National Institute for Health and Care Excellence

Final

Abortion care

[A] Accessibility and sustainability of abortion services

NICE guideline NG140

Evidence reviews

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Final

These evidence reviews were developed by the National Guideline Alliance hosted by the Royal College of Obstetricians and Gynaecologists

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Contents

Accessibility and sustainability of abortion services

This evidence report contains information on 2 reviews relating to the accessibility and sustainability of abortion services.

- What factors help or hinder the accessibility and sustainability of a safe abortion service?
- What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

Factors that help or hinder the accessibility and sustainability of a safe abortion service

Review question

What factors help or hinder the accessibility and sustainability of a safe abortion service?

Introduction

The aim of this review is to determine what factors help or hinder the accessibility and sustainability of a safe abortion service.

At the time of development, the title of this guideline was 'Termination of pregnancy' and this term was used throughout the guideline. In response to comments from stakeholders, the title was changed to 'Abortion care' and abortion has been used throughout. Therefore, both terms appear in this evidence report.

Summary of the protocol

See Table 1 for a summary of the population, perspective, comparison and outcome characteristics of this review.

Table 1: Summary of the protocol

Population	Termination of pregnancy services in OECD countries
Perspective	• Staff working in termination of pregnancy services in OECD countries • Women treated in termination of pregnancy services in OECD countries
Comparator	Not applicable
Outcomes	Any factors that have been reported that help or hinder the accessibility and sustainability of a safe termination of pregnancy service

OECD: Organisation for Economic Co-operation and Development

For further details see the full review protocol in appendix A.

Clinical evidence

Included studies

Only studies conducted from 2001 were considered for this review question as this is when the first UK National Strategy on Sexual Health was established. This predates any guidance from the World Health Organisation (2003).

Twenty-eight qualitative studies were included in this review (Aiken 2018a; Aiken 2018b ; Black 2015; Blanchard 2017; Cano 2016; Dawson 2017; Dennis 2015; Doran 2016; Dressler 2013; Freedman 2010; Grindlay 2013; Grindlay 2017; Heller 2016; Hulme 2015; Hulme-Chambers 2018; Jerman 2017; Kruss 2014; Kumar 2004; Kung 2018; Larsson 2016; MacFarlane 2017; Margo 2016; O'Donnell 2018; Ostrach 2014; Purcell 2014; Say 2005; White 2016; Wiebe 2008); however, data was not extracted for 5 studies (Aiken 2018a; Blanchard 2017; Dennis 2015; Heller 2016; Wiebe 2008) as data saturation had been reached.

There were 5 studies conducted in remote locations (Cano 2016; Doran 2016; Hulme-Chambers 2018; Kruss 2014; O'Donnell 2018); 1 study conducted with staff working with

women with communication difficulties (Larsson 2016) and 1 study conducted with staff in the context of fetal anomaly (Black 2015). Additionally, 3 studies reported themes that were specific to rural remote locations (Dressler 2013; Grindlay 2017; Hulme 2015), 3 studies reported themes specific to vulnerable women (Aiken 2018b; Larsson 2016; Ostrach 2014), 1 study reported themes specific to women with coexisting mental health problems (Aiken 2018b), 1 study reported themes specific to girls and younger women (Kruss 2014), and 1 study reported themes specific to women with communication difficulties (Kung 2018).

The included studies are summarised in Table 2.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review with reasons for their exclusions are provided in appendix K.

Summary of clinical studies included in the evidence review

A summary of the studies that were included in this review and the themes applied after thematic synthesis are presented in Table 2.

Table 2: Summary of included studies

Study and setting	Participants	Methods	Themes applied after thematic synthesis
Aiken 2018a	Data not extracted as data saturation had been reached		

Aiken 2018b
 	
UK
	n=519
	
	Women requesting medical abortion through Women on Web (WoW)
		Sampling: All British women requesting medical abortion through WoW
		
		Data collection: Open-ended questions on online consultation form
			• Service-level barriers:
			  ○ Long waiting times and delays
			• Financial barriers:
			  ○ Funding for people ineligible for free NHS services
			• Logistical barriers:
			  ○ Difficulty arranging time off work
			  ○ Difficulty arranging childcare
			  ○ Additional expenses and delays caused by travel arrangements
			• Personal barriers:
			  ○ Prior negative experiences
			  ○ Perceived stigma
			  ○ Comorbid medical conditions
			  ○ Threat of violence
			• Legal and policy barriers
			• Privacy and confidentiality concerns

Study and setting	Participants	Methods	Themes applied after thematic synthesis
Black 2015 Australia Fetal anomaly	n=22 Inclusion/exclusion criteria not reported	**Sampling:** Healthcare professionals from the public and private sector that referred women to abortion services, exclusively provided abortion services, or worked across the broader area of obstetrics and gynaecology **Data collection:** Interviews (structure not reported)	• Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals • Legal and policy barriers
Blanchard 2017	Data not extracted as data saturation had been reached		
Cano 2016 Canada Remote locations	n=16 English- or French-speaking women; aged at least 18 years old; abortion, while a resident of Yukon Territory, from 1st January 2005	**Sampling:** Email, study advertisements on online platforms and traditional and social media, and circulating study information through local organisations **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Long waiting times and delays ○ Difficulty navigating the healthcare system ○ Insufficient resources and hours of operation • Logistical barriers: ○ Arranging drive home can cause delays and necessitate unwanted disclosure
Dawson 2017 Australia	n=32 Inclusion/exclusion criteria not reported	**Sampling:** Purposive maximum variation sampling **Data collection:** Semi-structured interviews	• Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals • Training and education • Community prescribing and telemedicine introduce greater flexibility
Dennis 2015	Data not extracted as data saturation had been reached		
Doran 2016 Australia Remote locations	n=13 Sought access to abortion in last 15 years; living in rural New South Wales; at least 18 years of age; English-speaking	**Sampling:** Flyers displayed in public places, media releases, word of mouth and through women's services **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Long waiting times and delays ○ Difficulty navigating the healthcare system • Financial barriers: ○ Patient expenses • Logistical barriers: ○ Difficulty arranging childcare

Study and setting	Participants	Methods	Themes applied after thematic synthesis
			○ Additional expenses and delays caused by travel arrangements ○ Arranging drive home can cause delays and necessitate unwanted disclosure ○ More appointments needed for medical abortion is a barrier to choosing medical abortion • Personal barriers: ○ Perceived stigma ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals ○ Community prescribing and telemedicine introduce greater flexibility
Dressler 2013 Canada	n=20 Surgical abortion providers listed on the Pregnancy Options Service (POS)	**Sampling:** Questionnaires inviting participation in a brief interview were distributed to all surgical abortion providers in British Columbia listed on the POS **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Long waiting times and delays ○ Insufficient resources and hours of operation • Financial barriers: ○ Lack of financial input to services • Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals • Training and education
Freedman 2010 USA	n=30 Graduates from 4 obstetrics and gynaecology training programs with opt-out abortion training from 1996 to 2001	**Sampling:** Graduates contacted by director of training programs **Data collection:** Semi-structured interviews	• Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals • Legal and policy barriers
Grindlay 2013	n=40	**Sampling:** Women were invited to participate in the study at their	• Community prescribing and telemedicine

Study and setting	Participants	Methods	Themes applied after thematic synthesis
USA	Eligibility criteria for women: English-speaking' aged at least 18; choosing medical abortion; ≤63 days gestation; no contraindications to medical abortion Eligibility criteria for staff: doctor, advance practice clinician, nurse, medical assistant or clinic manager working at a Planned Parenthood clinic	initial clinic visit; clinic staff were invited to participate by a member of the research team. **Data collection:** Interviews (structure not-reported)	introduce greater flexibility
Grindlay 2017 USA	n=8 Physicians, advance practice clinicians, nurses, medical assistant/patient care coordinators, clinic managers or counsellors working at a clinic that provided medical abortion through telemedicine	**Sampling:** Planned parenthood clinics in Alaska using telemedicine to prescribe for medical abortion; recruitment strategy not reported **Data collection:** Semi-structured interviews	• Community prescribing and telemedicine introduce greater flexibility
Heller 2016	Data not extracted as data saturation had been reached		

Hulme 2015
 	
Canada
	n=72
	
	Inclusion/exclusion criteria not reported
		Sampling: purposive sampling; recruitment strategy not reported
		
		Data collection: Semi-structured interviews
			• Service-level barriers:
			  ○ Insufficient resources and hours of operation
			• Financial barriers:
			  ○ Patient expenses
			• Personal barriers:
			  ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals
			• Privacy and confidentiality concerns
			• Training and education
			• Community prescribing and telemedicine

Study and setting	Participants	Methods	Themes applied after thematic synthesis
			introduce greater flexibility
Hulme-Chambers 2018 Australia Remote locations	n=18 Women aged at least 16 years old who had an abortion at Gateway Health sexual health clinic between February 2016 and February 2017	**Sampling:** Women were provided with information about the study by a nurse at the clinic and contact details were passed to the research team if the woman agreed to participate **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Long waiting times and delays • Logistical barriers: ○ Additional expenses and delays caused by travel arrangements • Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referral
Jerman 2017 USA	n=29 Women aged at least 18 years old; travelled from outside state and/or >100 miles	**Sampling:** Eligible women were identified by clinic staff during intake and details of interested women were passed to the research team **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Difficulty navigating the healthcare system ○ Insufficient resources and hours of operation • Financial barriers: ○ Patient expenses • Logistical barriers: ○ Difficulty arranging time off work ○ Difficulty arranging childcare ○ Additional expenses and delays caused by travel arrangements • Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals • Legal and policy barriers • Privacy and confidentiality concerns
Kruss 2014 Australia Remote locations	n=11 Professionals with experience of women seeking emergency contraception, abortion or options counselling, and/or	**Sampling:** Professionals from the rural Grampians region of Victoria, Australia were recruited using snowball sampling **Data collection:** Interviews (structure not reported)	• Service-level barriers: ○ Long waiting times and delays ○ Insufficient resources and hours of operation • Financial barriers: ○ Patient expenses

Study and setting	Participants	Methods	Themes applied after thematic synthesis
	expertise in this area		• Logistical barriers: ○ Difficulty arranging childcare ○ Additional expenses and delays caused by travel arrangements ○ Teenagers more affected by logistical barriers than other women • Personal barriers: ○ Perceived stigma ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals • Privacy and confidentiality concerns • Training and education
Kumar 2004 UK	n=21 English-speaking women accessing abortion within the NHS; living within 1 of 3 inner city boroughs of London	**Sampling:** convenience sampling at the time of the abortion consultation **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Long waiting times and delays ○ Difficulty navigating the healthcare system • Personal barriers ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals
Kung 2018 UK, Colombia and Mexico	n=17 healthcare professionals (only interested in n=7 from the UK) Providers with experience applying the health exception for abortion, academic scholars with knowledge of the health exception and NGO partners focused on expanding access to abortion	**Sampling:** convenience sampling – no additional information reported **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Difficulty navigating the healthcare system • Training and education
Larsson 2016 Sweden	n=13 Inclusion/exclusion criteria not reported	**Sampling:** A contact person from each clinic was asked to suggest professionals with	• Service-level barriers

Study and setting	Participants	Methods	Themes applied after thematic synthesis
Women with communication difficulties		experience of providing abortion care **Data collection:** Semi-structured interviews	○ Insufficient resources and hours of operation • Personal barriers: ○ Threat of violence
MacFarlane 2017 Turkey	n=14 English- or Turkish-speaking women who had an abortion in Istanbul from January 1st 2009	**Sampling:** Women were recruited through social media, gender studies, reproductive health organisations and referrals **Data collection:** Semi-structured interviews	• Personal barriers: ○ Perceived stigma
Margo 2016 USA	n=45 English speaking women aged at least 18 years old	**Sampling:** Convenience sampling; interested women indicated their interest on a study form that was included in the clinic registration paperwork	• Service-level barriers: ○ Long waiting times and delays ○ Insufficient resources and hours of operation • Logistical barriers: ○ Difficulty arranging time off work ○ Additional expenses and delays caused by travel arrangements ○ Arranging drive home can cause delays and necessitate unwanted disclosure • Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals
O'Donnell 2018 USA Women living in rural counties	n=31 (only interested in n=15 who were in the process of obtaining, or had already obtained an abortion) English-speaking women aged 16-45 years old; resident in Central Appalachia counties defined as rural on the US census	**Sampling:** Stratified purposeful sampling - women were recruited from specialised and general reproductive health services and centres of commerce within rural counties **Data collection:** Semi-structured interviews	• Personal barriers: ○ Perceived stigma ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals ○ Social support

Study and setting	Participants	Methods	Themes applied after thematic synthesis

Ostrach 2014
 	
USA
	n=15
	
	Inclusion/exclusion criteria not reported
		Sampling: women approached by clinic staff to complete an optional survey and/or recruitment form for the interviews; staff were selected based on their job roles
		
		Data collection: Semi-structured interviews
			• Financial barriers:
			  ○ Patient expenses
			• Logistical barriers:
			  ○ Difficulty arranging time off work
			  ○ Difficulty arranging childcare
			  ○ Arranging drive home can cause delays and necessitate unwanted disclosure
			• Personal barriers:
			  ○ Perceived stigma
			  ○ Threat of violence
			  ○ Social support

Purcell 2014
 	
UK (Scotland)
	n=23
	
	Women at ≥16 weeks' gestation seeking abortion
	
	Exclusion: insufficient English to conduct interview; overly distressed when attending services
		Sampling: Convenience sampling; specialist nurses at 5 NHS regions provided potential participants with information about the study
		
		Data collection: Semi-structured interviews
			• Service-level barriers:
			  ○ Long waiting times and delays
			• Financial barriers:
			  ○ Patient expenses
			• Logistical barriers:
			  ○ Difficulty arranging time off work
			• Personal barriers:
			  ○ Prior negative experiences
			  ○ Perceived stigma
			  ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals
			• Privacy and confidentiality concerns
			• Training and education

Say 2005
 	
UK (Scotland)
	n=8
	
	Inclusion/exclusion criteria not reported
		Sampling: purposive sampling to represent a range of perspectives on abortion services in Scotland
		
		Data collection: Semi-structured interviews
			• Service-level barriers:
			  ○ Difficulty navigating the healthcare system
			• Financial barriers:
			  ○ Lack of financial input to services
			• Personal barriers:
			  ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals
			• Legal and policy barriers

Study and setting	Participants	Methods	Themes applied after thematic synthesis
			• Training and education
White 2016 USA	n=25 English-speaking women; aged at least 19 years old; travelling at least 30 miles one way	**Sampling:** women attending 2 clinics referred to researchers by clinic staff **Data collection:** Semi-structured interviews	• Service-level barriers: ○ Difficulty navigating the healthcare system ○ Insufficient resources and hours of operation • Financial barriers: ○ Patient expenses • Logistical barriers: ○ Difficulty arranging time off work ○ Difficulty arranging childcare ○ Arranging drive home can cause delays and necessitate unwanted disclosure • Personal barriers: ○ Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals • Privacy and confidentiality concerns
Wiebe 2008	Data not extracted as data saturation had been reached		

NGO: Non-governmental organisation; NHS: National Health Service; POS: Pregnancy Options Service; WoW: Women on Web

See the full evidence tables in appendix D for original themes applied by study authors, relevant quotes, and the themes applied after thematic synthesis. No meta-analysis was undertaken for this review so there are no forest plots in appendix E.

