an illegal abortion and that the fee was very high for me, I decided not to go through with it." (Participant 4)

Physical concerns

Fear of physical complications and possible medical consequences of abortion, including bleeding, infection, uterine injury, and even death, influenced some participants' decisions to abandon abortion. Warnings from physicians about the possible risks of the procedure heightened uncertainty and led to reconsideration.

Participant 11 explained:

"The doctor I visited to have the abortion gave me many warnings about its complications, including that I might experience bleeding or infection and that even my life could be at risk. Therefore, out of fear of possible physical problems, I decided not to have the abortion." (Participant 11)

Participant 9 added:

"My doctor told me that abortion could even cause my death." (Participant 9)

Overall, financial and physical concerns functioned as perceived threats that increased uncertainty among participants and, in some cases, led them to withdraw from seeking abortion.

Discussion

This qualitative study aimed to explore the reasons and dynamics influencing pregnant women's decisions to withdraw from seeking an illegal abortion in Iran. Our findings revealed that the decision to continue an unintended pregnancy is a complex, multi-dimensional process shaped by a dynamic interplay of interpersonal support networks, intrinsic cognitive and belief shifts (transformative levers), and structural or physical deterrents (perceived threats). These categories expand on previous literature which often frames abortion decision-making predominantly around socio-economic constraints or individual autonomy [6, 14].

The Dynamics of the Support Network

Social and interpersonal support emerged as a primary cornerstone in enabling women to withdraw from their initial decision to seek an illegal abortion. Within the Iranian cultural context, the husband's attitude toward family planning and his emotional reassurance play a decisive role. Our findings demonstrate that empathetic partners who provide emotional safety and favor family expansion significantly reduce maternal anxiety, thereby encouraging the continuation of pregnancy. This is consistent with qualitative evidence from Dolatabadi et al. [15], which highlighted that marital instability and a lack of spousal support are critical drivers toward induced abortion, whereas active paternal involvement acts as a protective factor.

Furthermore, extended family networks—particularly maternal sisters and mothers—offer a crucial safety net. This collective support system buffers the psychological pressure of an unintended pregnancy. While some international studies emphasize individual autonomy over family involvement [14], in Middle Eastern societies, family opinions and parental counseling remain highly influential in reproductive decisions.

An interesting finding in our study was the role of institutional support, specifically academic institutions. Pregnant student participants noted that academic flexibility, virtual attendance options, and supportive mentorship from university advisors significantly mitigated their fears of academic failure. This highlights the importance of institutional accommodation in supporting maternal health, suggesting that policies accommodating pregnant students can effectively reduce the perceived necessity for abortion due to educational conflicts.

In contrast, governmental support (e.g., childbearing loans, maternity leave) was perceived by participants as helpful but structurally insufficient. Following the passage of the Family Protection and Youth Population Law in 2021, the Iranian government implemented various financial incentives to boost fertility rates [16]. However, as noted by our participants, these incentives do not fully offset the long-term economic demands of child-rearing. This aligns with broader policy critiques showing that macro-level pro-natalist policies may fail to influence individual choices unless accompanied by robust, long-term economic stability and comprehensive social security [15, 16].

Although participants recognized governmental and institutional support as potentially helpful, they generally perceived such measures as insufficient to offset the long-term economic and practical demands of childrearing. Population and family-planning policies may shape reproductive decision-making by influencing the social and economic context in which families evaluate an unintended pregnancy. In Iran, the Family Protection and Youth Population Law has introduced financial, employment-related, and social measures intended to support families and encourage childbearing. However, the effectiveness of these measures is likely to depend on their effective implementation, equitable accessibility, and sustained monitoring rather than on their formal adoption alone [16].

Determinants of Change: Cognitive and Belief Shifts

The transition from considering abortion to embracing pregnancy involves profound internal transformations. A major catalyst in this process is the “redefinition of motherhood” and the development of prenatal attachment. Hearing the fetal heartbeat or observing the development of existing children often triggered immediate regret regarding the abortion decision, fostering maternal identity. Qualitative literature confirms that maternal-fetal attachment and the conceptualization of the fetus as a living individual with rights are powerful deterrents to abortion [17].

Religious and moral beliefs also acted as strong cognitive anchors. In Iran, Islamic teachings strongly condemn abortion, viewing the fetus as a divine trust and a gift from God. Fear of divine retribution (“sin”) and moral guilt were prominent themes among our participants. This is consistent with findings by Shahbazi et al. [18] and Alomair et al. [19], who identified religious values as important moral deterrents to abortion in Islamic societies.

Additionally, the role of “clinical assurance” was key. When healthcare providers confirmed the physical health of the fetus and offered empathetic counseling, women gained the confidence needed to carry the pregnancy to term. This finding highlights the ethical responsibility of healthcare professionals; non-judgmental clinical counselling can support informed and voluntary decision-making while reducing the risks associated with unsafe practices.

