Table 3. Overview of 35 Included Studies

Author, Year, Geographic Setting	Sample size, Population, Study Design	Setting of Data Collection	Recruitment Strategy	Inclusion Criteria	Types of disrespect and abuse outcomes measured	Legal Context
Kilander et al., 2018, Sweden	13 women, In depth interviews	Interviews conducted 4-6 weeks after abortion at a place preferred by the woman- 8 in women's homes, 4 in a private room at the library, & 1 over Skype	Women recruited at 5 hospitals in South-east Sweden. Purposive sampling	-Swedish-speaking -Women aged 18 or older -Had an abortion	Disrespect, stigma, misinformation/lack of information, mistreatment, undignified care, humiliation, distrust, contraceptive coercion	Abortion is legal for any reason up to 18th week of pregnancy. Post-abortion contraceptive counseling is mandatory which may influence women to experience contraceptive coercion. Sweden has high rates of repeat abortions, may contribute to negative experiences women face.
Cárdenas et al., 2018, Montevideo, Uruguay	10 women, Qualitative interviews	Interviews were conducted after their 4th visit in person with trained study team members or over the phone.	Women recruited at a major public hospital after their 2nd visit. Convenience sampling	-Women attended all 4 visits to receive an abortion at the public hospital	Disrespect, stigma, mistreatment, undignified care	Uruguay decriminalized abortion before 12 weeks in 2012. A woman requesting an abortion must attend 4 visits and think over her decision for 5 days. Conscientious objection allowed in all public facilities
Mutua et al., 2018, Kenya	21 women, Qualitative interviews	Interviews were conducted in a private room in the health facility	A sub-sample of 6 of 16 public and private health facilities in 3 regions of Kenya were chosen- 5 patients in each facility purposively sampled and recruited	Hospitals had to be "high-volume" Patients were treated for postabortion care (PAC) at one of the 6 facilities	Disrespect, stigma, neglect, breaches in privacy/confidentiality, discrimination, misinformation, lack of information mistreatment, undignified care, humiliation, condescension	Abortion is illegal unless mother's life is at risk or permitted by another law. Restrictive access to abortion care, many women may have received abortions with providers but recorded as PAC. Women may be more afraid to disclose experiences during their care because of the restrictive laws.
LaRoche and Foster, 2018, Canada	41 women, Qualitative interviews	Interviews conducted over phone or Skype	Multimodal recruitment strategy, purposively sampled women in every province and territory	Women who had multiple abortions 5 years prior to the interview	Internalized and Externalized Stigma	No legal restrictions on abortion. High rate of repeat abortions, which continue to be stigmatized
Penfold et al., 2018, Western Kenya	22 women, Qualitative Interviews	Interviews conducted face-to-face in a private location convenient to women.	Systematic sampling of 5 women from each of the 6 Marie Stopes (MS) clinics. Women were selected from a previous qualitative study conducted at 9 Marie Stopes clinics and those who agreed to an interview	-Women 18 or older -Received safe abortion services at MS -Completed a questionnaire for a previous qualitative study conducted at MS	Misinformation, lack of information, mistreatment, undignified care	Due to the highly restriction abortion laws in Kenya, many women undergo unsafe abortions or access PAC at a facility for an incomplete abortion.

Brandi et al., 2018, US	31 women, Qualitative interviews	Interviews conducted in a private, non-clinical setting by a female researcher.	All women eligible were approached and if interested an interview was schedule for another date.	-Women 18 or older -Speak English -Undergoing medical or surgical abortion	Stigma, contraceptive coercion after abortion	Although legal since Roe v. Wade, each state differs on type of restrictive laws. The U.S. Supreme Court holds that a state cannot ban abortion before viability or create an undue burden on a woman seeking an abortion.
Kebede et al., 2018, Addis Ababa, Ethiopia	25 women, Qualitative interviews	Interviews conducted after women were discharged from hospital in a location of the woman's choice.	3 referral hospitals and 5 health centers in catchment areas of hospitals were chosen and healthcare staff recruited women	-Women 18-24 years old -Never been married or pregnant before -Undergone unsafe abortion leading to a complication treatment	Stigma, mistrust/distrust, lack of information	In 2006, abortion was expanded to be legal in cases of rape, incest, fetal impairment, women's health, or physically/mentally unprepared for childbirth. 50% of abortions in Ethiopia require care for unsafe abortion complications
Jayaweera et al., 2018, Nairobi, Kenya	71 women and girls, Qualitative FGDs	FGDs were held in a private location to ensure confidentiality	Participants were recruited from a local women's empowerment group. Convenience sample	-Women and girls aged 15-35 living in an informal settlement in Nairobi	Stigma, misinformation, lack of information	Abortions are highly stigmatized in Kenya and many women do not know where to access services or fear a breach in privacy when seeking PAC
Appiah-Agyekum, 2018, University of Ghana, Legon, Ghana	32 female undergraduate students, Qualitative interviews	Interviews were held in private lecture rooms, meetings rooms, or faculty offices after lecture	Random sampling of female students on campus through flyer posting. Students volunteer to be in study	-Female students -Have had an abortion	Stigma attached to persons entering or leaving the premises	Abortion is permitted only in cases of rape, incest, fetal abnormality, or woman's life is at risk. 50% of abortions are unsafe. Younger women in Ghana more likely to use medication abortion
Aiken et al., 2018, Northern Ireland	30 women, Qualitative interviews	Interviews were conducted by phone	Participants were invited through 3 organizations who have contact with women seeking abortion in Northern Ireland. Eligible women contact research team to set up interview.	-Women 18 or older -Had an abortion in the last 8 years -lived in Northern Ireland -traveled or used online telemedicine for abortion	Stigma, misinformation, lack of information, mistrust/distrust	Abortion is only permitted to preserve mother's life or to prevent damage to physical or mental health. In 2017, women could access free abortion care in England and Wales. Many women still choose to use online telemedicine, which limits their access to healthcare provider care.
Cleeve et al., 2017, Kampala, Uganda	17 women, Qualitative interviews	16 interviews were conducted in a private room at a public national referral hospital and 1 interview was conducted at the woman's home	Midwives at the hospital recruited women. Eligible women who agreed were approached by a research team member to set up an interview on another day	-Women aged 15-24 –Had an induced abortion -Reported their most recent induced abortion	Stigma, misinformation, lack of information	Abortions are permitted only to save the life of a pregnant woman. Abortions are highly restricted and stigmatized, thus most abortions are unsafe.
Gerdts et al., 2017, Cape Town, South	42 women, Quantitative face-to-face	Surveys administered via Survey Monkey by female interviewers in	Respondent-driven sampling to identify a seed to distribute	-Women aged 18-50 -Speaks English -Attempted informal	Stigma, mistreatment, undignified care, mistrust, distrust	Abortions allowed up to 12 weeks and for socioeconomic or medical reasons up to 20 weeks. After 20 weeks, 2 medical