Quality assessment of clinical studies included in the evidence review

See the clinical evidence profiles in appendix F.

Economic evidence

Included studies

A systematic review of the economic literature was conducted but no economic studies were identified which were applicable to this review question.

A single economic search was undertaken for all topics included in the scope of this guideline. Please see supplementary material 2 for details.

Excluded studies

No full-text copies of articles were requested for this review and so there is no excluded studies list.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

Evidence statements

Theme 1: Service level barriers

Subtheme 1.1: Long waiting times and delays – mixed populations and remote locations

High quality evidence from 9 studies (n=686) conducted in Australia, Canada, the UK and the USA with women and staff reported that, normally, there were long waiting times and delays in getting GP appointments, blood tests and ultrasounds, and appointments for the abortion and decreasing waiting times was an important avenue for improving care.

Sub-theme 1.2: Difficulty navigating the healthcare system – mixed populations, remote locations and women with communication difficulties

High quality evidence from 7 studies (n=119) conducted in Australia, Canada, the UK and the USA with women and staff reported that the process to obtain an abortion is complicated and is not transparent, there is a lack of information, particularly for women in certain communities and/or women with communication difficulties, and that streamlined services, more integrated healthcare and centralised referral would improve access to abortion services.

Sub-theme 1.3: Insufficient resources and hours of operations – mixed populations, remote locations and women with communication difficulties

Moderate quality evidenced from 8 studies (n=231) conducted in Australia, Canada, Sweden and the UK with women and staff reported that that there were insufficient resources and/or appointment times available for abortion services, no routines or guidelines that allowed for extended appointments for foreign born women and that expanding services, in terms of both increased staffing and hours, would improve access to abortion services.

Theme 2: Financial barriers

Sub-theme 2.1: Funding for people ineligible for free NHS services – mixed population

Very low quality evidence from 1 study (n=519) conducted in the UK with women reported that there was insufficient funding for abortion care for women ineligible for free NHS services.

Sub-theme 2.2: Patient expenses – mixed populations and remote locations

Moderate quality evidence from 7 studies (n=188) conducted in Australia, Canada, the UK and the USA with women and staff reported that raising funds for travel and accommodation can cause difficulty accessing abortion services and cause delays while funds are raised, particularly for women living in rural locations.

Sub-theme 2.3: Lack of financial input to services – mixed populations

Very low quality evidence from 2 studies (n=28) conducted in Canada and the UK with staff reported that there is insufficient financial input and support for abortion services which affects the service that can be provided.

Theme 3: Logistical barriers

Sub-theme 3.1: Difficulty arranging time off work – mixed populations

High quality evidence from 6 studies (n=656) conducted in the UK and the USA with women reported that arranging time off work can cause delays to accessing abortion services.

Sub-theme 3.2: Difficulty arranging childcare – mixed populations and remote locations

High quality evidence from 6 studies (n=612) conducted in the UK and the USA with women and staff reported that arranging childcare can cause delays to accessing abortion services.

Sub-theme 3.3: Additional expenses and delays caused by travel arrangements – mixed populations and remote locations

High quality evidence from 6 studies (n=635) conducted in Australia, the UK and the USA with women and staff reported that long travel distances causes additional expenses and making arrangements can delay access to abortion services, and that local service provision, improved access to medical abortion and providing travel assistance would improve access to abortion services.

Sub-theme 3.4: Arranging drive home can cause delays and necessitate unwanted disclosure – mixed populations and remote locations

Moderate quality evidence from 5 studies (n=114) conducted in Australia, Canada and the USA with women reported that arranging a drive home after the abortion can cause delays and necessitate unwanted disclosure.

Sub-theme 3.5: Teenagers more affected by logistical barriers than other women – girls and younger women

Very low quality evidence from 1 study (n=11) conducted in Australia with staff reported that teenagers are more affected by logistical barriers than other women and, therefore, will experience more issues accessing abortion services.

Sub-theme 3.6: More appointments needed for medical abortion is a barrier to choosing medical abortion – remote locations

Low quality evidence from 1 study (n=13) conducted in Australia with women reported that the greater number of appointments that are needed for a medical abortion compared with a surgical abortion is a barrier to women choosing a medical abortion, which may be easier to access.

Theme 4: Personal barriers

Sub-theme 4.1: Prior negative experiences – mixed populations

Low quality evidence from 2 studies (n=542) conducted in the UK with women reported that prior negative experiences with staff and the abortion procedure itself may put women off having another abortion and/or cause delays in women seeking abortion procedures.

Sub-theme 4.2: Perceived stigma – mixed populations and remote locations

High quality evidence from 7 studies (n=610) conducted in Australia, Turkey, the UK and the USA with women and staff reported that there is a perceived stigma associated with abortions, that women fear reactions and judgments from others and that there is an anti-abortion climate.

Sub-theme 4.3: Comorbid medical conditions – coexisting mental health problems

Very low quality evidence from 1 study (n=519) conducted in the UK with women reported that severe anxiety was a barrier to seeking an abortion because of fear of leaving the house.

Sub-theme 4.4: Threat of violence – women with communication difficulties and vulnerable women

Moderate quality evidence from 3 studies (n=547) conducted in Sweden, the UK and the USA with women and staff reported that the threat of violence, controlling circumstances and cultural background that accepts honour based violence can be a barrier to seeking and accessing abortion services.

Sub-theme 4.5: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals – mixed populations, remote locations and fetal anomaly

High quality evidence from 15 studies (n=384) conducted in Australia, Canada, the UK and the USA with women and staff reported difficulty in obtaining a referral for an abortion due to negative attitudes regarding abortions and physicians personal beliefs, that physicians' personal beliefs, particularly those of senior staff, can create a barrier to delivering abortion services at a service-level and that staff refusing to participate in abortion procedures can cause delays and impact the delivery of services .

Sub-theme 4.6: Social support – mixed population and remote locations

Low quality evidence from 2 studies (n=30) conducted in the USA with women and staff reported that lack of social support is a barrier to accessing abortion services in itself and also makes it difficult to overcome other barriers. In contrast, good social support can help women to overcome barriers.

Theme 5: Legal and policy barriers – mixed populations and fetal anomaly

Very low quality evidence from 5 studies (n=608) conducted in Australia, the UK and the USA with women and staff reported that decision making by ethics committee cause delays to accessing abortion services, that Catholic health networks pose extensive restrictions on reproductive health care services provided within their properties and by their employees, that state imposed waiting periods and arbitrary gestational limits cause variable access and delays to accessing abortion services, is a barrier to accessing abortion at later gestational ages and can increase the need to travel to have an abortion, and that de-criminalising self-sourced and self-managed abortions would improve access to abortion services.

Theme 6: Privacy and confidentiality concerns – mixed populations and remote locations

High quality evidence from 6 studies (n=679) conducted in Australia, Canada, the UK and the USA with women and staff reported that women, particularly in rural locations, have concerns about seeing someone that they know personally when accessing abortion services unless

they travel some distance and that women may need to disclose their abortion to unwanted people in order to overcome logistical barriers.

Theme 7: Training and education – mixed populations and remote locations

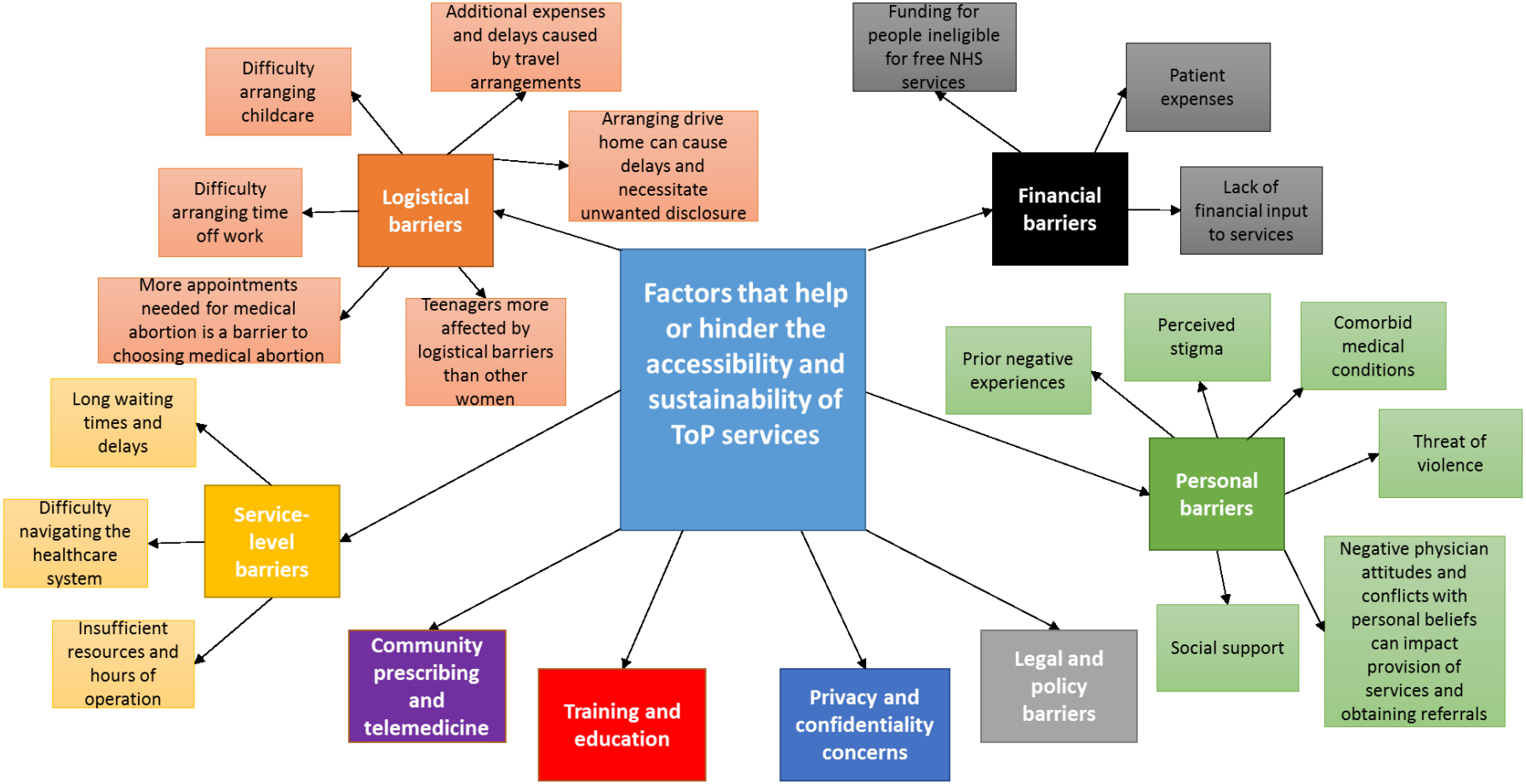
Moderate quality evidence from 7 studies (n=173) conducted in Australia, Canada and the UK with women and staff reported that general practitioners were confused or unclear regarding details of services such as routes for referral and gestational limits, that further education was needed for the public and healthcare providers and a lack of knowledge and skills among healthcare providers is a barrier to performing certain abortion procedures, that NHS hospital-based providers are losing their clinical skills due to abortions occurring mainly in independent sector clinics, that rural physicians lack professional support, the opportunity for continued professional education and appropriate replacements if they were not available to delivery services and the lack of volume of abortions in the rural setting was a deterrent to the local training of abortion providers, and reported that expanding the role of nursing staff in medical abortion would improve access but is hindered by shortfalls in the NHS training budgets.

Theme 8: Community prescribing and telemedicine introduce greater flexibility – mixed populations and remote locations

Moderate quality evidence from 5 studies (n=165) conducted in Australia, Canada and the USA with women and staff reported that community prescribing for medical abortion and telemedicine either has, or would, improve access to abortion services, increase flexibility and facilitate a more woman-centred approach to care.

See Appendix M for all relevant quotes related to each theme applied after thematic synthesis.

Figure 1: Thematic map – factors that help or hinder the accessibility and sustainability of a safe abortion service



The committee's discussion of the evidence

See The committee's discussion of the evidence in the Strategies that improve the factors that help or hinder the accessibility and sustainability of a safe abortion service section.

Strategies that improve the factors that help or hinder the accessibility and sustainability of a safe abortion service

Review question

What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

Introduction

The aim of this review is to determine the strategies that improve the factors that help or hinder the accessibility and sustainability of a safe abortion service.

At the time of development, the title of this guideline was 'Termination of pregnancy' and this term was used throughout the guideline. In response to comments from stakeholders, the title was changed to 'Abortion care' and abortion has been used throughout. Therefore, both terms appear in this evidence report.

Summary of the protocol

See Table 1 for a summary of the population, intervention, comparison and outcome (PICO) characteristics of this review.

Table 3: Summary of the protocol (PICO table)

Population	Termination of pregnancy services in OECD countries
Intervention	Setting: • Community (local) • Hospital (centralised) • Telemedicine Staffing: • Mid-level provider-led services • Physician-led services Referral: • Self-referral • GP-referral Training models: • Routine integration of termination training into core curriculum • Opt-in termination training • Opt-out termination training Comorbid medical conditions: • MDT approach • Key Worker approach Navigating the healthcare system: • Centralised booking system/single point of contact

	• Public and/or professional awareness campaign • School-based/youth group education programmes Perceived stigma: • Public and/or professional awareness campaigns • Provider and/or trainee workshops
Comparison	• Community services versus hospital services • Community services versus telemedicine • Hospital services versus telemedicine • Mid-level provider-led services versus physician led services • Self-referral versus GP referral • Routine integration of termination training into core curriculum versus termination training not integrated into core curriculum • Opt-in termination versus opt-out termination training • MDT approach versus key worker approach • MDT approach versus treatment as usual • Key worker approach versus treatment as usual • Centralised booking system/single point of contact versus no centralised booking system/single point of contact • Public and/or professional awareness campaign versus no awareness campaign • School-based/youth group education programme versus no education programme • Provider and/or trainee workshops versus no workshops
Outcome	**Critical outcomes** • Patient satisfaction • Time between referral and termination of pregnancy (accessibility) • Proportion of clinicians who are either providing, or intending to provide, termination of pregnancy services during or after completing training (sustainability) **Important outcomes** • Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman (patient satisfaction and accessibility) • Professional quality of life

GP: general practitioner; MDT: multidisciplinary team; OECD: Organisation for Economic Co-operation and Development

For further details see the full review protocol in appendix A.