Furthermore, positive family backgrounds—such as having grown up in large, supportive families—shaped participants’ long-term reproductive desires. Experiences of warmth and companionship in large childhood families fostered optimism, making the prospect of raising another child more acceptable despite the unplanned nature of the pregnancy.

Perceived Threats: Legal, Financial, and Physical Deterrents

A central finding of this study is that “perceived threats” associated with illegal abortion paradoxically acted as protective factors for the continuation of pregnancy. Here, a conceptual distinction must be made between *illegal abortion* (the legal status of the procedure under domestic law) and *unsafe abortion* (defined by the World Health Organization as a procedure performed by persons lacking the necessary skills or in an environment lacking medical standards) [2].

In Iran, elective abortion is legally restricted. Under Article 56 of the Family Protection and Youth Population Law of 2021, unauthorized abortion carries severe legal penalties, including fines and imprisonment for both the pregnant woman and the provider [16, 20]. This legal framework forces the majority of elective abortions into the informal, unregulated sector.

Consequently, the “financial concerns” associated with procuring an illegal abortion emerged as a significant barrier. Due to the illegality of the procedure, black-market abortions in Iran are highly expensive and lack insurance coverage. For low-income families, the prohibitive cost of clandestine medical or surgical procedures makes abortion financially inaccessible, forcing them to reconsider and

ultimately continue the pregnancy. This cost barrier represents a structural deterrent that, while preventing the abortion, highlights the economic vulnerability of these women.

Moreover, the “physical concerns” and fear of complications associated with unsafe procedures played a major role in the participants’ decision-making. Since illegal abortions are frequently performed under unsafe conditions, women expressed intense fear of severe complications such as infertility, infection, hemorrhage, or death. According to global estimates, approximately 45% of all abortions are unsafe, with 97% of unsafe abortions occurring in developing regions, leading to high rates of maternal morbidity [2, 21]. The acute awareness of these physical risks, combined with the lack of access to safe, legal medical facilities, created a high level of perceived threat that outweighed the challenges of raising an unplanned child.

Strengths and Limitations

A key strength of this study is its qualitative approach, which allowed for a deep exploration of the lived experiences of Iranian women who decided to withdraw from seeking an abortion—a population that is hard to reach due to the legal and social stigma surrounding the topic.

However, this study has limitations. The qualitative nature and purposeful sampling from health centers in Karaj limit the generalizability of the findings to rural areas or different socio-cultural contexts within Iran. Additionally, discussing illegal abortion is highly sensitive; despite assurances of confidentiality, some participants might have exhibited social desirability bias, underreporting the strength of their initial intention to seek abortion or overemphasizing religious considerations. Finally, researching such a sensitive topic presents reflexivity challenges for the researchers, as maintaining neutrality while conducting interviews and analyzing narratives on a highly stigmatized subject requires continuous self-reflection to avoid personal bias.

Conclusions

This study demonstrates that the decision to withdraw from seeking an illegal abortion is driven by social support, maternal-fetal attachment, religious convictions, and fear of the legal, financial, and physical risks of unsafe procedures. To support women facing unintended pregnancies, policymakers should focus on strengthening social and economic safety nets rather than relying solely on legal prohibitions.

Clinically, healthcare providers—particularly obstetricians, midwives, and family counselors—should receive training in non-judgmental counseling. Offering early clinical reassurance regarding fetal health, ensuring access to mental health services, and facilitating institutional support for student mothers can help women make informed decisions, reducing the reliance on unsafe, clandestine practices and safeguarding maternal health.

Abbreviations

COREQ: Consolidated Criteria for Reporting Qualitative Research

SIB: Iranian Integrated Health System

Declarations

Ethics approval and consent to participate

This study was approved by the Research Ethics Committee of Alborz University of Medical Sciences, Iran (IR.ABZUMS.REC.1402.365). All participants received information about the purpose and procedures of the study, the voluntary nature of participation, confidentiality, and their right to withdraw at any time without consequences. Written informed consent was obtained from all participants before data collection, including consent for audio-recording the interviews. All procedures were conducted in accordance with relevant institutional and national ethical standards.

Consent for publication

Not applicable. No identifiable individual data are presented in this article.

Availability of data and materials

The qualitative datasets generated and analysed during the current study are not publicly available because they contain sensitive information that could compromise participant confidentiality. De-identified data may be available from the corresponding authors upon reasonable request and subject to approval by the relevant ethics committee and applicable confidentiality restrictions.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

NN conducted the interviews, transcribed the data, performed the initial coding and analysis, and drafted the manuscript. ZT and RL contributed to the study conceptualization and methodology, supervised data collection and analysis, reviewed the coding and category development, and critically revised the manuscript. All authors contributed to the interpretation of the findings, read and approved the final manuscript, and agreed to be accountable for all aspects of the work.

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