Africa	questionnaires	a non-specified location	recruitment coupons to women they knew.	abortion in the last 5 years		professionals must approve. Abortion fairly accessible but highly stigmatized.
Grindlay et al., 2017, US	21 U.S. Servicewomen Qualitative interviews	Interviews were conducted by phone	Flyers were posted at abortion clinics near US military bases, on social media and online sites. Participants volunteered to be interviewed	- Women 18 or older -Fluent in English -had an abortion during active service in the past 2 years	Stigma, breaches in privacy/confidentiality	Military health insurance only covers abortions in cases of mother's life, rape or incest. Abortions are highly stigmatized and politicized in the US
MacFarlane et al., 2017, Istanbul, Turkey	14 women, Qualitative Interviews	Interviewers were conducted face-to-face with an interpreter in an unspecified location	Multimodal recruitment strategy using social media and local reproductive health organizations. Participants volunteered to be in study.	-Women 18 or older -Had an abortion on/after 2009 -Fluent in Turkish or English	Stigma, neglect, breaches in privacy/confidentiality, mistreatment, undignified care	Abortions are allowed up to the 10th week for any reason and up to the 20th week for fetal anomaly, rape, incest, or mother's health. Married women require spousal consent, minors require parental consent Access to medication abortion is limited
Mossie-Chekol et al., 2016, Addis Ababa, Ethiopia	424 Women, Mixed-Methods 16 in depth interviews 1 FGD with 8 participants 400 surveys	Focus groups conducted in the research team's office. Interviews and surveys were conducted in unspecified locations	High caseload health facilities were chosen based on # of women accessing abortion services the month prior. 4 public and 4 private facilities were selected. Purposive sampling Health workers helped recruit. Women in the FGDs or interviews were not in the survey	-Women receiving abortion care at one of the 8 health facilities selected	Breaches in privacy/confidentiality, misinformation/lack of information, mistrust/distrust	Most abortions in Ethiopia are unsafe and conducted outside health facilities due to poor acceptability, legal restrictions, and social stigma
Purcell et al., 2017, Scotland	1662 women, Mixed-methods 23 interviews 1662 Surveys	Self-complete surveys were returned in a mailbox. Interviews were conducted 8 weeks after abortion in a location of the woman's choice or over the phone	Women were recruited at 6 National Health Service abortion clinics across Scotland if they were undergoing repeat abortions.	-Women 16 or older -Had an abortion in the past 2 years and returning for another abortion -Able to read and speak English	Stigma, humiliation, condescension	United Kingdom allows abortions up to 23 weeks and 6 days of pregnancy. However, the UK commonly cites repeat abortions as a concern
Dennis et al., 2015, Massachusetts, US	27 women, Qualitative Interviews	Interviews were conducted over the phone	Women recruited through flyers in local organizations and on websites like Craigslist. Interested, eligible women were scheduled for a phone interview.	-Women 18 or older -Had abortion after January 2009 -live Massachusetts -Uninsured, on public insurance plan, or meet	Breaches in privacy/confidentiality protests	Low-income women and women of color in the US are disproportionately affected by abortion restrictions in the US This study aimed to look at low-income women's experiences with abortion care.

				financial criteria for public insurance		
Doran and Hornibrook, 2016, Rural New South Wales (NSW), Australia	13 women, Qualitative interviews	Interviews conducted face-to-face in an unspecified location or over the phone	Women recruited through flyers posted on local community boards, on the back of public toilet stalls, media releases, word of mouth, & women's services. Interested women volunteered	-Women 18 or older -Had an abortion in the last 15 years -Live in rural NSW -Able to converse in English	Stigma, misinformation/lack of information, protests, humiliation, condescension	Abortion highly political and stigmatized issue, with different laws in each state and territory. Providers allowed conscientious objection and negative attitudes among providers are common. Women in rural areas may face more barriers to access quality, abortion care.
Puri et al., 2015, Nepal	25 women, Qualitative interviews	Women chose their preferred place and time for the interview	Women who were denied abortion due to higher gestational age from 2 health facilities (public & NGO) in Nepal were recruited. Eligible women were invited for an interview 2 months later.	-Women ages 18-49 -Seeking abortion services -Denied abortion services due to gestational age on day of recruitment	Disrespect, stigma, misinformation/lack of information, protests, mistreatment/undignified care	Abortions were legalized in 2002 and services were established at almost all health clinics in 2004. Nepali government has implemented policies to ensure abortion access is easier however, many women still face barriers.
Heller et al., 2016, Scotland	16 women, Qualitative Interviews	Interviews were conducted over the phone 5 weeks to 6 months after the abortion	Convenience sample of women attending a rural, district general hospital were approached by nurses about interest in the study. Eligible women were contacted 3-6 weeks after abortion	-Women 18 or older -Undergoing abortion under non-medical grounds -First time at the hospital clinic	Stigma, mistreatment, undignified care	In 2008, Scottish government introduced a target that 70% of women should undergo abortion before 64 days gestation. The remote setting of this study reflect more challenges in reaching this goal
Margo et al., 2016, South Carolina, US	45 women, Qualitative Interviews	Interviews conducted in private rooms in the abortion clinics	A convenience sample of women who came in for abortions at one of the 3 clinics included in study, on days when the interviewer was on-site.	-Women 18 or older -English-speaking women -Undergoing abortion care	Disrespect, stigma, misinformation/lack of information, protests, mistreatment, undignified care	South Carolina is a southern state in the US with a range of restrictive state abortion laws that disproportionally affect women of color, rural women, and younger women. Abortion stigma is typically more prevalent in southern states.
McCallum et al., 2016, Salvador, Bahia, Brazil	11 women, 113 healthcare providers, Mixed-methods interviews and surveys	Interviews and surveys conducted after abortion in a location suggested by the women. Interviews with healthcare professionals were conducted inside hospital	Participants were selected from a larger study at a public maternity and teaching hospital in Salvador. 11 women were selected out of 39 previous interviews based on their spontaneous or induced abortions	-Women aged 15-24 -Underwent spontaneous or induced abortion -Health professionals at maternity hospital	Disrespect, verbal abuse, stigma, neglect, breaches in privacy/ confidentiality, discrimination, misinformation/lack of information, mistreatment, undignified care, humiliation, condescension	Abortion is highly restricted but very common in Brazil. Many women undergo unsafe abortions and access healthcare services for postabortion care or complications. Highly stigmatized- many women may claim an abortion as a miscarriage