Clinical evidence

Included studies

Only studies conducted from 2001 were considered for this review question as this is when the first UK National Strategy on Sexual Health was established. This predates any guidance from the World Health Organisation (2003).

Originally, only non-randomised studies with n≥100 in each arm were going to be included. However, this was reduced to n≥40 due to the paucity of evidence identified for this question. As a result of this change, 9 papers reporting 10 studies (number of participants, N=7,061)

were included in the review; 2 randomised controlled trials (RCTs; Kopp Kallner 2014; Olavarrieta 2015), 2 prospective cohort studies (Cameron 2016; Grossman 2011), 5 retrospective cohort studies (Allen 2010; Amu 2010; Cameron 2016; Harvey 2005; Steinauer 2008), and 1 before-after study (Martin 2014).

One prospective cohort study and 1 retrospective cohort study compared community services against hospital services (Cameron 2016). One prospective cohort study compared community or hospital services against telemedicine (Grossman 2011). Two RCTs and 1 retrospective cohort study compared mid-level provider-led services against physician-led services (Harvey 2005; Kopp Kallner 2014; Olavarrieta 2015). One retrospective cohort study compared self-referral against general practitioner (GP) referral (Amu 2010). Two retrospective cohort studies compared routine integration of abortion training into the core curriculum against abortion training not integrated into the core curriculum (Allen 2010; Steinauer 2008). Two retrospective cohort studies compared opt-in abortion training against opt-out abortion training (Allen 2010; Steinauer 2008). One before-after study compared provider and/or trainee workshops against no workshops (Martin 2014). No studies compared a multidisciplinary team (MDT) approach against a key worker approach or treatment as usual; a key worker approach against treatment as usual; a centralised booking system/single point of contact against no centralised booking system/single point of contact; public and/or professional awareness campaign against no awareness campaign; or a school-based/youth group education programme against no education programme. None of the included studies reported subgroup data for any of the subgroups of interest.

The included studies are summarised in Table 2.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review with reasons for their exclusions are provided in appendix K.

Summary of clinical studies included in the evidence review

A summary of the studies that were included in this review are presented in Table 4.

Table 4: Summary of included studies

Study and setting	Population	Intervention/ comparison	Outcomes
Allen 2010 Retrospective cohort USA	n=494 Fourth-year residents from accredited obstetrics and gynaecology residency programs in the USA	**Routine/opt-out training:** Defined as: all residents are trained to perform abortions unless they have a religious or moral objection **Elective/opt-in training:** Defined as: residents elect to receive training **Training not available**: Further details not applicable	• Intending to provide termination of pregnancy services after completing training (elective terminations)

Study and setting	Population	Intervention/ comparison	Outcomes
Amu 2010 Retrospective cohort UK (England)	n=514 Women undergoing referral for abortion at 2 district hospitals	**Self-referral:** Women who self-referred to 1 NHS general hospital via a dedicated telephone service and had surgical abortion **GP referral:** Women who were formally-referred to 1 NHS general hospital via healthcare providers (including family planning clinics and GPs); Both surgical and medical abortion were available	• Time between referral and termination of pregnancy
Cameron 2016 Retrospective cohort study for chart review of safety; prospective cohort study for satisfaction study UK (Scotland)	n=1,342 women for safety data and time between referral and assessment n=305 for satisfaction study Women aged ≥16 years old with pregnancy ≤9 weeks' gestation and no contraindications to medical abortion; lived within 40 minutes of hospital/community and had adult support at home; no cause for concern and did not require interpreter	Both services used the same centralised referral service and provided clinics on 2 days a week. The clinical lead was the same for both services and the same protocols and laboratories were used. **Hospital setting:** Royal Infirmary of Edinburgh No further information provided. **Community setting:** The Chalmers Sexual Health Centre in Edinburgh	• Patient satisfaction • Time between referral and assessment
Grossman 2011 Prospective cohort study USA	n=449 Women aged ≥18 years of age requesting medical abortion; ≤63 days gestation	**Telemedicine:** Consultation with women undertaken via video conference; physicians entered a password that remotely unlocked a drawer in front of the women containing the mifepristone and misoprostol **Face-to-face:** Consultation with women undertaken, and medication, given face-to-face	• Patient satisfaction

Study and setting	Population	Intervention/ comparison	Outcomes
Harvey 2005 Retrospective cohort study UK (Scotland)	n=236 All women undergoing medical abortion (<9 weeks' gestation; 13-17 weeks' gestation) or surgical abortion (7-13 weeks' gestation) in one hospital in Scotland	**Nurse-led clinic:** New, nurse-led clinic, led by a senior staff nurse with a certificate in family planning; 4 clinics a week, each with the capacity to see 4 women **Physician-led clinic:** No details reported	• Time between referral and assessment
Kopp Kallner 2014 RCT Sweden	n=938 Women ≥18 years old in good general health; wanted, and had no contraindications to, medical abortion; gestational age ≤63 days	In both arms, further information and the medication for abortion were given by a nurse-midwife. **Nurse-midwife:** The examination, ultrasound dating of the pregnancy and contraceptive counselling was provided by nurse-midwives **Physician:** The examination, ultrasound dating of the pregnancy and contraceptive counselling was provided by a doctor	• Patient satisfaction
Martin 2014 Before-after study USA	n=55 Any employee with direct abortion care responsibilities.	**Providers Share Workshop:** 5 sessions, each lasting 1-2 hours, over an 8-12 week period. Topics covered: 1) what abortion work means to me, 2) memorable stories, 3) abortion and identity, 4) abortion politics, and 5) strategies for self-care	• Professional quality of life
Olavarrieta 2015 RCT Mexico city	n=884 Women ≥18 years old, reporting LMP of <70 days, who wanted a medical abortion	Women were screened for eligibility by a nurse participating in the study and then were randomised to study arm and received clinical care according to treatment assignment (nurse-led or physician-led).	• Patient satisfaction
Steinauer 2008	n=2,149	No details provided about the different types	• Providing termination of pregnancy services

Study and setting	Population	Intervention/ comparison	Outcomes
Retrospective cohort study USA	All obstetrician-gynaecologists that became board certified in the USA between 1998 and 2001	of training program (routine/opt-out, elective/opt-in and not available)	after completing training

GP: general practitioner; LMP: last menstrual period; NHS: National Health Service; RCT: randomised controlled trial

See the full evidence tables in appendix D and the forest plots in appendix E.

Quality assessment of clinical studies included in the evidence review

See the clinical evidence profiles in appendix F.

Economic evidence

Included studies

A systematic review of the economic literature was conducted but no economic studies were identified which were applicable to this review question.

A single economic search was undertaken for all topics included in the scope of this guideline. Please see supplementary material 2 for details.

Excluded studies

Studies not included in this review with reasons for their exclusions are provided in appendix K.

Economic model

See economic analysis in appendix J

Evidence statements

Comparison 1. Community services versus hospital services

Critical outcomes

Patient satisfaction – overall satisfaction (10-point scale)

Non-RCT evidence did not detect a clinically important difference in patient satisfaction between the 'community services' group and the 'hospital services' group when measured continuously (1 observational study, n=297; MD=0.40 [95% CI 0.19, 0.61]; very low quality); however, there was uncertainty around the estimate. There was a higher clinically important difference in rate of women rating their overall satisfaction as 10/10 in the 'community services' group compared with the 'hospital services' group (1 observational study, n=297; RR=1.34 [95% CI 1.14, 1.58]; very low quality).

Patient satisfaction – contraceptive discussion

Non-RCT evidence showed there was no clinically important difference between the rates of women rating the contraceptive discussion as 'helpful/very helpful' (1 observational study,

n=295; RR=1.03 [95% CI 0.98, 1.08]; very low quality) or who 'did not feel under pressure to choose a particular contraceptive method' (1 observational study, n=303; RR=1.03 [95% CI 0.97, 1.09]; very low quality) in the 'community services' group and the 'hospital services' group.

Patient satisfaction – information received

Non-RCT evidence showed there was no clinically important difference between rates of women agreeing that they 'felt quite/very prepared for abortion' (1 observational study, n=299; RR=1.07 [95% CI 1.02, 1.12]; very low quality) or 'felt quite/very clear what would happen/what abortion would involve' (1 observation study, n=297; RR=1.01 [95% CI 0.99, 1.03]; very low quality) based on the information received in the 'community services' group and the 'hospital services' group.

Time between referral and assessment (days)

Non-RCT evidence showed there was no clinically important difference between the time between referral and assessment in the 'community services' group and the 'hospital services' group (1 observational study, n=1,342; MD=-1.10 [95% CI -1.45, -0.75]; very low quality).

Proportion of clinicians who are either providing, or intending to provide, termination services during or after completing training

No evidence was identified to inform this outcome.

Important outcomes

Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman

No evidence was identified to inform this outcome.

Professional quality of life

No evidence was identified to inform this outcome.

Comparison 2. Community or hospital services versus telemedicine

Critical outcomes

Patient satisfaction – overall satisfaction

Non-RCT evidence showed there was no clinically important difference between the rate of women rating overall satisfaction as 'very satisfied' (1 observational study, n=431; RR=1.07 [95% CI 1.01, 1.13]; very low quality) in the 'community or hospital services' group and the 'telemedicine' group. Non-RCT evidence did not detect a clinically important difference in the rates of women rating overall satisfaction as 'somewhat satisfied' (1 observational study, n=431; RR=0.48 [95% CI 0.23, 1.00]; very low quality), or 'somewhat or very dissatisfied' (1 observational study, n=431; RR=1.01 [95% CI 0.06, 16.11]; very low quality) between the 'community or hospital services' group and the 'telemedicine' group; however, there was uncertainty around the estimates.

Patient satisfaction – would recommend to friend

Non-RCT evidence showed there was no clinically important difference between the rate of women that would recommend a medical abortion in the clinic they attended to a friend in the 'community or hospital services' group and the 'telemedicine' group (1 observational study, n=431; RR=1.08 [95% CI 1, 1.17]; very low quality).

Patient satisfaction – information received

Non-RCT evidence showed there was no clinically important difference between the rate of women rating the information they received as 'very helpful' (1 observational study, n=431; RR=0.98 [95% CI 0.93, 1.03]; very low quality) in the 'community or hospital services' group and the 'telemedicine' group. Non-RCT evidence did not detect a clinically important difference in the rate of women rating the information they received as 'somewhat helpful or not helpful' (1 observational study, n=431; RR=1.25 [95% CI 0.62, 2.53]; very low quality) between the 'community or hospital services' group and the 'telemedicine' group; however, there was uncertainty around the estimate.

Patient satisfaction – conversation with doctor

Non-RCT evidence showed there was no clinically important difference between the rate of women rating the conversation with the doctor as 'very satisfied' (1 observational study, n=431; RR=1.01 [95% CI 0.91, 1.12]; very low quality) in the 'community or hospital services' group and the 'telemedicine' group. Non-RCT evidence did not detect a clinically important difference in the rates of women rating the conversation with the doctor as 'somewhat satisfied' (1 observational study, n=431; RR=0.96 [95% CI 0.62, 1.47]; very low quality), or 'somewhat or very dissatisfied' (1 observational study, n=431, RR=1.86 [95% CI 0.70, 4.94]; very low quality) between the 'community or hospital services' group and the 'telemedicine' group; however, there was uncertainty around the estimates.

Time between referral and termination of pregnancy

No evidence was identified to inform this outcome.

Proportion of clinicians who are either providing, or intending to provide, termination services during or after completing training

No evidence was identified to inform this outcome.

Important outcomes

Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman

No evidence was identified to inform this outcome.

Professional quality of life

No evidence was identified to inform this outcome.

Comparison 3. Mid-level provider-led services versus physician-led services

Critical outcomes

Patient satisfaction – satisfaction with provider

RCT evidence showed a higher clinically important difference in the rate of women who preferred their allocated provider in the 'mid-level provider-led services' group compared with the 'physician-led services' group (1 RCT, n=1,068; RR=16.6 [9.39, 29.36]; high quality). However, RCT evidence showed there was no clinically important difference between the rate of women rating their satisfaction with provider as 'very satisfied' (1 RCT, n=884; RR=1.04 [95% CI 0.97, 1.12]; high quality) in the 'mid-level provider-led services' group and the 'physician-led services' group. RCT evidence did not detect a clinically important difference in the rates of women rating their satisfaction with provider as 'satisfied' (1 RCT, n=884; RR=0.88 [95% CI 0.69, 1.13]; moderate quality), or 'dissatisfied' (1 RCT, n=884; RR=1.04 [95% CI 0.07, 16.52]; low quality) between the 'mid-level provider-led services' group and the 'physician-led' services group; however, there was uncertainty around the estimates.

Patient satisfaction – pain control

RCT evidence showed there was no clinically important difference between the rate of satisfaction with pain control being rated as 'did enough to control pain' (1 RCT, n=884; RR=0.99 [95% CI 0.92, 1.05]; high quality) in the 'mid-level provider-led services' group and the 'physician-led' services group. RCT evidence did not detect a clinically important difference in the rates of satisfaction with pain control being rated as 'did not experience pain' (1 RCT, n=884; RR=1.44 [95% CI 0.92, 2.24]; moderate quality), or 'could have done more to control pain' (1 RCT, n=884; RR=0.84 [95% CI 0.58, 1.23]; moderate quality) between the 'mid-level provider-led services' group and the 'physician-led' services group; however, there was uncertainty around the estimates.

Patient satisfaction – would recommend to friend

RCT evidence showed there was no clinically important difference between the rate of recommend to friend ratings of 'yes' (1 RCT, n=884; RR=1.00 [95% CI 0.98, 1.01]; high quality) in the 'mid-level provider-led services' group and the 'physician-led' services group. RCT evidence did not detect a clinically important difference in rates of recommend to friend ratings of 'maybe' (1 RCT, n=884; RR=1.45 [95% CI 0.46, 4.54]; low quality) or 'no' (1 RCT, n=884; RR=0.35 [95% CI 0.01, 8.46]; low quality) between the 'mid-level provider-led services' group and the 'physician-led' services group; however, there was uncertainty around the estimates.

Patient satisfaction – medical care received

RCT evidence showed there was no clinically important difference between the rate of medical care received being rated as 'better than expected' (1 RCT, n=884; RR=0.98 [95% CI 0.95, 1.01]; high quality) in the 'mid-level provider-led services' group and the 'physician-led' services group. RCT evidence did not detect a clinically important difference in the rate of medical care received being rated as 'as expected' (1 RCT, n=884; RR=1.36 [95% CI 0.76, 2.44]; low quality) between the 'mid-level provider-led services' group and the 'physician-led' services group; however, there was uncertainty around the estimate.

Time between referral and assessment (days)

Non-RCT evidence showed a lower clinically important difference in the time between referral and assessment (1 observational study, n=236; MD=-5.20 [95% CI -6.97, -3.43]; very

low quality) and there was a higher clinically important difference in the rate of women seen within 5 days of referral (1 observational study, n=236; RR=4.37 [95% CI 1.90, 10.05]; very low quality) in the 'mid-level provider-led services' group compared with the 'physician-led' services group. However, non-RCT evidence did not detect a clinically important difference in the rate of women seen within 14 days of referral between the 'mid-level provider-led services' group and the 'physician-led' services group (1 observational study, n=236; RR=1.20 [95% CI 0.99, 1.45]; very low quality); however, there was uncertainty around the estimate.

Proportion of clinicians who are either providing, or intending to provide, termination services during or after completing training

No evidence was identified to inform this outcome.

Important outcomes

Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman

No evidence was identified to inform this outcome.

Professional quality of life

No evidence was identified to inform this outcome.

Comparison 4. Self-referral versus GP referral

Critical outcomes

Patient satisfaction

No evidence was identified to inform this outcome.

Time between referral and termination of pregnancy

Non-RCT evidence showed a higher clinically important difference in the rate of women having their abortion within 7 days of referral was clinically in the 'self-referral' group compared with the 'GP referral group' (1 observational study, n=514; RR=2.00 [95% CI 1.69, 2.35]; very low quality). However, non-RCT evidence did not detect a clinically important difference in the rate of women having their abortion within 14 days of referral between the 'self-referral' group and the 'GP referral' group (1 observational study, n=514; RR=1.15 [95% CI 1.06, 1.25]; very low quality); however, there was uncertainty around the estimate.

Proportion of clinicians who are either providing, or intending to provide, termination services during or after completing training

No evidence was identified to inform this outcome.

Important outcomes

Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman

No evidence was identified to inform this outcome.

Professional quality of life

No evidence was identified to inform this outcome.

Comparison 5. Routine integration of termination training into core curriculum versus termination training not integrated into core curriculum

Critical outcomes

Patient satisfaction

No evidence was identified to inform this outcome.

Time between referral and termination of pregnancy

No evidence was identified to inform this outcome.

Proportion of clinicians who are either providing, or intending to provide, termination services during or after completing training

Non-RCT evidence showed a higher clinically important difference in the proportion of clinicians providing, or intending to provide, termination of pregnancy services after training in the 'routine integration of termination training into core curriculum' group compared with the 'termination training not integrated into core curriculum' group (2 observational studies, n=1,484; RR=3.09 [95% CI 2.45, 3.90]; very low quality).

Important outcomes

Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman

No evidence was identified to inform this outcome.

Professional quality of life

No evidence was identified to inform this outcome.

Comparison 6. Opt-in training versus opt-out training

Critical outcomes

Patient satisfaction

No evidence was identified to inform this outcome.

Time between referral and termination of pregnancy

No evidence was identified to inform this outcome.

Proportion of clinicians who are either providing, or intending to provide, termination services during or after completing training

Non-RCT evidence showed a lower clinically important difference in the proportion of clinicians providing, or intending to provide, termination of pregnancy services after training lower in the 'opt-in training' group compared with the 'opt-out training' group (2 observational studies, n=1,576; RR=0.54 [95% CI 0.42, 0.71]; very low quality).

Important outcomes

Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman

No evidence was identified to inform this outcome.

Professional quality of life

No evidence was identified to inform this outcome.

Comparison 7. Provider and/or trainee workshops versus no provider and/or trainee workshops

Critical outcomes

Patient satisfaction

No evidence was identified to inform this outcome.

Time between referral and termination of pregnancy

No evidence was identified to inform this outcome.

Proportion of clinicians who are either providing, or intending to provide, termination services during or after completing training

No evidence was identified to inform this outcome.

Important outcomes

Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman

No evidence was identified to inform this outcome.

Professional quality of life

Non-RCT evidence showed there was no clinically important difference between professional quality of life measured by the Abortion Provider Stigma Survey (APSS) total score (1 before-after study, n=52; MD=-1.1 [95% CI -2.8, 0.60]; low quality), APSS Disclosure subscale (1 before-after study, n=52; MD=-0.3 [95% CI -1.70, 1.10]; low quality), APSS Resistance and Resilience subscale (1 before-after study, n=52; MD=-0.3 [95% CI -1.10, 0.50]; low quality) in the ‘provider and/or trainee workshops’ group and the ‘no provider and/or trainee workshops’ group. Non-RCT evidence did not detect a clinically important difference in professional quality of life measured by the APSS Discrimination subscale (1 before-after study, n=52; MD=0.30 [95% CI -0.40, 1.00]; very low quality) between the ‘provider and/or trainee workshops’ group and the ‘no provider and/or trainee workshops’ group; however, there was uncertainty around the estimate.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

The aim of the qualitative review was to identify factors that help or hinder the accessibility and sustainability of a safe abortion service. The committee agreed that the views of both women and staff in abortion services should be considered to capture a broad range of perspectives. The committee did not pre-specify any factors as they did not want to constrain the evidence; therefore, any factors that were reported by women or staff as helping or hindering access to, or sustainability of, abortion services were included in the review.

The views of women and staff in non-OECD countries and countries where abortion is prohibited altogether or only done to save the woman's life were not considered for this question as the committee agreed that factors identified from these countries would be of less relevance to the UK setting.

The quantitative review aimed to identify strategies that improve the factors identified in the qualitative review, and therefore improve the accessibility and sustainability of abortion services. The committee agreed that the time between referral and abortion was the most critical measure of accessibility as timely access to services is likely to decrease distress, increase the choice of methods available to the woman and have fewer associated risks. The proportion of clinicians who are either providing, or intending to provide, abortion services during or after completing training was selected as a critical outcome to measure sustainability as the committee agreed that without new staff entering the service following training, there will not be enough providers to sustain abortion services in the future. Patient satisfaction was also selected as a critical outcome as this is likely to be affected by factors that impact accessibility and sustainability.

The percentage of all abortions that were conducted of the type (medical or surgical) preferred/requested by the woman was selected as an important outcome as the committee agreed it was important that women have a choice of appropriate methods and that access to both medical and surgical abortion should be facilitated. Finally, professional quality of life was selected as an important outcome as this will likely affect staff performance and turnover, which will impact the sustainability of services.

The quality of the evidence

The quality of evidence for the qualitative review was assessed using the GRADE CERQual methodology. Evidence for service-level barriers (theme 1) ranged from moderate to high quality. Themes 1.1 (long waiting times and delays) and 1.2 (difficulty navigating the healthcare system) were based on high quality evidence whereas theme 1.3 (insufficient resources and hours of operation) was based on moderate quality evidence and was downgraded due to concerns with the relevance of the data. Evidence for financial barriers (theme 2) ranged from very low to moderate quality. Evidence for themes 2.1 (funding for people ineligible for NHS services) and 2.3 (lack of financial input to services) was very low quality and was downgraded due to concerns with the methodological quality and the relevance and adequacy of the data; theme 2.2 (patient expenses) was based on moderate quality evidence and was downgraded due to concerns with the relevance of the data. Evidence for logistical barriers (theme 3) ranged from very low to high quality. Themes 3.1 (difficulty arranging time off work), 3.2 (difficulty arranging childcare) and 3.3 (additional expenses and delays caused by travel arrangements) were based on high quality evidence and theme 3.4 (arranging drive home can cause delays and necessitate unwanted disclosure) was based on moderate quality evidence and was downgraded due to concerns

with the relevance of the data. Evidence for theme 3.5 (teenagers more affected by logistical barriers) was very low quality and downgraded due to concerns with methodological quality, relevance and adequacy; theme 3.6 (more appointments needed for medical abortion is a barrier to choosing medical abortion) was based on low quality evidence and downgraded due to concerns with relevance and adequacy of the data. Evidence for personal barriers (theme 4) ranged from very low to high quality. Evidence for themes 4.2 (perceived stigma) and 4.5 (negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals) was high quality; theme 4.4 (threat of violence) was based on moderate quality evidence and downgraded due to concerns with the relevance of the data. Prior negative experiences (theme 4.1) and personal barriers (theme 4.6) were based on low quality evidence and downgraded due to concerns with methodological quality, relevance and adequacy; evidence for theme 4.3 (comorbid medical conditions) was very low quality and downgraded due to methodological concerns and the relevance and adequacy of the data. Evidence for theme 5 (legal and policy barriers) was of very low quality and was downgraded due to concerns with methodological quality, relevance and adequacy. Theme 6 (privacy and confidentiality concerns) was based on high quality evidence. Themes 7 (training and education) and 8 (community prescribing and telemedicine introduce greater flexibility) were both based on moderate quality evidence and downgraded due to methodological concerns and the relevance of the data, respectively.

The evidence in the pairwise comparisons for the quantitative review was assessed using the GRADE methodology. The majority of the evidence was very low quality as it came from observational studies; further, some of the evidence for time between referral and abortion was indirect as studies reported the time between referral and initial assessment, rather than the abortion itself. There was also indirect evidence for the comparison of self-referral versus GP referral, as referrals were made by a broader range of healthcare professionals than GPs. There was RCT evidence for patient satisfaction with mid-level provider-led services and physician-led services; this ranged from low to high quality and was downgraded due to imprecision around the estimate caused by wide confidence intervals.

There was no evidence for the percentage of all abortions that were conducted of the type (medical or surgical) preferred/requested by the woman and no evidence for the following comparisons: MDT approach versus key worker approach, MDT approach versus treatment as usual, key worker approach versus treatment as usual, centralised booking system/single point of contact versus no centralised booking system/single point of contact, public and/or professional awareness campaign versus no awareness campaign or school-based/youth group education programmes.

Benefits and harms

Making it easier to access services

Good evidence from the qualitative review showed that the process to obtain an abortion is complicated and is not transparent, that there is a lack of information available about how to access services and that more integrated, streamlined services and centralised referral would improve access to abortion services. However, there was no evidence available for the strategies to improve navigating the healthcare system that were included in the quantitative review protocol (namely centralised booking systems/single point of contact, public and/or professional awareness campaigns and school-based/youth group education programmes). The committee agreed that providers and commissioners of abortion services need to ensure that women are aware of how to access services and that information about services is widely available. Whilst there was not any evidence to specify how and where information should be available, the committee agreed that providing GPs, sexual health and contraception services and schools with written information about local abortion services, and ensuring such information is available through trusted websites, may be beneficial. The

committee agreed that women's' choice should be prioritised, but that it is not feasible for surgical abortions to be available from all services or in all locations and that some services may lack the expertise or resources to perform abortions after a specific gestational age. Therefore, they recommended that timely onward referral should be made if services cannot offer an abortion after a specific gestational age or by the woman's preferred method.

There was evidence that more women who self-referred had their abortion within 7 days of referral compared with women who were referred by a healthcare professional; however, this was based on very low quality evidence and there was no difference in the proportion of women who had their abortion within 14 days of referral. High quality evidence showed that decreasing waiting times was an important avenue for improving care and there are delays in getting GP appointments; further, there was high quality evidence that negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals for abortion. The committee also noted that women having an abortion tend to be young, healthy women who may not have an established relationship with a regular GP. Therefore, the committee agreed that direct access was an important mechanism for overcoming these barriers. No evidence was identified that compared different methods of facilitating direct access so it was not possible to recommend a specific approach. However, the committee noted that several systems were effective in practice including dedicated booking systems with extended opening hours or call back services, drop-in open access services and online booking, and there was high quality evidence that centralised referral would improve access.

There was good evidence that physicians' personal beliefs can create a barrier to delivering abortion services and providing referrals. Therefore, the committee agreed that healthcare professionals should ensure that their views do not create a barrier or delays to providing or arranging an abortion.

A number of themes highlighted the difficulty of accessing abortion services for women living in remote areas. The committee were aware that the NHS Healthcare Travel Costs Scheme reimburses travel costs for people receiving benefits or qualifying for the NHS Low Income Scheme. However, costs for women who need to travel to reach a provider that is not locally commissioned in order to receive the necessary treatment are likely to be much greater than normal costs associated with accessing healthcare. Therefore, the committee agreed that help with funding for travel and accommodation would be beneficial for these women even if they didn't have low income. The committee noted that the scheme only reimburses costs after the appointment. Women having an abortion often have to travel at very short notice, compared with women having treatment for other conditions that may have several weeks' notice before an appointment, and may have difficulty arranging funds before the appointment. Therefore, the committee agreed that upfront funding of women's travel and accommodation costs could improve access for women with low-income and women travelling to a provider that is not locally commissioned.

Waiting times

There was good evidence that there were insufficient resources and appointment times available for abortion services. The committee agreed that increased staffing and hours would improve access to abortion services, but that increased appointment times may not always be feasible. Therefore, the committee agreed that providers should ensure they have the capacity to deliver services with minimal delays, which may or may not involve increased appointment times. There was good evidence that there are long waiting times and delays when accessing abortion services and that decreasing waiting times is an important avenue for improving care. Further, the committee agreed that the earlier women are referred for abortion services, the more choice there will be regarding the type of procedure they have and a greater proportion of women will be able to have a medical abortion with expulsion at

home, which would reduce associated costs and resource use. Therefore, the committee agreed that waiting times must be kept to a minimum. The committee were also aware of evidence that mortality from abortion, whilst remaining very low in absolute terms, increases for every additional week of gestation (Bartlett 2004) and therefore recommended that providers should ensure there is minimal delays throughout the abortion pathway and ideally undertake initial assessment within 1 week of requesting an abortion, and treatment within 1 week of assessment. The committee acknowledged that assessment and treatment may need to be expedited after 22^{+0} weeks' gestation to allow treatment within the legal restrictions for abortion (up to and including 23^{+6} weeks' gestation unless there is a fetal anomaly or risk to the life of the women). The committee noted that these recommendations would be broadly consistent with current RCOG guidance which recommends that women are assessed within 5 days of referral and have the abortion procedure within 5 days of making a decision to proceed (Royal College of Obstetricians and Gynaecologists 2011). The committee agreed that it was more appropriate to specify the time between assessment and abortion, compared with decision to proceed and abortion, as evidence shows the majority of women are certain of their decision to proceed at the time of the assessment (Cameron 2013). However, the committee acknowledged that it is not practical, or economically viable, for abortion services to be available from all providers every day, and that some services, particularly in rural areas, may only offer abortions on certain days of the week. Therefore, sometimes travel may be required to receive an abortion within the recommended timeframes. In these circumstances, the committee agreed that women need to be provided with sufficient information about the risks associated with delaying an abortion, and how this may affect the options available to them, to enable them to make an informed decision between travelling to access services within the recommended timeframe and having a longer wait to receive them locally. The committee also agreed that some women might want additional time to consider their decision after the assessment and that they should be given the time to do this but also be informed about the risks as stated above.