Wallin-Lundell et al., 2015, Sweden	708 women, Quantitative surveys	Surveys were completed in the waiting room at the hospital clinic before women underwent an abortion procedure	All women who requested an induced abortion at one of the 6 public hospitals in Sweden were approached.	-Women requesting induced abortion -Able to read and understand Swedish	Disrespect, breaches in privacy/confidentiality, mistreatment, undignified care	Medical abortions are increasingly being performed at home in Sweden and midwives can now perform medication abortion care.
Yegon et al., 2016, Kenya	Community members in the Machakos and Trans Nzoia counties in Kenya, Qualitative 26 FGDs	FGDs were conducted in unspecified locations	Data from another study was used to randomly select 2 counties with high and low incidence of unsafe abortion. Each county was disaggregated into 3 main regions. Community members were recruited by 4 community health volunteers at social locations	-Reside in one of two selected counties in Kenya	Disrespect, verbal abuse, stigma, neglect, breaches in privacy/confidentiality, mistreatment, undignified care, mistrust/distrust	Abortions are highly restricted in Kenya. A lack of knowledge, availability, and accessibility cause many women to seek out unsafe abortions. FGDs were conducted to gain community level attitudes and beliefs around abortion.
Marlow et al., 2014, Western Kenya	Women in Busia, Bungoma and Trans Nzoia counties in Western Kenya, Qualitative FGDs	FGDs were conducted separately among unmarried women and married women in unspecified locations	Women were selected from an earlier community-based participatory research study. Women were selected based on their leadership roles in the community	-Married women (aged 24-49) -Unmarried women (younger than 20) and in school	Disrespect, stigma, misinformation, lack of information, mistreatment, undignified care	Due to abortion restrictions in Kenya, women commonly discussed unsafe methods to induce abortion like traditional herbs or metal rods.
Clyde et al., 2013, Mexico City, Mexico	Female adolescents and abortion providers, Mixed-methods FGDs, interviews, mystery client visits, surveys	Data collection was conducted at public health centers around Mexico City.	A convenience sampling strategy was used for 2 weeks to recruit all female patients leaving the health centers, who were eligible, and interested.	-Female adolescents aged 12-17 -Had an unwanted pregnancy -Abortion service providers -Clinic staff at public and NGO abortion facilities	Stigma, breaches in privacy/confidentiality, misinformation/lack of information	In 2007, Mexico City legalized abortion up to 12 weeks for any reason. This increased access for many women but regulations still require adolescents under 18 to get parental consent for any public abortion services.
Shellenberg and Tsui, 2012, US	4188 women, Quantitative surveys	Nationwide Guttmacher Institute's 2008 Abortion Patient Survey (APS)	95 participating facilities (hospitals and non-hospitals) included in the APS. Surveys given to all women receiving abortions with a 74% response rate	-Received an abortion at one of the 95 participating facilities	Stigma	Many women perceive and experience stigma related to abortion care, with certain groups more likely to face and report experiencing stigma in the US

Becker et al., 2011, Mexico City, Mexico	402 women, Quantitative surveys	Surveys were conducted at the health facility after the abortion was complete	Selected 3 of the highest volume public sector abortion sites out of 13 in Mexico City, including a general hospital, a maternity hospital, and a primary health center. Women receiving medication abortion were recruited on their follow up visit while women undergoing surgical abortion were recruited after their procedure	-Women older than 18 -Seeking a first trimester abortion	Misinformation, lack of information	Although abortion has been legalized in Mexico City, access to legal abortion is reported as highly challenging and stigmatizing for women. Most states in Mexico still outlaw abortions. Social stigma around abortion persists in Mexico
Regmi and Madison, 2010, Kathmandu, Nepal	50 women, Quantitative surveys	Surveys were conducted after women's abortion procedure at an unspecified location	Purposive sampling was used to recruit women receiving second trimester abortion services at a Maternity Hospital and Kathmandu Medical College	-Women aged 15-40 -Presented for a second-trimester abortion	Breaches in privacy/confidentiality, misinformation, lack of information, mistreatment, undignified care	Legalizing abortion in Nepal and allowing abortion services to include second trimester services has reduced MMR. However, many women are still unaware of legal abortion services or fear stigma.
Jewkes et al., 2005, Gauteng province in South Africa	46 women, Mixed- methods interviews using open & closed questions	Face-to-face questionnaire with open questions were conducted in an unspecified location	All eligible women presenting with incomplete abortions at one of 3 hospitals (2 tertiary hospitals and 1 regional hospital) in Gauteng province were included.	-Women with incomplete abortions	Verbal abuse, stigma, misinformation, lack of information, humiliation, condescension	Despite legalization of abortion up to 12 weeks in South Africa, women were still undergoing illegal and unsafe abortions. Perceived poor care and negative attitudes towards provides hinders many women
Bennett, 2001, Lombok, Eastern Indonesia	Single women 8 abortion providers, Qualitative Participant observation, FGDs, interviews, life histories & case studies	Data collection conducted as part of an ethnographic fieldwork research study.	Unspecified	-Single women aged 16-25 in Mataram, Lombok, Eastern Indonesia -Abortion providers -Older, married women who had experienced an unwanted pregnancy and abortion	Disrespect, stigma, neglect, discrimination, misinformation, lack of information, mistreatment, undignified care	Abortion is illegal in Indonesia unless the woman's life is at risk. However, abortions are very common and a variety of health providers (nurses, midwives) provide illegal, unsafe abortions. Abortions and premarital sex are socially condemned for young, unmarried women
DePineres et al., 2017, Bogota, Colombia	21 women, Qualitative interviews	Initial short interviews were conducted right after denial	2 nursing assistants and 1 psychologist approached all women denied abortions after their	-Women aged 16-24 -Denied abortion due to gestational age limits at a private	Disrespect, verbal abuse, stigma, neglect, breaches in privacy, discrimination, misinformation, lack of	In 2006, Colombia's government overturned a complete ban on abortion and decriminalized abortions for rape, incest, fetal anomaly, or woman's life at risk.