There was good evidence that difficulty organising time off work and childcare can cause delays accessing services. The committee did not think is was feasible to make recommendations about childcare as this may be required overnight, depending on gestational age and distance travelled, and it was not in the scope of this guideline to make recommendations about time off work. The committee agreed that the provision of same-day services where possible may be more convenient and minimise delays. However, it was not possible to recommend same-day services as we did not review evidence comparing same-day and multiple-day services.

There was some evidence that legislation and local policies, such as the use of ethics committees and state imposed waiting periods can cause delays in accessing abortion services. Whilst some of these restrictions may not be applicable to UK clinical practice, the committee agreed that women who are certain of their decision should be able to access services immediately without the need for compulsory counselling or enforced delays. The committee also agreed that women should be provided with or referred for support making a decision if they request this, feel free to change their mind and should be given information as to who to contact if they wanted further discussion or to cancel an appointment or procedure.

Location of services

There was evidence that there was no difference in the rate of women who were very satisfied and would recommend the service to a friend between abortion services delivered by telemedicine compared with face-to-face services. It was unclear whether or not there were clinically important differences in rates of women who were somewhat satisfied or dissatisfied between those services. There was either no difference in patient satisfaction

with community and hospital services, or women preferred community services to hospital services. However, the evidence was very low quality and the committee agreed that women can have low expectations for abortion services so this outcome may not be very sensitive to differences between services if satisfaction is rated highly in both instances, compared to expectations. There was good evidence that making travel arrangements can cause delays to accessing abortion services and that community prescribing for medical abortion and telemedicine either has, or would, improve access to abortion services, increase flexibility and facilitate a more woman-centred approach to care. There was also evidence that the greater number of appointments needed for a medical abortion compared with a surgical abortion is a barrier to women choosing a medical abortion. When the quantitative and qualitative evidence were considered together, the committee agreed that community services and the use of remote assessments via telephone or videoconference may improve access to abortion services, but these methods may not be suitable for all women and more traditional hospital-based and face-to-face services should also be available. The committee agreed that appropriate methods of remote assessment may also include online services and may expand with future advances in technology. The committee acknowledged that current regulations in England would prevent some aspects of the care pathway being delivered by telemedicine but the circumstances in which services could be delivered remotely may expand following the legalisation of home use of misoprostol up to and including 9^{+6} weeks' gestation in England at the end of 2018. These recommendations have the potential to reduce inequalities associated with certain groups who find it particularly difficult to travel to abortion services. For example, there was moderate quality evidence that the threat of violence, controlling circumstances and cultural backgrounds that accepts honour-based violence can be barriers to accessing abortion services as women may have difficulty leaving the house or be worried about the consequences if people knew they were having an abortion. There was also very low quality evidence that teenagers are more affected by logistical barriers than other women.

There was good evidence that arranging for someone to drive women home after an abortion can cause delays and necessitate unwanted disclosure. There was also evidence that lack of social support is a barrier to accessing abortion and can worsen other barriers. It would not be feasible to recommend that social support and transport are available for women having an abortion and needing someone to drive them home may sometimes be unavoidable, such as following surgical abortion with sedation. However, the committee agreed that these factors may improve as a result of the above recommendations as travel distances may be reduced.

Workforce and training

There was good evidence that women preferred nurse-midwife-led services over physician-led services and that there was no difference between these services in a number of patient satisfaction domains. There was also very low quality evidence that there was a shorter time between referral and assessment in nurse-led services compared with physician-led services and a greater proportion of women were seen within 5 days of referral, which is supported by moderate quality evidence that expanding the role of nurses in medical abortion would improve access. The extent of nurse involvement varied across included studies and regulations in England would restrict nurses and midwives from delivering some aspects of the care pathway; however, the committee agreed that, with appropriate supervision and restrictions as required by law, expanding the role of nurses and midwives in abortion services would help improve access to services.

There was good evidence that GPs were confused or unclear regarding details of services such as routes for referral and gestational limits, that further education was needed for the public and healthcare providers, and that the role of nursing staff in medical abortion would

improve access but is hindered by shortfalls in training. Therefore, the committee recommended that healthcare professionals who may care for women requesting an abortion, such as nurses, midwives and GPs, should be able to gain experience in abortion services during training. The committee agreed that increasing exposure to abortion may be an important avenue for reducing stigma.

There was also evidence that a lack of knowledge and skills among healthcare providers was a barrier to performing certain abortion procedures. The core curriculum for obstetrics and gynaecology in the UK dictates that people have practical experience of medical and surgical abortion (Royal College of Obstetricians and Gynaecologists 2013, updated 2016); however, only 30% of abortion services in the UK are provided by the NHS (Department of Health 2018) and the evidence showed that NHS hospital-based providers are losing their clinical skills due to abortions occurring mainly in the independent sector. The committee noted that the amount of exposure to abortion services gained during training will depend in part on geographical location, which is supported by evidence that rural physicians lack professional support, continued professional education and that the lack of volume of abortions in the rural setting was a deterrent to the local training of abortion providers. The evidence showed that clinicians were more likely to provide, or intend to provide, abortion services when they had abortion training available to them during training and where curriculums were organised using an “opt-out” approach, such that trainees gained experience in abortion care unless they specifically opted-out for reasons of personal belief. Therefore, the committee agreed that all clinicians training in specialities where abortion training is part of the core curriculum should be enrolled in training, unless they opt out due to conscientious objection, and receive practical exposure to abortion services during training, either within the NHS or the independent sector. The committee agreed it was important for curricula to adopt this “opt-out” approach otherwise abortion care can be viewed as optional and unimportant, whilst for women it is a common procedure, with 1 in 5 pregnancies in England and Wales (excluding miscarriage) ending in abortion (Office for National Statistics, 2018). Further, the committee agreed that if abortion training is seen as optional, this may perpetuate the stigma surrounding abortion.

The committee agreed, based on their knowledge and experience, that, in order to ensure the future longevity of abortion services, abortion training needs to remain in the core curriculum for obstetricians and gynaecologists and sexual and reproductive health specialists; however, they could not make recommendations in this area as it is beyond the scope of this guideline.

Complex comorbidities

No evidence was identified for strategies that improved accessibility or sustainability of services for women with comorbid medical conditions. There was some evidence that accessing services is difficult for women with anxiety problems and the committee agreed that they would benefit from increased availability of telemedicine. However, the committee agreed that with many services being delivered in community settings and outside of the traditional hospital network, women with complex needs faced difficulties in accessing adequate care. The committee were particularly concerned that there may be delays in accessing treatment due to the need for referral and that services many not have adequate skills to safely deliver all treatment options. The committee were aware that, at the time of the development of this guideline, NHS England were in the process of developing the specification and commissioning framework for delivery of complex abortion care within each of the seven regions of England. Therefore, the committee did not define who should be considered as having complex needs or significant comorbidities or the requirements of the specialist service as these factors will be defined in the service specification. The committee agreed the importance of specialist centres for women with complex needs or significant

comorbidities as safety has to be the priority and if such services are unavailable, then women with complex needs may be forced to continue with the pregnancy. There also needs to be robust pathways for referral that minimise delays, when care is not available locally. However, the committee agreed that safe care for this population may require some delays and travel.

Avoiding stigma

There was good evidence that there is a perceived stigma associated with abortion and some evidence that prior negative experiences with staff in abortion services may put some women off having another abortion and cause delays in presentation. Therefore, the committee agreed that healthcare professionals should be aware of the impact of their communication on women seeking abortion services.

Evidence showed that provider workshops were ineffective at reducing stigma; however, the evidence was low quality and from a study validating the Abortion Provider Stigma Survey, which has since been refined. Therefore, the committee agreed that there was insufficient evidence to recommend a specific approach to reduce stigma associated with abortion. The committee noted that awareness campaigns have been successful at targeting driving while intoxicated and stigma associated with HIV and mental health (Evans-Lacko 2014, Stang 2013, Yadav 2015); however, there was no evidence available for the effectiveness of such campaigns in relation to abortion.

Good evidence showed that women have concerns about the privacy and confidentiality of abortion services, reactions and judgements from others, and the need to disclose their abortion to unwanted people in order to overcome logistical barriers. Therefore, the committee agreed that abortion services should be sensitive to these concerns and that information should only be disclosed if there is a compelling need and is in the woman's interest. Evidence for methods of maintaining confidentiality were not reviewed and specific methods could not be recommended. Recommending that direct access to abortion services is available may improve privacy by minimising the number of people involved in the referral process.

The committee were aware that women having an abortion being near other women continuing with pregnancies has been raised as a patient experience issue and can be distressing. The committee discussed that one method of addressing this concern could be to have wards or clinics for women having an abortion that are separate from other maternity wards. However, the committee agreed this may not be possible in rural areas where there would likely be insufficient resources to have separate clinics. The committee also agreed that at later gestations maternity wards are likely to be the safest place for women having an abortion. There were also concerns that separating women might actually perpetuate the stigma around abortion and may risk inadvertently identifying women as having an abortion if they are accessing an area that only provides this service. In the absence of evidence to recommend a specific approach to address this issue, the committee did not recommend separating these groups.

Future research

As there was sufficient evidence to inform the recommendations, the committee decided to prioritise other areas addressed by the guideline for future research and therefore made no research recommendations regarding strategies that improve the factors that help or hinder the accessibility and sustainability of a safe abortion service.

Cost effectiveness and resource use

Making it easier to access services

Whilst the committee recommended that women should be able to directly refer for abortions they were unable to recommend a specific method given a paucity of effectiveness and cost effectiveness evidence. The committee agreed that enabling direct access may require changes to commissioning, as some commissioners currently require a referral for an abortion, and services, if they do not currently have a system for receiving direct referrals. Dedicated booking systems with extended opening hours, call back services, drop-in open access services and online booking will all incur costs to set-up where they are not already available. There was high quality evidence from the qualitative review that centralised booking would increase access (see the benefits and harms section on making it easier to access services) and from the results of the bespoke economic model on waiting times substantial cost savings could be achieved through women presenting earlier for abortion.

The NHS Healthcare Travel Costs Scheme already reimburses travel costs for women receiving benefits or qualifying for the NHS Low Income Scheme. Therefore, providing upfront funding for this population will not result in an absolute increase in costs, rather there will be a difference in timing of when funding is provided. The committee noted that some local commissioners and providers have informal processes in place where they will arrange and fund travel for women before the abortion, but this is not a common occurrence. Therefore, providers will need to introduce processes that allow them to provide upfront funding, which may have associated costs and resource use; however, these costs are likely to be one-off and may be offset from women having earlier abortions. There will be an increased cost associated with providing funding for women who do not have low income but are travelling to a provider that is not locally commissioned, as these women are not covered by the national policy. However, where locally commissioned services are not available, abortions could be delayed due to women trying to arrange travel which would lead to increased costs as the abortion would take place at a later gestational age, or could even result in the woman being unable to have the abortion if she is unable to travel.

Waiting times

Bespoke economic modelling was undertaken around waiting times to look at the potential cost savings from earlier access and reduced waiting times. The model assumed that with shorter waiting times women would access an abortion at an earlier gestational week and that cost savings would be realised through the lower NHS tariff, lower rates of complications for earlier gestational weeks and an increase in the number of medical abortions. All recommendations in this area are likely to increase access and either reduce waiting times or the time until initial presentation. The model made no distinction between reductions in time to procedure for either.

All recommendations in this topic are aimed at decreasing waiting times or the time until accessing abortion procedures. The economic model did not attempt to consider any particular intervention and its associated costs as there were no evidence that could quantify reductions from suggested interventions. These costs savings were interpreted by the committee in the context that there would be likely costs to enacting interventions to achieve these outcomes, such as reconfiguring services so that they are available on a greater number of days a week and have processes in place for self-referral. The economic model showed that even with very small decreases in waiting times that significant cost saving could be made. A reduction in 1 day for all abortions could save £9 per procedure or £1.6 million across all abortions per year. A decrease of a week would save £61 per procedure or £11.5 million across all abortions. The majority of these costs savings (>80%) came from

women switching from surgical to medical abortion with nearly all the rest from women dropping between the 14 week and 20 week cuts in the NHS Reference Costs. A reduction in adverse events had minimal impact on costs as a result of these being rare events at all gestational weeks.

The committee pointed out that the model may underestimate the true cost savings from reducing waiting times as the model used a tariff based on inpatient procedures. It is very likely that if women are able to access abortions earlier either through shorter waiting times they may be able to have an abortion on an outpatient basis saving hundreds of pounds on those procedures. The cut point for 14 weeks and 20 weeks are also very insensitive and would only pick up cost savings when women passed those particular weeks. In reality even small differences in gestational weeks lead to less medically and resource intensive procedures.

It was the committees belief that even small reductions in waiting times would lend support to even relatively expensive interventions being cost saving. Despite being unable to look at it, explicitly reducing waiting times would almost certainly also lead to improvements in quality of life through a greater choice of procedures, a less intensive procedure and a reduction in time a woman had to continue with a pregnancy. The committee thought it appropriate to set an ideal maximum waiting time to encourage providers to keep times as short as possible. Whilst some areas are already meeting these targets others are quite a significant way from doing so and may incur significant costs in providing systems and interventions to achieve them. The committee strongly asserted that any effort to do so would be an efficient use of NHS resources and also potentially cost saving.

Location of services

There is unlikely to be any increase resource use around the recommendation for telemedicine as telephone and/or videoconferencing facilities will already be available in the vast majority of settings. Where these are not available they can be set up relatively inexpensively through for example ‘off the shelf’ videoconferencing software. There is potential with increased telemedicine to increase the number of women seen in a set amount of time and also potentially through a reduction in the number of missed appointments. It is expected that any upfront cost will be regained quickly.

A greater use of community services through telemedicine and as a result of the announcement to legalise home use of misoprostol is also likely to be cost saving through a reduction in the number of appointments, reduction in travel costs for those in remote areas and through reduction in barriers to presenting earlier for abortion allowing for less costly procedures.

Workforce and training

Increasing the responsibility and roles of nurses in the provision of abortions, within the constraints of the law (see the benefits and harms sections on workforce and training), will decrease the costs through less time spent by doctors (with a higher wage rate) providing these services. Increased access will also lead to women presenting earlier for less costly abortions. The evidence did identify a need for training in this area for nurses, but any upfront costs associated with providing training will likely be reimbursed though improved access.

It is expected that the recommendations around training needs, if included as part of the core training curriculums will be cost neutral.

Complex comorbidities

The development of specialist commissioning services is currently in progress and has a tariff structure in place. Therefore, there should not be a cost impact of recommending specialist centres are available.

Recommendations to minimise delay may produce some cost-savings due to less complicated procedures being required. However, medical abortions are often more costly than surgical abortions in this population, as they require admission for a number of days. Therefore, cost savings associated with reduced delays will not be as large as for women without comorbid medical conditions, where greatest savings come from more women having a medical rather than surgical abortion if they present to services earlier.

There is likely to be some savings associated with avoiding repeated assessments or investigations.

Avoiding stigma

The way healthcare professionals communicate with women having an abortion, and issues of confidentiality and sensitivity, should already be embedded in their training and, therefore, these recommendations should not be associated with any increased resource impact.

Evidence was identified that prior negative experience around abortion discouraged some women from seeking an abortion and resulted in later presentation. Whilst not explicitly exploring stigma, the economic model highlighted both the increased cost and increase in adverse events from women receiving an abortion at a later gestational week and even reductions of a few days could lead to potentially large cost savings.

There was a paucity of evidence for specific methods of reducing stigma associated with abortion. Therefore, no specific methods of reducing stigma or raising awareness were recommended. However, training programmes or information campaigns aimed at both people involved in providing abortion services and the wider public could have a significant resource impact depending on their medium.

Other considerations

There was some evidence that a lack of financial input into abortion services is impacting the care that can be provided. Whilst the committee could not make recommendations specifying the funding required for abortion services, they agreed that it is the responsibility of commissioners to ensure services are available to deliver the recommendations made in this guideline. There was also evidence that there is insufficient funding for abortion services for women ineligible for free NHS services; however, the committee could not make recommendations in this area as it is outside the scope of the guideline.

As the focus of these review question were accessibility and sustainability, evidence on the safety and efficacy of abortion services was not included in this review. However, the committee were aware of evidence from a Cochrane review (Barnard 2015) that showed no difference in the efficacy of medical abortion, or the complication rate following surgical abortion, conducted by mid-level providers (nurses, midwives and physician assistants) compared with physicians. There was some evidence from observational studies that the risk of failure or incomplete surgical abortion was higher for mid-level providers compared with physicians, but this effect was not observed in the RCT evidence. No complications following medical abortion were reported in either arm of any of the included studies. Therefore, the committee agreed that mid-level providers (nurses, midwives and physician assistants) can deliver abortion services safely and effectively.

The committee agreed that the recommendations made (particularly those related to location of services, making it easier to access services and comorbid medical conditions) have the potential to reduce current inequalities in accessing abortion services for the following groups by improving referral pathways, minimising travel and decreasing the number of appointments that women need to attend in person: women living in remote areas, women with low income, women with comorbid physical and/or mental health problems, vulnerable women, and girls and younger women.

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Appendices

Appendix A – Review protocols

Review protocol for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

Field (based on PRISMA-P	Content
Review question in SCOPE	What strategies ensure the sustainability of a safe and accessible termination of pregnancy service? What strategies enhance access to termination of pregnancy services?
Review question in guideline	What factors help or hinder the accessibility and sustainability of a safe termination of pregnancy service?
Type of review question	Qualitative
Objective of the review	To determine what factors help or hinder the accessibility and sustainability of a safe termination of pregnancy service
Eligibility criteria – population	ToP services in OECD countries Exclusions: - Studies with indirect populations will not be considered - Studies from OECD countries where termination is prohibited altogether or only done to save the woman's life (Chile, Ireland, Mexico although not Mexico City)
Eligibility criteria – perspective	- Staff working in ToP services in OECD countries - Women treated in ToP services in OECD countries
Eligibility criteria – comparator(s)	N/A
Outcomes – areas of interest	Any factors that have been reported that help or hinder the accessibility and sustainability of a safe termination of pregnancy service
Eligibility criteria – study design	- Systematic reviews of qualitative studies - Qualitative studies - Other study designs that report qualitative evidence (e.g., surveys with open-ended questions)
Other inclusion exclusion criteria	Inclusion: - English-language - Data extraction/study inclusion will stop after data saturation has been reached
Proposed sensitivity/sub-group analysis, or meta-regression	Formal subgroup analyses are not appropriate for this question due to qualitative data but views of women from the following groups will be given special consideration, where possible:

Field (based on PRISMA-P	Content
	- Complex pre-existing medical conditions - Vulnerable women (including sex workers and homeless) - Women living in remote areas - Coexisting mental health problems - Learning disabilities - Girls and younger women - Women with communication difficulties
Selection process – duplicate screening/selection/analysis	Dual sifting will be undertaken for this question using NGA STAR software, with resolution of discrepancies in discussion with the senior reviewer if necessary. Sifting, data extraction, appraisal of methodological quality and GRADE-CERQual assessment will be performed by the systematic reviewer. Quality control will be performed by the senior systematic reviewer. Dual data extraction will not be performed for this question.
Data management (software)	NGA STAR software will be used for study sifting, data extraction, recording quality assessment using checklists and generating bibliographies/citations
Information sources – databases and dates	Sources to be searched: Medline, Medline In-Process, CCTR, CDSR, DARE, HTA, Embase, plus AMED, Psycinfo, Cinahl and Web of Science. Additional databases may also be considered. Limits (e.g. date, study design): Apply standard animal/non-English language exclusion Dates: from 2001 Studies conducted from 2001 will be considered for this review question as this is when the first UK National Strategy on Sexual Health was established. This predates any guidance from the World Health Organisation (2003).
Identify if an update	Not an update
Author contacts	For details please see the guideline in development web site.
Highlight if amendment to previous protocol	For details please see section 4.5 of Developing NICE guidelines: the manual
Search strategy – for one database	For details please see appendix B
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables) or appendix H (economic evidence tables).
Data items – define all variables to be collected	For details please see evidence tables in appendix D (clinical evidence tables) or appendix H (economic evidence tables).
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see

Field (based on PRISMA-P	Content
	section 6.2 of Developing NICE guidelines: the manual The risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/
Criteria for quantitative synthesis (where suitable)	N/A
Methods for analysis – combining studies and exploring (in)consistency	Appraisal of methodological quality: The methodological quality of each study will be assessed using an appropriate checklist: • GRADE-CERQual for qualitative studies Synthesis of data: Synthesis consisting of extraction of common themes/thematic analysis will be conducted where appropriate using CERQual, Excel and Wordwere.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Assessment of confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual
Rationale/context – Current management	For details please see the introduction to the evidence review.
Describe contributions of authors and guarantor	A multidisciplinary committee developed the guideline. The committee was convened by The National Guideline Alliance and chaired by Professor Iain Cameron in line with section 3 of Developing NICE guidelines: the manual. Staff from The National Guideline Alliance will undertake systematic literature searches, appraise the evidence, conduct meta-analysis and cost-effectiveness analysis where appropriate, and draft the guideline in collaboration with the committee. For details please see the methods chapter.
Sources of funding/support	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists
Name of sponsor	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists
Roles of sponsor	NICE funds The National Guideline Alliance to develop guidelines for those working in the NHS, public health, and social care in England
PROSPERO registration number	Not registered

CERQual: Confidence in the Evidence from Reviews of Qualitative research; GRADE: Grading of Recommendations Assessment, Development and Evaluation; N/A: not applicable; NHS: National Health Service; NICE: National Institute for Health and Care Excellence; NGA: National Guideline Alliance; OECD: Organisation for Economic Co-operation and Development; ToP: termination of pregnancy

Review protocol for review question: What strategies that improve the factors that help or hinder the accessibility and sustainability of a safe abortion service

Field (based on PRISMA-P	Content
Review question in SCOPE	What strategies ensure the sustainability of a safe and accessible termination of pregnancy service? What strategies enhance access to termination of pregnancy services?
Review question in guideline	What strategies improve the factors that help or hinder the accessibility and sustainability of a safe termination of pregnancy service?
Type of review question	Intervention
Objective of the review	To determine the strategies that improve the factors that help or hinder the accessibility and sustainability of a safe termination of pregnancy service identified by Review Question 4.1 and those pre-specified below and to examine the impact of (improvement in) such factors on accessibility and sustainability of a safe termination of pregnancy service.
Eligibility criteria – population	ToP services in OECD countries Exclusions: - Studies with indirect populations will not be considered - Studies from OECD countries where termination is prohibited altogether or only done to save the woman's life (Chile, Ireland, Mexico, although not Mexico City) Pre-specified factors: • Waiting times (likely important to women and reducing accessibility, but also likely to be arguments to enforce a wait in order "to prevent regret") • Complex cases (including late terminations) - best service configuration • Choice of procedure – women's choice versus convenience of access • Delivery of care model – community versus hospital (or local versus centralised), nurse delivered versus medical, direct access/self-referral, telephone consultations/telemedicine (will also look at distance to travel for ToP) • Training, recruitment and retention of staff (incl. trained and willing providers,

Field (based on PRISMA-P	Content
	and gynaecology trainees gaining ToP training and experience within the NHS) Additional factors identified by Review question 4.1: • Comorbid medical conditions • Navigating the healthcare system • Perceived stigma
Eligibility criteria – intervention(s)	Setting: • Community (local) • Hospital (centralised) • Telemedicine Staffing: • Mid-level provider-led services • Physician-led services Referral: • Self-referral • GP-referral Training models: • Routine integration of termination training into core curriculum • Opt-in termination training • Opt-out termination training Comorbid medical conditions: • MDT approach • Key Worker approach Navigating the healthcare system: • Centralised booking system/single point of contact • Public and/or professional awareness campaign • School-based/youth group education programmes Perceived stigma: • Public and/or professional awareness campaigns • Provider and/or trainee workshops
Eligibility criteria – comparator(s)	Comparisons: 1. Community services versus hospital services 2. Community services versus telemedicine 3. Hospital services versus telemedicine 4. Mid-level provider-led services versus physician led services 5. Self-referral versus GP referral 6. Routine integration of termination training into core curriculum versus termination training not integrated into core curriculum

Field (based on PRISMA-P	Content
	7. Opt-in termination versus opt-out termination training 8. MDT approach versus key worker approach 9. MDT approach versus treatment as usual 10. Key worker approach versus treatment as usual 11. Centralised booking system/single point of contact versus no centralised booking system/single point of contact 12. Public and/or professional awareness campaign versus no awareness campaign 13. School-based/youth group education programme versus no education programme 14. Provider and/or trainee workshops versus no workshops
Outcomes and prioritisation	**Critical outcomes:** • Patient satisfaction • Time between referral and termination of pregnancy (accessibility) • Proportion of clinicians who are either providing, or intending to provide, ToP services during or after completing training (sustainability) **Important outcomes:** • Percentage of all terminations that were conducted of the type (medical or surgical) preferred/requested by the woman (patient satisfaction and accessibility) • Professional quality of life
Eligibility criteria – study design	- Systematic reviews of RCTs - RCTs - If insufficient RCTs for a given factor: comparative prospective cohort studies (including before-after studies) n≥100 each arm - If insufficient prospective cohort studies for a given factor: comparative retrospective cohort studies (including before-after studies) n≥100 each arm
Other inclusion exclusion criteria	Inclusion: - English-language - Studies conducted from 2001 (see below)
Proposed sensitivity/sub-group analysis, or meta-regression	Stratified analyses based on the following sub-groups of women, where possible:

Field (based on PRISMA-P	Content
	Medical conditions: - Complex pre-existing medical conditions - No complex pre-existing medical conditions Vulnerable women: - Vulnerable women (including sex workers; homeless, women who are poor) - Non-vulnerable women Geographical location: - Women living in remote areas - Women not living in remote areas Mental health: - Coexisting mental health problems - No coexisting mental health problems Learning disabilities: - Learning disabilities - No learning disabilities Age: - Girls <18 - Younger women ≥18-≤25 - Older women >25 Communication difficulties: - Women with communication difficulties - Women without communication difficulties
Selection process – duplicate screening/selection/analysis	Dual weeding will be performed for this question Sifting, data extraction, appraisal of methodological quality and GRADE assessment will be performed by the systematic reviewer. Quality control will be performed by the senior systematic reviewer. Dual data extraction will not be performed for this question.
Data management (software)	Pairwise meta-analyses will be performed using Cochrane Review Manager (RevMan5). 'GRADEpro' will be used to assess the quality of evidence for each outcome. NGA STAR software will be used for study sifting, data extraction, recording quality assessment using checklists and generating bibliographies/citations,
Information sources – databases and dates	Sources to be searched: Medline, Medline In-Process, CCTR, CDSR, DARE, HTA, Embase

Field (based on PRISMA-P	Content
	Limits (e.g. date, study design): Apply standard animal/non-English language exclusion Dates: from 2001 Studies conducted from 2001 will be considered for this review question as this is when the first UK National Strategy on Sexual Health was established. This predates any guidance from the World Health Organisation (2003).
Identify if an update	Not an update
Author contacts	For details please see the guideline in development web site.
Highlight if amendment to previous protocol	For details please see Section 4.5 of Developing NICE guidelines: the manual
Search strategy – for one database	For details please see appendix B
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables) or appendix H (economic evidence tables)
Data items – define all variables to be collected	For details please see evidence tables in appendix D (clinical evidence tables) or appendix H (economic evidence tables)
Methods for assessing bias at outcome/study level	Appraisal of methodological quality: The methodological quality of each study will be assessed using an appropriate checklist: • RoBIS for systematic reviews • Cochrane risk of bias tool for RCTs • Newcastle-Ottawa scale for non-randomised studies The risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/
Criteria for quantitative synthesis (where suitable)	For details please see Section 6.4 of Developing NICE guidelines: the manual
Methods for analysis – combining studies and exploring (in)consistency	Synthesis of data: Pairwise meta-analysis will be conducted where appropriate for all other outcomes. When meta-analysing continuous data, change scores will be pooled in preference to final scores. For details regarding inconsistency, please see the methods chapter. Minimally important differences: Default values will be used of: 0.8 and 1.25 for dichotomous outcomes; 0.5 times SD

Field (based on PRISMA-P	Content
	(for control group) for continuous outcomes.
Meta-bias assessment – publication bias, selective reporting bias	For details please see Section 6.2 of Developing NICE guidelines: the manual. If sufficient relevant RCT evidence is available, publication bias will be explored using RevMan software to examine funnel plots.
Assessment of confidence in cumulative evidence	For details please see Sections 6.4 and 9.1 of Developing NICE guidelines: the manual
Rationale/context – Current management	For details please see the introduction to the evidence review.
Describe contributions of authors and guarantor	A multidisciplinary committee developed the guideline. The committee was convened by The National Guideline Alliance and chaired by Profession Iain Cameron in line with section 3 of Developing NICE guidelines: the manual. Staff from The National Guideline Alliance will undertake systematic literature searches, appraise the evidence, conduct meta-analysis and cost-effectiveness analysis where appropriate, and draft the guideline in collaboration with the committee. For details please see the methods chapter.
Sources of funding/support	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists
Name of sponsor	The National Guideline Alliance is funded by NICE and hosted by the Royal College of Obstetricians and Gynaecologists
Roles of sponsor	NICE funds The National Guideline Alliance to develop guidelines for those working in the NHS, public health, and social care in England
PROSPERO registration number	Not registered

GP: general practitioner; GRADE: Grading of Recommendations Assessment, Development and Evaluation; MDT: multidisciplinary team; N/A: not applicable; NHS: National Health Service; NICE: National Institute for Health and Care Excellence; NGA: National Guideline Alliance; OECD: Organisation for Economic Co-operation and Development; RCT: randomised controlled trial; RoBIS: risk of bias in systematic reviews; ToP: termination of pregnancy; SD: standard deviation

Appendix B – Literature search strategies

Literature search strategy for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

The search for this topic was last run on 21st November 2018 during the re-runs for this guideline.