		Second interviews were conducted over the phone 2 months after the initial interview	medical visit and screened for eligibility.	non-profit clinic in Bogota -Able to speak Spanish	information, protests, mistreatment, undignified care, humiliation, condescension	Primary health facilities can provide abortions up to 15 weeks, after 15 weeks they must be performed at a higher-level facility. However, many women are denied legal abortion services or face numerous barriers to access care
Altshuler et al., 2017, California, US	20 women, Qualitative interviews	Interviews conducted face-to-face in a non-medical setting or over the phone	Women were recruited through ads on Craigslist, flyers at community colleges, & public libraries around an area with abortion clinics and birth facilities	-Women aged 18-49 –Had an abortion in the last 5 years -Had a prior birth at any time in the US -Not pregnant at time of interview	Stigma, breaches in privacy/confidentiality, protests, mistreatment, undignified care	California tends to have more liberal abortion laws and less social stigma around abortion. However, abortions are still highly politicized & stigmatized in the US
Brack et al., 2017, Bogota, Colombia	17 women, Qualitative interviews	Interviews were conducted face-to-face in private rooms at the clinics.	Women were recruited at 2 public and 2 private health clinics. The directors and psychologists of the clinics identified and recruited women	-Women 18 years of older -Had legal abortions the previous year -Verbal competence in Spanish	Disrespect, neglect, breaches in privacy/confidentiality, mistreatment, undignified care, humiliation, condescension	Although, Colombia partially decriminalized abortion in 2006 most abortions remain illegal and unsafe. Many women are denied abortion services or experience delays in access. Providers are allowed conscientious objection
Madeiro and Rufino, 2017, Brazil	78 women, Qualitative interviews	Interviews were conducted in a private room within the hospital	Women who performed illegal abortions and admitted to a public referral hospital in Teresina, Piaui, Brazil.	-Women 18 years or older -Who provided oral informed consent -Hospitalized for uterine curettage -Did not have a spontaneous abortion -All consenting women were interviewed but only interview data for women reporting inducing their abortion were transcribed	Disrespect, physical abuse, verbal abuse, stigma, neglect, humiliation/ condescension, discrimination, mistreatment/ undignified care	Abortions are highly restricted in Brazil and many women undergo unsafe, illegal abortions that result in complications. Women in this study induced an abortion outside of formal abortion sectors and had to receive postabortion care in a health facility. The stigma around abortion and the fear of mistreatment are a few of the challenges women face when accessing abortion services.

Table 4. Methodologies and Quality Assessment of Included Studies

Author, Year, Country	Methodology & Study Recruitment	Data Ascertainment	Quality Assurance Methods	Analytical Methods	Principal Findings
Appiah-Agyekum, 2018, Ghana	Qualitative Methods; Participants were recruited through postings around campus where interested students reached out to the research team. 3 weeks later eligible students were contacted for a private interview held on campus. Interviews were recorded, transcribed, and given to respondents for approval of accuracy and authenticity.	Self-reported abortion; in-depth interview in person for disrespect and abuse (D&A) outcomes	The interview guide was piloted before data collection. Transcribed interviews given to participants to sign-off on and confirm accuracy & authenticity of information.	Thematic analysis of data, followed by charting to rearrange data into themes, then mapping & interpretation were done.	Students aware of safe abortion services but chose to self-induce with medication abortions for privacy, cost, proximity, and stigma.
Aiken et al. 2018, United Kingdom	Qualitative Methods; Women were recruited through 3 local organizations that assist women who are seeking abortion. Eligible women contacted the research team. Semi-structured interviews were conducted anonymously over the phone before and after a UK policy to provide free abortion services in Great Britain for those from Northern Ireland.	Self-reported abortion; phone interview for D&A outcomes	4 pilot interviews conducted before data collection. Each interview was transcribed by 2 researchers who discussed coding and thematic analysis to gather key themes	Interviews analyzed using grounded theory to find key themes. Used Dedoose qualitative analysis software.	Women experience multiple barriers to travel to get abortions, self-induced medication abortion preferred than traveling, obstruction of medication abortion by Ireland customs causes stress, lack of knowledge and trust around healthcare providers.
Altshuler et al. 2017, US	Mixed Methods; Participants were recruited through Craigslist advertisements, community college and public library postings. An obstetrics/gynecologist-researcher interviewed participants over the phone and in-person in a non-medical setting. Participants then completed an Individual Level Abortion Stigma Scale assessment to evaluate the degree of personal stigma.	Self-reported abortion; phone interview for D&A outcomes	Interviews professionally transcribed verbatim and 2 reviewers made codebook and consulted with 3rd reviewer to develop theoretical perspectives on data.	Dedoose used for qualitative data and STATA used for quantitative data. Developed codebook and used grounded theory	Women want to be supported as decision-makers, be able to determine their degree of awareness during abortion, & have care provided discreetly and judgment-free.
Becker et al. 2011, Mexico	Quantitative Methods; Women receiving surgical abortions were recruited after their appointment was over, while women receiving medication abortion were recruited during their follow-up	Abortions determined by medical staff reporting to researchers. D&A outcomes ascertained from in-	Tested all analytical models using the valid Brant test	All survey data entered into EpiInfo and analyses on STATA. Conducted ordinal logistic regression	Patients reported a high quality of abortion care with an overall mean score of 8.8 out of 10.