Database: Medline & Embase & PsycINFO (Multifile)

Last searched on **Embase Classic+Embase** 1947 to 2018 November 20, **Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R)** 1946 to November 20, 2018, **PsycINFO** 1806 to November Week 3 2018

Date of last search: 21st November 2018

#	Searches
1	exp abortion/ use emczd
2	exp pregnancy termination/ use emczd
3	exp Abortion, Induced/ use ppez
4	Abortion Applicants/ use ppez
5	exp Abortion, Spontaneous/ use ppez
6	exp Abortion, Criminal/ use ppez
7	Aborted fetus/ use ppez
8	fetus death/ use emczd
9	exp Induced Abortion/ use psyh
10	exp Spontaneous Abortion/ use psyh
11	exp Abortion Laws/ use psyh
12	exp "Abortion (Attitudes Toward)"/ use psyh
13	abortion.mp.
14	(abort$ or postabort$ or preabort$).mp.
15	((f?etal$ or f?etus$ or gestat$ or midtrimester$ or pregnan$ or prenatal$ or pre natal$ or trimester$) and terminat$).mp.
16	((f?etal$ or f?etus$) adj loss$).mp.
17	((gestat$ or midtrimester$ or pregnan$ or prenatal$ or pre natal$ or trimester$) adj3 loss$).mp.
18	(((elective$ or threaten$ or voluntar$) adj3 interrupt$) and pregnan$).mp.
19	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18
20	exp Health Services Accessibility/ use ppez
21	health care access/ use emczd
22	health care utilization/ use psyh
23	"Delivery of Health Care"/ use ppez
24	Delivery of Health Care, Integrated/ use ppez
25	health care delivery/ use emczd
26	integrated health care system/ use emczd
27	health care delivery/ use psyh
28	"Quality of Health Care"/ use ppez
29	health care quality/ use emczd
30	"Quality of Care"/ use psyh

#	Searches
31	service use$1.tw.
32	((access$ or attend$ or aversion or barrier$ or equit$ or facilitat$ or inequit$ or inequalit$ or obstacle$ or obstruct$ or refus$ or takeup$ or take up$ or uptake or utiliz$ or utilis$) adj5 (care or healthcare or intervention$ or program$ or referral$ or service$ or system$ or therap$ or treat$)).tw.
33	((access$ or attend$ or aversion or barrier$ or equit$ or facilitat$ or inequit$ or inequalit$ or obstacle$ or obstruct$ or refus$ or takeup$ or take up$ or uptake or utiliz$ or utilis$) adj3 (abortion or termination)).tw.
34	((adult$ or carer$ or caregiver$ or care giver$ or client$ or consumer$ or customer$ or famil$ or father$ or individual$ or mentor$ or men or minorities or mother$ or outpatient$ or patient$ or people$ or person$ or population$ or teacher$ or women$ or woman$ or user$ or adolescen$ or child$ or teen$ or (young$ adj (people or person$ or patient$ or population$)) or youngster$ or youth$1) adj3 (access$ or attend$ or aversion or barrier$ or equit$ or facilitat$ or inequalit$ or inequit$ or non attend$ or obstacle$ or obstruct$ or refus$ or takeup$ or take up $ or uptake or utiliz$ or utilis$)).tw.
35	((clinician$ or doctor$ or facilitator$ or gp$1 or healthcare or health profession$ or leader$ or nurs$ or personnel$ or physician$ or practitioner$ or pharmacist$ or professional$ or provider$ or specialist$ or staff$ or worker$) adj3 (barrier$ or obstacle$ or facilitat$ or obstruct$ or takeup$ or take up$)).tw.
36	((service$ or infrastructure$ or infra structure$) adj3 (sustain$ or continuation or durabl$ or viabl$ or stabl$)).tw.
37	20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36
38	19 and 37
39	limit 38 to english language
40	limit 39 to yr="2001 -Current"
41	letter/
42	editorial/
43	news/
44	exp historical article/
45	Anecdotes as Topic/
46	comment/
47	case report/
48	(letter or comment*).ti.
49	41 or 42 or 43 or 44 or 45 or 46 or 47 or 48
50	randomized controlled trial/ or random*.ti,ab.
51	49 not 50
52	animals/ not humans/
53	exp Animals, Laboratory/
54	exp Animal Experimentation/
55	exp Models, Animal/
56	exp Rodentia/
57	(rat or rats or mouse or mice).ti.
58	51 or 52 or 53 or 54 or 55 or 56 or 57
59	letter.pt. or letter/
60	note.pt.
61	editorial.pt.
62	case report/ or case study/

#	Searches
63	(letter or comment*).ti.
64	59 or 60 or 61 or 62 or 63
65	randomized controlled trial/ or random*.ti,ab.
66	64 not 65
67	animal/ not human/
68	nonhuman/
69	exp Animal Experiment/
70	exp Experimental Animal/
71	animal model/
72	exp Rodent/
73	(rat or rats or mouse or mice).ti.
74	66 or 67 or 68 or 69 or 70 or 71 or 72 or 73
75	58 use ppez
76	74 use emczd
77	75 or 76
78	40 and 77
79	40 not 78
80	remove duplicates from 79

Database: Cochrane Library via Wiley Online

Date of last search: 21st November 2018

#	Searches
#1	MeSH descriptor: [Abortion, Induced] explode all trees
#2	MeSH descriptor: [Abortion Applicants] explode all trees
#3	MeSH descriptor: [Abortion, Spontaneous] explode all trees
#4	MeSH descriptor: [Abortion, Criminal] explode all trees
#5	MeSH descriptor: [Aborted Fetus] explode all trees
#6	"abortion":ti,ab,kw (Word variations have been searched)
#7	(abort* or postabort* or preabort*):ti,ab,kw (Word variations have been searched)
#8	((fetal* or fetus* or foetal* or foetus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*):ti,ab,kw (Word variations have been searched)
#9	((fetal* or fetus* or foetal* or foetus*) next loss*):ti,ab,kw (Word variations have been searched)
#10	((gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) near/3 loss*):ti,ab,kw (Word variations have been searched)
#11	(((elective* or threaten* or voluntar*) near/3 interrupt*) and pregnan*):ti,ab,kw (Word variations have been searched)
#12	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11
#13	MeSH descriptor: [Health Services Accessibility] explode all trees
#14	MeSH descriptor: [Delivery of Health Care] this term only
#15	MeSH descriptor: [Delivery of Health Care, Integrated] this term only
#16	MeSH descriptor: [Quality of Health Care] this term only
#17	service use*:ti,ab,kw (Word variations have been searched)
#18	((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or take up* or uptake or utiliz* or utilis*) near/5

#	Searches
	(care or healthcare or intervention* or program* or referral* or service* or system* or therap* or treat*)):ti,ab,kw (Word variations have been searched)
#19	((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or take up* or uptake or utiliz* or utilis*) near/5 (abortion or termination)):ti,ab,kw (Word variations have been searched)
#20	((adult* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women* or woman* or user* or adolescen* or child* or teen* or (young* adj (people or person* or patient* or population*)) or youngster* or youth*) near/3 (access* or attend* or aversion or barrier* or equit* or facilitat* or inequalit* or inequit* or non attend* or obstacle* or obstruct* or refus* or takeup* or take up * or uptake or utiliz* or utilis*)):ti,ab,kw (Word variations have been searched)
#21	((clinician* or doctor* or facilitator* or gp* or healthcare or health profession* or leader* or nurs* or personnel* or physician* or practitioner* or pharmacist* or professional* or provider* or specialist* or staff* or worker*) near/3 (barrier* or obstacle* or facilitat* or obstruct* or takeup* or take up*)):ti,ab,kw (Word variations have been searched)
#22	((service* or infrastructure* or infra structure*) NEAR/3 (sustain* or continuation or durabl* or viabl* or stabl*))
#23	#13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22
#24	#12 and #23 Publication Year from 2001 to 2018

Database: Cinahl Plus

Date of last search: 21st November 2018

#	Searches
S15	S15 Limiters - Publication Year: 2001-2018; English Language
S15	S4 AND S14
S14	S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13
S13	TI (service use*1) OR AB (service use*1)
S12	TI ((service* or infrastructure* or infra structure*) N3 (sustain* or continuation or durabl* or viabl* or stabl*)) OR AB ((service* or infrastructure* or infra structure*) N3 (sustain* or continuation or durabl* or viabl* or stabl*))
S11	TI ((clinician* or doctor* or facilitator* or gp*1 or healthcare or health profession* or leader* or nurs* or personnel* or physician* or practitioner* or pharmacist* or professional* or provider* or specialist* or staff* or worker*) N33 (barrier* or obstacle* or facilitat* or obstruct* or takeup* or take up*)) OR AB ((clinician* or doctor* or facilitator* or gp*1 or healthcare or health profession* or leader* or nurs* or personnel* or physician* or practitioner* or pharmacist* or professional* or provider* or specialist* or staff* or worker*) N33 (barrier* or obstacle* or facilitat* or obstruct* or takeup* or take up*))
S10	TI ((adult* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women* or woman* or user* or adolescen* or child* or teen* or youngster* or youth*1) N3 (access* or attend* or aversion or barrier* or equit* or facilitat* or inequalit* or inequit* or non attend* or obstacle* or obstruct* or refus* or takeup* or take up * or uptake or utiliz* or utilis*)) OR AB ((adult* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women* or woman* or user* or adolescen* or child* or teen* or youngster* or youth*1) N3 (access* or attend* or aversion or barrier* or equit* or facilitat* or inequalit* or inequit* or non attend* or obstacle* or obstruct* or refus* or takeup* or take up * or uptake or utiliz* or utilis*))
S9	TI ((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or take up* or uptake or utiliz* or utilis*) N3

#	Searches
	(abortion or termination)) OR AB ((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or take up* or uptake or utiliz* or utilis*) N3 (abortion or termination))
S8	TI ((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or take up* or uptake or utiliz* or utilis*) N5 (care or healthcare or intervention* or program* or referral* or service* or system* or therap* or treat*)) OR AB ((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or take up* or uptake or utiliz* or utilis*) N5 (care or healthcare or intervention* or program* or referral* or service* or system* or therap* or treat*))
S7	(MH "Quality of Health Care")
S6	(MH "Health Care Delivery") OR (MH "Health Care Delivery, Integrated")
S5	(MH "Health Services Accessibility+")
S4	S1 OR S2 OR S3
S3	TI ((f?etal* or f?etus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*) OR AB ((f?etal* or f?etus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*)
S2	TI (abort* or postabort* or preabort*) OR AB (abort* or postabort* or preabort*)
S1	(MH "Abortion, Habitual") OR (MH "Abortion, Criminal") OR (MH "Abortion, Spontaneous") OR (MH "Abortion, Incomplete")

Database: Web of Science Core Collection

Timespan=2001-2018. Date of last search: 21st November 2018

#	Searches
# 11	#10 Refined by: LANGUAGES: (ENGLISH) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
#10	#9 AND #3 Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
#9	#8 OR #7 OR #6 OR #5 OR #4 Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 8	TS=((service* or infrastructure* or infra structure*) SAME (sustain* or continuation or durabl* or viabl* or stabl*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 7	TS=((clinician* or doctor* or facilitator* or healthcare or health profession* or leader* or nurs* or personnel* or physician* or practitioner* or pharmacist* or professional* or provider* or specialist* or staff* or worker*) SAME (barrier* or obstacle* or facilitat* or obstruct* or takeup*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 6	TS=((adult* or carer* or caregiver* or care giver* or client* or consumer* or customer* or famil* or father* or individual* or mentor* or men or minorities or mother* or outpatient* or patient* or people* or person* or population* or teacher* or women* or woman* or user* or adolescen* or child* or teen* or youngster* or youth*) SAME (access* or attend* or aversion or barrier* or equit* or facilitat* or inequalit* or inequit* or non attend* or obstacle* or obstruct* or refus* or takeup* or uptake or utiliz* or utilis*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 5	TS=((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or uptake or utiliz* or utilis*) SAME (abortion or termination)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018

#	Searches
# 4	TS=((access* or attend* or aversion or barrier* or equit* or facilitat* or inequit* or inequalit* or obstacle* or obstruct* or refus* or takeup* or uptake or utiliz* or utilis*) SAME (care or healthcare or intervention* or program* or referral* or service* or system* or therap* or treat*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 3	#2 OR #1 Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 2	TI=((f?etal* or f?etus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 1	TI=(abort* or postabort* or preabort*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018

Literature search strategy for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

The search for this topic was last run on 21st November 2018 during the re-runs for this guideline.

Database: Medline & Embase (Multifile)

Last searched on **Embase Classic+Embase** 1947 to 2018 November 20, **Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R)** 1946 to November 20, 2018

Date of last search: 21st November 2018

#	Searches
1	exp abortion/ use emczd
2	exp pregnancy termination/ use emczd
3	exp Abortion, Induced/ use ppez
4	Abortion Applicants/ use ppez
5	exp Abortion, Spontaneous/ use ppez
6	exp Abortion, Criminal/ use ppez
7	Aborted fetus/ use ppez
8	fetus death/ use emczd
9	abortion.mp.
10	(abort$ or postabort$ or preabort$).tw.
11	((f?etal$ or f?etus$ or gestat$ or midtrimester$ or pregnan$ or prenatal$ or pre natal$ or trimester$) and terminat$).tw.
12	((f?etal$ or f?etus$) adj loss$).tw.
13	((gestat$ or midtrimester$ or pregnan$ or prenatal$ or pre natal$ or trimester$) adj3 loss$).tw.
14	(((elective$ or threaten$ or voluntar$) adj3 interrupt$) and pregnan$).tw.
15	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14
16	Social Stigma/ use ppez
17	social stigma/ use emczd
18	Health Education/mt use ppez
19	Health Promotion/mt use ppez
20	*health education/ use emczd
21	*health promotion/ use emczd
22	((abortion or termination or ToP) adj3 stigma$).tw.
23	((reduc$ or lower or decreas$) adj3 stigma$).tw.
24	((rais$ or increas$ or improv$ or promot$ or expand$ or spread$ or creat$) adj3 awareness$).tw.
25	(awareness$ adj campaign$).tw.
26	((provider$ or trainee$ or regional$ or communit$ or outreach$ or value$) adj3 workshop$).tw.
27	(educat$ adj (program$ or intervention$)).tw.
28	((streamlin$ or centrali?ed) adj3 (process$ or procedure$ or service$ or pathway$ or access$ or program$ or system$ or refer$ or appointment$ or booking$)).tw.
29	(navigat$ adj3 health$).tw.