Table 4. Methodologies and Quality Assessment of Included Studies					
Author, Year, Country	**Methodology & Study Recruitment**	**Data Ascertainment**	**Quality Assurance Methods**	**Analytical Methods**	**Principal Findings**
	appointment. Staff members informed all eligible women about the study and women who were interested met with the interviewer in a private space at the health site to complete the survey.	person written survey answers.		analysis	
Bennett 2001, Indonesia	Qualitative Methods; Ethnographic fieldwork with women employing a variety of methods including participant observations, FGDs, in depth interviews, life histories and case studies. 35 women did in-depth interviews of these women 15 shared life-histories and information for case studies. 8 FGDs were conducted with a total of 58 women and 7 SRH educational workshops were held after FGDs. Informal and formal participant observations of women were conducted. 8 abortion providers were also interviewed. All information was de-identified.	Self-reported abortion; D&A outcomes ascertained through in-person verbal interviews	Unspecified	Unspecified	Single women experienced poor quality abortion care due to the social stigma around premarital sex and faced D&A from providers.
Brack et al. 2018, Colombia	Qualitative Methods; Women who had an abortion in the last 12 months and showed verbal competence in Spanish were recruited through workers at the health facility clinics. Interviews were conducted face-to-face in Spanish in a private office in the clinic and lasted from 30 minutes to 2 hours.	Medical staff reported abortion patients; D&A outcomes ascertain in-person verbal interviews	A Colombian transcribed interviews to maintain cultural nuances in data.	MAXQDA used to analyze interview data. A phenomenological approach was used to focus on the experiences of each individual	Physical, emotional, financial, cultural barriers exist around receiving safe abortion services. The lack of training and conscientious objection affected the care provided
Brandi et al. 2018, US	Qualitative Methods; The research team approached eligible women after their appointment to schedule interested	Abortions identified by medical records of women in clinic. D&A	Used a validated scale to establish interview guide. Piloted interview	NVivo software was used for data analysis. Modified grounded	42% of women felt pressure to choose contraception and 26%

Table 4. Methodologies and Quality Assessment of Included Studies					
Author, Year, Country	**Methodology & Study Recruitment**	**Data Ascertainment**	**Quality Assurance Methods**	**Analytical Methods**	**Principal Findings**
	patients for an interview on another date. Semi-structured interviews were conducted in a private, non-clinical setting by a female clinical researcher. The Integrated Behavioral Model and Reproductive Autonomy Scale were used to develop the interview guide.	ascertained through in-person verbal interviews	guides, and 2 researchers coded half of the interviews to ensure high reliability	theory used to gather key themes	of those felt providers were pressuring them to choose LARC methods, Women given more time to consider contraception reported higher reproductive autonomy.
Cárdenas et al. 2018, Uruguay	Qualitative Methods; Women were recruited at a major public hospital in Montevideo, Uruguay after their second appointment. Women were invited by a nurse to participate in the study and if interested provided their contact information. 10 women were chosen by convenience sampling After their 4th appointment, interviews were conducted in person or by telephone. Among a sample of 72 health professionals, 10 completed an in-depth interview. Interviews were conducted by trained study coordinators	Abortion care identified by nurses in health facility patient is receiving care at. D&A ascertained through in-person verbal interviews and phone interviews	All codes in codebook were individually scrutinized and the entire research team developed key themes in response. In-vivo codes were also used	Dedoose used to code and analyze interview data. Thematic analysis was conducted by two researchers	Patients express satisfaction with implementation of new law in Uruguay but still face several barriers to access abortions. Stigmatizing attitudes persist among healthcare staff
Cleeve et al. 2017, Uganda	Qualitative Methods; Midwives working on the ward recruited participants. Only women who reported their most recent induced abortion were included. Interviews were conducted on a separate date and occurred in a private room at the hospital. A semi-structured interview guide was used to gather women's experience of abortion. Interviews were conducted in English or Luganda.	Self-report of induced abortion; D&A outcomes ascertained through in-person verbal interviews	Interview guide was pilot-tested before data collection. A Ugandan researcher trained in qualitative research conducted all translations of transcripts.	Thematic analysis using an inductive process was used. Data-driven analysis was used to develop themes from data	Reproductive agency for women was strongly limited by gender norms, power structures, a lack of knowledge & resources, and stigma.
Clyde et al. 2013, Mexico	Mixed-Methods; FGDs, in-depth interviews, and quantitative surveys were conducted with adolescents seeking an abortion. Quantitative surveys of abortion	Self-reported abortions or identified by medical staff. D&A ascertained through in-person	N/A	All data entered into CSPro and coded by 6 researchers. Survey data analyzed using SPSS	Consent rules need to be clarified for adolescents and providers. Adolescents

Table 4. Methodologies and Quality Assessment of Included Studies					
Author, Year, Country	**Methodology & Study Recruitment**	**Data Ascertainment**	**Quality Assurance Methods**	**Analytical Methods**	**Principal Findings**
	clinic directors and staff at public and NGO facilities and of adolescents leaving a public hospital who were in the process of seeking or had obtained a legal abortion were conducted.	verbal interviews and in-person surveys		and through an Excel matric.	need access to abortion information without required parental accompaniment and consent.
Dennis et al. 2015 US	Qualitative Methods; Participants were recruited through posted flyers on Craigslist and in community-based organizations around Massachusetts. Women were invited to contact the research team if interested, and if eligible a telephone interview was scheduled. Interview guides focused on 1) health insurance 2) paying for an abortion and 3) paying for contraceptives.	Self-reported abortion; phone interviews used to ascertain D&A outcomes	All coding was reviewed by another reviewer to ensure intercoder reliability	ATLAS software used to analyze interview data. Data discussed with research team to develop major themes	Women had access to quality abortion care, however some women said they needed better emotional support and privacy. Younger women and immigrant women faced more barriers to care than others
DePiñeres et al. 2017, Colombia	Qualitative Methods; Interviewers approached women after their medical visits to screen for eligibility and obtain consent. Interviewers were conducted right after with women for about 15 minutes. Women were also contacted 2 months after for a longer interview to find out women's experiences after being denied an abortion.	Self-reported abortion; D&A ascertained through in-person verbal interviews and phone interviews	Coding and transcripts were analyzed repeatedly and the entire team review key themes	Data analyzed using a qualitative content analysis approach. Data was analyzed using Dedoose and synthesized using Excel.	Women faced barriers to abortion services before being denied care. Many women received poor care and faced stigmatizing experiences
Doran and Hornibrook 2016, Australia	Qualitative Methods; Women were recruited through flyers on local community boards, in public restrooms, media releases, and women's services. Women interested contacted the researcher and chose to have a phone or face-to-face interview. The interview guide focus on 1) knowledge on abortion clinics 2) logistics to traveling to the clinic 3) follow up care and 4) how to be better supported when accessing an	Self-reported abortion; D&A ascertained through in-person verbal and phone interviews	Both authors used data to gather 5 key themes from data	Thematic analysis was used to analyze interview data	Women in rural areas experience many barriers to abortion access. Travel, financial, emotional, and informational barriers existed for many women

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Author, Year, Country	**Methodology & Study Recruitment**	**Data Ascertainment**	**Quality Assurance Methods**	**Analytical Methods**	**Principal Findings**
	abortion.				
Gerdts et al. 2017, South Africa	Quantitative Methods; Respondent driven sampling was used to identify participants. One woman was chosen through a referral to distribute coupons to women she knew. Women who redeemed their coupon and completed a survey received another 6 coupons to distribute to women who also had an informal abortion experience. Surveys were administered face-to-face using Survey Monkey.	Self-reported abortion; in-person verbal surveys to ascertain D&A outcomes	N/A	Stata 13 used to gather descriptive statistics	Braches in privacy and mistreatment were the main reasons women sought unsafe abortion services. Most women used other community members as main sources of information
Grindlay et al. 2017, US	Qualitative Methods; Participants were recruited through information sheets and flyers posted at abortion clinics near military bases and on military group Facebook pages. Semi-structured interviews were conducted by phone and focused on pregnancy-related and abortion care experiences during their service.	Self-reported abortion; D&A ascertained through phone interviews	2 interviewers coded each transcript to ensure intercoder reliability	Thematic analysis used with inductive and deductive codes using qualitative data analysis software Atlas	US servicewomen were concerned about breaches in privacy during abortions and underwent more invasive procedures to maintain privacy.
Heller et al. 2016, United Kingdom	Qualitative Methods; Clinic nurses through a convenience sample recruited women. Eligible women chose whether to have an interview face-to-face or over the phone. Interviews were conducted 5 weeks to 6 months after the abortion. All interviews were conducted over the phone using a flexible topic guide that addressed experiences, attitudes, and logistics around their abortion.	Medical staff identified and approached women undergoing abortion care; D&A ascertained through in-person verbal or phone interviews	Two researchers revised the coding framework after independently reviewing the codes and themes.	Thematic analysis using systematic doing was used to gather broad themes. NVivo was the data analysis software used.	Major barriers to access abortions include traveling, temporal factors, attitudes of healthcare staff, and stigma around abortion in Scotland
Jayaweera et al. 2018, Kenya	Qualitative Methods; Participants were a convenience sample recruited from a local organization that held SRH	Self-reported abortion from select participants in FGDs; D&A	Staff members not involved in developing discussion guides	Thematic analyses of focus group transcripts were done using	Several factors influenced women’s abortion experiences

Table 4. Methodologies and Quality Assessment of Included Studies

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	initiatives. 7 FGDs with 9-13 women and girls each were held in a private location to ensure privacy. Trained staff members led the FGDs through a semi-structured open-ended discussion guide. FGDs were conducted in Swahili and ranged from 40-80 minutes.	ascertained through in-person verbal FGDs	piloted the guide to ensure clarity and comprehension.	MAXQDA software.	including a lack of information, stigma, fear of mistreatment, mistrust of healthcare staff, and limited access to services.
Jewkes et al. 2005, South Africa	Mixed-Methods; The researchers interviewed all women who were eligible and consented for the study. A total of 151 women were interviewed but only 46 had induced abortions outside of designated settings. Women had to fill out closed-questions in a survey covering a variety of topics but were also asked by the interviewer to describe their experience through open questions.	Self-reported abortion; D&A outcomes through in-person verbal questionnaire	Any woman who was sad when they started bleeding was classified as miscarriage, while everyone else was classified as induced abortion.	Data entered into EpiInfo and analyzed using STATA. Open-ended questions analyzed through content analysis by 2 authors	Two-thirds of women self-induced an abortion and many of these women did this because they could not access legal abortion services. Barriers related to knowledge, privacy, fear of mistreatment prevented women from legal abortion services
Kebede et al. 2018, Ethiopia	Qualitative Methods; Recruitment occurred at 3 referral hospitals and 5 health centers where the nurse or physician treating a patient for an incomplete abortion recruited their patients. Individual, repeat interviews were conducted in Amharic and lasted 2-3 hours.	Medical staff referred women undergoing postabortion care; D&A ascertained through in-person verbal interviews	Repeat interview design chosen to explore theme and gain full understanding of women's experiences. Guides for second interviews were developed based on each woman's first interview.	Reflexive and thematic analysis used to gather themes in data.	Young, unmarried women felt their only choice was unsafe abortion services due to their affordability and their privacy. Social stigma around abortion instilled fear in many women.
Kilander et al. 2018, Sweden	Qualitative Methods; Midwives and gynecologists recruited women during their abortion counseling. Purposive sampling was used and women who were eligible and interested were contacted via email or telephone. Interviews were conducted 4-6 weeks after the abortion-8 interviews were performed in the	Medical staff who met women during abortion counseling identified abortion patients; D&A ascertained through in-person verbal interviews or web-based interview	Interviews guides piloted before data collection. Data analysis was performed independently by 3 researchers who discussed and agreed on findings and themes	Interview data analyzed using the Moustaka's modification of the Stevick-Colaizzi-Keen method to identify themes.	Women need more respectful contraceptive counseling during post-abortion care and need guidance when choosing contraception.

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	women's home, 4 were in a private location, and 1 was conducted over Skype. Interviews lasted around 50 minutes.				
LaRoche and Foster 2018, Canada	Qualitative Methods; A multimodal recruitment strategy included social media posts, clinic advertisements, and listservs were used. Interviews were conduced over the phone and averaged 60 minutes long. Interviewers focused on demographics, reproductive health history, pregnancy history, experiences accessing abortion services, and similarities and differences between multiple abortion experiences.	Self-reported abortions; D&A outcomes ascertained through phone or Skype interviews	Researchers set the timeframe to only women who had abortions in the past 5 years to minimize recall bias.	Content and thematic analysis used to identify themes. ATLAS software used to manage data.	Multiple factors influencing women's abortion including relationship status, family & friend support, finances, health, previous abortions and pregnancies. Women undergoing a repeat abortion faced more stigma than others
MacFarlane et al. 2017, Turkey	Qualitative Methods; A multimodal recruitment strategy including social media posts and outreach via reproductive health organizations was used. Interview guides focused on demographics, reproductive health history, and process of getting abortion care, and how services could be improved.	Self-reported abortions; D&A ascertained through in-person verbal interviews	Main interviewer memoed notes during and after interview to critically reflect on interview dynamics and identify themes.	Content and thematic analysis used to identify key themes. ATLAS software used to code and manage data.	Women receiving abortions in a private facility had more positive experiences. Unmarried women reported more challenges to abortion access.
Madeiro and Rufino. 2017, Brazil	Qualitative methods; Women admitted to a public referral hospital in Teresina were included if eligible and consented to the study.	Medical records review to identify abortions; D&A outcomes ascertained through in-person verbal interviews	Independent reviewers to code and review data	Interviews were read and coded by 2 independent reviewers who compared patterns and determined key themes.	A third of the women interviewed experienced maltreatment and discrimination.

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Margo et al. 2016, US	Qualitative Methods; Women were recruited through convenience sampling from all women who came in for abortions during the days researchers were on-site. The interview guide focused on knowledge around abortion services, experiences with healthcare staff, and barriers to accessing services. Interviews were conduced in a private room at the clinic and lasted 10-30 minutes.	Self-reported receiving abortion care; D&A ascertained through in-person verbal interviews	Independent review of interviewers to ensure reliability. Coding conflicts resolved through discussion.	Thematic analysis approached used. NVivo used to code and compare intercoder reliability. Process mapping used to construct women's paths to accessing abortion care.	Financial difficulties were the largest barrier to access abortion care along with transportation barriers. Women commonly experienced stress & stigma with their decision to get an abortion.
Marlow et al. 2014, Kenya	Qualitative Methods; Community leaders recruited participants. Two semi-structured focus group guides focused on community knowledge and attitudes towards abortions, methods used to induce abortion, and the need for abortion method information. FGDs were conducted in English or Swahili and translated back into English when needed.	Self-report of abortion from select participants during FGDs; D&A outcomes ascertained through in-person verbal FGDs	N/A	NVivo was used to manage all focus group data and codes. Themes were decided among all authors. Excel matrices were used to examine prevalence of each type of abortion method.	Women often sought unsafe abortions due to the stigma, legal restrictions, financial barriers, and fear of health care facilities.
McCallum et al. 2014, Brazil	Mixed- Methods; Women were contacted post-abortion but while they were still in the hospital. Interviews were conducted after they left the hospital in locations that the participants chose. Questionnaires were conducted with healthcare professionals with open questions related to abortions.	Medical staff identified women undergoing abortion care; D&A outcomes through in-person verbal interviews and questionnaires	N/A	Unspecified	Discrimination against women who have had abortions in deeply embedded within the health institution's structure and culture and not solely due to the individual healthcare provider
Mossie-Chekol et al. 2018, Ethiopia	Mixed-methods; 4 public and 4 private facilities that offer medical abortion and manual vacuum aspiration were selected. Purposive sampling was used to maximize variation and rich data. Health workers recruited participants and interviews and a FGD occurred right after	Medical staff identified women undergoing abortion care services; D&A outcomes ascertained through in-person verbal interviews and FGDs	Two experts selected the 35 items used in the surveys and pilot tested this to reach a 26-item survey.	Data entered into EpiInfo and analyzed in SPSS. Exploratory factor analysis confirmatory factor analysis using Analysis of Moment Structure	Satisfaction with abortion care consists of interpersonal relationships with provider, physical environment where care is provided, information

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	discharge. Women in the focus group or interviews were not included in the surveys. The sample size for the survey was proportionate to the number of abortions performed the previous month. All women receiving abortion services from the health facilities within data collection period were approached and asked if they would like to participate.	and in-person written surveys		software was also used. Conceptual and thematic analysis was done to analyze qualitative data	related to abortion given to patient, privacy and confidentiality, and quality of care provider.
Mutua et al. 2018, Kenya	Qualitative Methods; Purposive sampling was used to include only health facilities that dealt with high numbers of post abortion care. A sample of 6 out of the 16 facilities was included where 5 patients and 1 healthcare provider were recruited from each facility. However, only 21 patients were interviewed. Patient interviews lasted on average 21 minutes and provider interviews lasted on average 34 minutes. Women who were treated for PAC were interviewed after their appointment.	Women identified as being treated for postabortion care through medical records were interviewed; D&A outcomes ascertained through in-person verbal interviews	Reviewers listened to audio-recordings of interviews to determine quality and ensure improvement by providing feedback to interviewers.	Data analyzed deductively and inductively between two reviewers. NVivo was used to manage data.	Poorly trained providers, negative attitudes towards abortion, a lack of resources, and a lack of capacity within facilities hinder postabortion care services.
Penfold et al. 2018, Kenya	Qualitative Methods; Women who were interviewed on the day of the procedure for the pre-intervention phase of the study were invited for a second interview 3 months later. Interested respondents were systematically sampled and interviews were conduced face-to-face in a private location and lasted up to 1 hour. Interview guides focused on abortion-seeking behavior, knowledge of abortion providers, and experiences obtaining abortion.	Self-report abortion or PAC; D&A ascertained through in-person verbal interviews	2 coders reviewed the first 4 interviews to reach consensus on coding structure.	Descriptive thematic analysis using inductive and deductive coding was done.	Women reported wanting to use abortion services at clean, safe center with respectful, private providers. Many women experienced complex pathways to seeking safe abortion care.

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Purcell et al. 2017, Scotland, United Kingdom	Mixed-Methods; Recruitment was conducted by trained clinic staff who asked eligible women to conduct an anonymous self-complete questionnaire. The 31-item questionnaire was based on questions from existing sexual health surveys. Women who had undergone more than one abortion in the previous 2 years were asked to undergo an in-depth interview at a later time. Interviews were conduced up to 8 weeks after their abortion in a private location or over the phone.	Healthcare staff recruited women who had an abortion; D&A ascertained through in-person verbal or phone interviews, self-complete surveys	Integrative analysis of both strands of data done via an iterative process to draw out key synergistic contributions.	Qualitative data analyzed thematically using NVivo and findings were addressed through integrative analysis. Quantitative data analyzed using STATA to get bivariate comparisons and multinomial logistic regression	Women undergoing more than one abortion within 2 years may face certain challenges like contraceptive use, IPV, and socioeconomic barriers.
Puri et al. 2015, Nepal	Qualitative Methods; Clinic staff recruited women the day they were denied an abortion and were contacted 2 months after recruitment for an interview. Participants were a purposive sample focused on diversity. Health facility providers noted the reason women were denied services. In-depth interviews were conducted face-to-face in Nepali and translated to English. The interview guide was open-ended and focused on abortion decision-making processes, experiences with abortion denial, future plans, and advice for others wanting an abortion.	Women denied abortion services were approached by research team; D&A outcomes ascertained through in-person verbal interviews	2 independent reviewers trained in qualitative analysis coded the data to ensure reliability of codes and clarity of codebook.	Thematic analysis was used to identify key themes in data. Dedoose was the analytical software used to manage data.	Women most commonly cited financial and health reasons for seeking abortions. After women were denied abortion care, 12 decided to continue their pregnancy, 12 terminated elsewhere, and 1 self-induced using medication abortion.

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Regmi and Madison 2009, Nepal	Quantitative Methods; A purposive sampling method was used to ensure demographic diversity. Physicians helped recruit participants at their initial visit and the research team assessed eligibility at this initial approach. At the patients' second visit after their abortion was complete they received the structured questionnaire that assess satisfaction levels with their experience and overall care.	Medical records were reviewed to identify women undergoing abortion; D&A outcomes ascertained through in-person written questionnaires	N/A	Unspecified	Women expressed dissatisfaction with their care, specifically in the aspects of privacy & confidentiality, and the need for support.
Shellenberg and Tsui 2012, US	Quantitative Methods; Research staff in abortion facilities recruited patients who had undergone an abortion and if interested and eligible agreed to fill out a self-administered paper survey that was available in English and Spanish. The survey had 2 modules that measured perceived and internalized stigma, sociodemographic, reproductive health, and 3 situational variables such as how supportive the man involved in the pregnancy was in the abortion decision.	Medical records were reviewed to identify abortion patients; D&A outcomes ascertained through self-administered surveys	Design-based analyses were done to ensure accurate estimates of data.	Data was analyzed using Stata. Univariate statistics were calculated and stratified multivariate logistic regression analysis was conducted	Two-thirds of women felt they would be looked down upon if others found out about their abortion, more than half of women needed to keep their abortion a secret from family & friends.
Wallin Lundell et al. 2015, Sweden	Quantitative Methods; All women who requested an induced abortion were recruited and if eligible completed the first survey before their abortion. 2 surveys were sent to the women 3 and 6 months after the abortion. Screen questionnaire-Posttraumatic Stress Disorder (SQ-PTSD), Hospital Anxiety and Depression Scale, and the Quality from the Patient's Perspective questionnaires were used.	Medical staff identified women undergoing abortion care; D&A outcomes ascertained through in-person written surveys and mail-in surveys	Use of the validated SQ-PTSD, and QPP questionnaires and the HADS scale to ascertain data	Survey data was measured using validated HADS and QPP scales. Mean scores were calculated, classified, and compared.	16% of participants reported abortion care as deficient, 22% experienced intense pain during medical abortion. Women with PTSD/PTSS reported more negative experiences during abortion care

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Yegon et al. 2016, Kenya	Qualitative Methods; 2 counties were randomly selected and each county was disaggregated so that one focus group was conduced with unmarried men, unmarried women, married men, and married women separately. 12 FGDs occurred in Machakos county and 14 occurred in Tranz Nzoia county. FGDs focused on community attitudes towards abortion, women's experiences with abortions, and the stigma they faced during their experience. FGDs lasted around 2 and half hours.	Self-reported abortion; D&A outcomes ascertained through in-person verbal FGDs	2 researchers coded each transcript independently.	Atlas software was used to manage qualitative data. Thematic analysis was done to find key themes	Community members described various stigmatizing terms around abortion. Health providers, especially younger, unmarried women, treated women poorly.