#	Searches
30	exp "Referral and Consultation"/ use ppez
31	patient referral/ use emczd
32	((abortion or termination or ToP) adj3 referral$).tw.
33	((GP$ or general practitioner$) adj refer$).tw.
34	(self refer$ or self-refer$ or selfrefer$).tw.
35	Patient Care Team/ use ppez
36	*patient care/ use emczd
37	"multidisciplinary team care"/ use emczd
38	(((patient$ or medical or health) adj1 care team) or healthcare team).tw.
39	((multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj5 (clinic$ or center$ or centre$ or service$ or team$ or group$ or staff$ or care or therap$ or management or approach$ or treat$ or panel$ or program$ or system$ or setting$ or unit)).tw.
40	MDT$1.tw.
41	Interdisciplinary Communication/ use ppez
42	interdisciplinary communication/ use emczd
43	((multiprofess$ or multi-profess$ or interprofess$ or inter-profess$ or transprofess$ or trans-profess$ or multidisciplin$ or multi-disciplin$ or interdisciplin$ or inter-disciplin$ or transdisciplin$ or trans-disciplin$ or crossdisciplin$ or cross-disciplin$) adj3 (communic$ or network? or collaborat$ or relation$)).tw.
44	(key worker$ or key person or case worker$ or case manager$).tw.
45	"Internship and Residency"/ use ppez
46	(*education, medical/ or *education, nursing/) use ppez
47	(schools, medical/ or schools, nursing/) use ppez
48	(students, medical/ or students, nursing/) use ppez
49	Curriculum/ use ppez
50	Clinical Competence/ use ppez
51	resident/ use emczd
52	(*medical education/ or *nursing education/ or residency education/) use emczd
53	(medical student/ or nursing student/) use emczd
54	medical school/ use emczd
55	curriculum/ use emczd
56	clinical competence/ use emczd
57	((abortion or termination or ToP) adj3 (education$ or training)).tw.
58	(residen$ adj training).mp.
59	((opt-in or opting-in or opting in or opt-out or opting-out or opting out or elective or non-elective) adj5 training).tw.
60	(training adj (program$ or model$)).mp.
61	(*health personnel/ or *case managers/ or *faculty, medical/ or *faculty, nursing/ or *medical staff/ or *physicians/ or *physician assistants/ or *midwifery/ or exp *nurses/ or exp *nursing staff/) use ppez
62	(*nurse's role/ or *physician's role/) use ppez
63	*Attitude of Health Personnel/ use ppez
64	(*health care personnel/ or *case manager/ or *medical staff/ or exp *nursing staff/ or exp *nurse/ or *physician/ or *physician assistant/ or *midwife/) use emczd

#	Searches
65	(*nurse attitude/ or *physician attitude/) use emczd
66	*health personnel attitude/ use emczd
67	((abortion or termination or ToP) adj5 (provider$ or provision$)).tw.
68	((physician$ or nurs$ or midwife$ or midwives$ or doctor$ or mid-level$ or midlevel$ or mid level$) adj3 (provider$ or provision$)).tw.
69	(provider-led or physician-led or nurse-led or midwife-led or doctor-led).tw.
70	(Telemedicine/ or Telenursing/ or Remote Consultation/) use ppez
71	(telemedicine/ or telenursing/ or teleconsultation/) use emczd
72	(telemedicine or tele-medicine or telenurs$ or tele-nurs$ or telemedical or tele-medical or videoconsult$ or video-consult$ or teleconsult$ or tele-consult$ or e-consult$).tw.
73	((remote$ or distanc$ or distant or audio or audio-visual or audiovisual or telephone$ or phone$ or video$ or internet$ or computer$ or webcam or website$ or electronic or smartphone$ or email or e-mail) adj5 (consult$ or communicat$ or assess$ or examin$ or evaluat$)).tw.
74	or/16-73
75	((community$ or local$ or remote$ or rural$) adj3 (setting$ or facilit$ or unit$ or delivery$ or service$ or context$ or provider$)).tw.
76	((hospital$ or central$ or in-clinic$) adj3 (setting$ or facilit$ or unit$ or delivery$ or service$ or context$ or provider$)).tw.
77	15 and 74
78	15 and 75 and 76
79	77 or 78
80	limit 79 to english language
81	limit 80 to yr="2001 -Current"
82	letter/
83	editorial/
84	news/
85	exp historical article/
86	Anecdotes as Topic/
87	comment/
88	case report/
89	(letter or comment*).ti.
90	82 or 83 or 84 or 85 or 86 or 87 or 88 or 89
91	randomized controlled trial/ or random*.ti,ab.
92	90 not 91
93	animals/ not humans/
94	exp Animals, Laboratory/
95	exp Animal Experimentation/
96	exp Models, Animal/
97	exp Rodentia/
98	(rat or rats or mouse or mice).ti.
99	92 or 93 or 94 or 95 or 96 or 97 or 98
100	letter.pt. or letter/
101	note.pt.
102	editorial.pt.

#	Searches
103	case report/ or case study/
104	(letter or comment*).ti.
105	100 or 101 or 102 or 103 or 104
106	randomized controlled trial/ or random*.ti,ab.
107	105 not 106
108	animal/ not human/
109	nonhuman/
110	exp Animal Experiment/
111	exp Experimental Animal/
112	animal model/
113	exp Rodent/
114	(rat or rats or mouse or mice).ti.
115	107 or 108 or 109 or 110 or 111 or 112 or 113 or 114
116	99 use ppez
117	115 use emczd
118	116 or 117
119	81 and 118
120	81 not 119

Database: Cochrane Library via Wiley Online

Date of last search: 21st November 2018

#	Searches
#1	MeSH descriptor: [Abortion, Induced] explode all trees
#2	MeSH descriptor: [Abortion Applicants] explode all trees
#3	MeSH descriptor: [Abortion, Spontaneous] explode all trees
#4	MeSH descriptor: [Abortion, Criminal] explode all trees
#5	MeSH descriptor: [Aborted Fetus] explode all trees
#6	"abortion":ti,ab,kw (Word variations have been searched)
#7	(abort* or postabort* or preabort*):ti,ab,kw (Word variations have been searched)
#8	((fetal* or fetus* or foetal* or foetus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*):ti,ab,kw (Word variations have been searched)
#9	((fetal* or fetus* or foetal* or foetus*) next loss*):ti,ab,kw (Word variations have been searched)
#10	((gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) near/3 loss*):ti,ab,kw (Word variations have been searched)
#11	(((elective* or threaten* or voluntar*) near/3 interrupt*) and pregnan*):ti,ab,kw (Word variations have been searched)
#12	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11
#13	MeSH descriptor: [Social Stigma] this term only
#14	MeSH descriptor: [Health Education] this term only and with qualifier(s): [methods - MT]
#15	MeSH descriptor: [Health Promotion] this term only and with qualifier(s): [methods - MT]
#16	(((abortion or termination or ToP) NEAR/3 stigma*)):ti,ab,kw
#17	(((reduc* or lower or decreas*) NEAR/3 stigma*)):ti,ab,kw
#18	(((rais* or increas* or improv* or promot* or expand* or spread* or creat*) NEAR/3 awareness*)):ti,ab,kw

#	Searches
#19	((awareness* NEXT campaign*)):ti,ab,kw
#20	(((provider* or trainee* or regional* or communit* or outreach* or value*) NEAR/3 workshop*)):ti,ab,kw
#21	((educat* NEXT (program* or intervention*))):ti,ab,kw
#22	(((streamlin* or centralised or centralized) NEAR/3 (process* or procedure* or service* or pathway* or access* or program* or system* or refer* or appointment* or booking*))):ti,ab,kw
#23	((navigat* NEAR/3 health*)):ti,ab,kw
#24	MeSH descriptor: [Referral and Consultation] explode all trees
#25	(((abortion or termination or ToP) NEAR/3 referral*)):ti,ab,kw
#26	(((GP* or general practitioner*) NEXT refer*)):ti,ab,kw
#27	((self refer* or self-refer* or selfrefer*)):ti,ab,kw
#28	MeSH descriptor: [Patient Care Team] this term only
#29	((((patient* or medical or health) NEAR/1 care team) or healthcare team)):ti,ab,kw
#30	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR/5 (clinic* or center* or centre* or service* or team* or group* or staff* or care or therap* or management or approach* or treat* or panel* or program* or system* or setting* or unit))):ti,ab,kw
#31	(MDT*):ti,ab,kw
#32	MeSH descriptor: [Interdisciplinary Communication] this term only
#33	(((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) NEAR/3 (communic* or network? or collaborat* or relation*))):ti,ab,kw
#34	((key worker* or key person or case worker* or case manager*)):ti,ab,kw
#35	MeSH descriptor: [Internship and Residency] this term only
#36	MeSH descriptor: [Education, Medical] this term only
#37	MeSH descriptor: [Education, Nursing] this term only
#38	MeSH descriptor: [Schools, Medical] this term only
#39	MeSH descriptor: [Schools, Nursing] this term only
#40	MeSH descriptor: [Students, Medical] this term only
#41	MeSH descriptor: [Students, Nursing] this term only
#42	MeSH descriptor: [Curriculum] this term only
#43	MeSH descriptor: [Clinical Competence] this term only
#44	(((abortion or termination or ToP) NEAR/3 (education$ or training))):ti,ab,kw
#45	((residen* NEXT training)):ti,ab,kw
#46	(((opt-in or opting-in or opting in or opt-out or opting-out or opting out or elective or non-elective) NEAR/5 training)):ti,ab,kw
#47	((training NEXT (program* or model*))):ti,ab,kw
#48	MeSH descriptor: [Health Personnel] this term only
#49	MeSH descriptor: [Case Managers] this term only
#50	MeSH descriptor: [Faculty, Medical] this term only
#51	MeSH descriptor: [Faculty, Nursing] this term only
#52	MeSH descriptor: [Medical Staff] this term only
#53	MeSH descriptor: [Physicians] this term only
#54	MeSH descriptor: [Physician Assistants] this term only

#	Searches
#55	MeSH descriptor: [Midwifery] this term only
#56	MeSH descriptor: [Nurses] explode all trees
#57	MeSH descriptor: [Nursing Staff] explode all trees
#58	MeSH descriptor: [Nurse's Role] this term only
#59	MeSH descriptor: [Physician's Role] this term only
#60	MeSH descriptor: [Attitude of Health Personnel] this term only
#61	(((abortion or termination or ToP) NEAR/5 (provider* or provision*))):ti,ab,kw
#62	(((physician* or nurs* or midwife* or midwives* or doctor* or mid-level* or midlevel* or mid level*) NEAR/3 (provider* or provision*))):ti,ab,kw
#63	((provider-led or physician-led or nurse-led or midwife-led or doctor-led)):ti,ab,kw
#64	MeSH descriptor: [Telemedicine] this term only
#65	MeSH descriptor: [Telenursing] this term only
#66	MeSH descriptor: [Remote Consultation] this term only
#67	((telemedicine or tele-medicine or telenurs* or tele-nurs* or telemedical or tele-medical or videoconsult* or video-consult* or teleconsult* or tele-consult* or e-consult*)):ti,ab,kw
#68	(((remote* or distanc* or distant or audio or audio-visual or audiovisual or telephone* or phone* or video* or internet* or computer* or webcam or website* or electronic or smartphone* or email or e-mail) NEAR/5 (consult* or communicat* or assess* or examin* or evaluat*))):ti,ab,kw
#69	#13 or #14 or #15 #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66 or #67 or #68
#70	#12 AND #69
#71	(((community* or local* or remote* or rural*) NEAR/3 (setting* or facilit* or unit* or delivery* or service* or context* or provider*))):ti,ab,kw
#72	(((hospital* or central* or in-clinic*) NEAR/3 (setting* or facilit* or unit* or delivery* or service* or context* or provider*))):ti,ab,kw
#73	#12 AND #71 AND #72
#74	#70 or #73

Database: Cinahl Plus

Date of last search: 21st November 2018

#	Searches
S58	S54 OR S57 Limiters - Publication Year: 2001-2018; English Language
S57	S4 AND S55 AND S56
S56	TI ((hospital* or central* or in-clinic*) N3 (setting* or facilit* or unit* or delivery* or service* or context* or provider*)) OR AB ((hospital* or central* or in-clinic*) N3 (setting* or facilit* or unit* or delivery* or service* or context* or provider*))
S55	TI ((community* or local* or remote* or rural*) N3 (setting* or facilit* or unit* or delivery* or service* or context* or provider*)) OR AB ((community* or local* or remote* or rural*) N3 (setting* or facilit* or unit* or delivery* or service* or context* or provider*))
S54	S4 AND S53
S53	S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37

#	Searches
	OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52
S52	TI ((remote* or distanc* or distant or audio or audio-visual or audiovisual or telephone* or phone* or video* or internet* or computer* or webcam or website* or electronic or smartphone* or email or e-mail) N5 (consult* or communicat* or assess* or examin* or evaluat*)) OR AB ((remote* or distanc* or distant or audio or audio-visual or audiovisual or telephone* or phone* or video* or internet* or computer* or webcam or website* or electronic or smartphone* or email or e-mail) N5 (consult* or communicat* or assess* or examin* or evaluat*))
S51	TI (telemedicine or tele-medicine or telenurs* or tele-nurs* or telemedical or tele-medical or videoconsult* or video-consult* or teleconsult* or tele-consult* or e-consult*) OR AB (telemedicine or tele-medicine or telenurs* or tele-nurs* or telemedical or tele-medical or videoconsult* or video-consult* or teleconsult* or tele-consult* or e-consult*)
S50	(MH "Remote Consultation")
S49	(MH "Telemedicine") OR (MH "Telenursing")
S48	TI (provider-led or physician-led or nurse-led or midwife-led or doctor-led) OR AB (provider-led or physician-led or nurse-led or midwife-led or doctor-led)
S47	TI ((physician* or nurs* or midwife* or midwives* or doctor* or mid-level* or midlevel* or mid level*) N3 (provider* or provision*)) OR AB ((physician* or nurs* or midwife* or midwives* or doctor* or mid-level* or midlevel* or mid level*) N3 (provider* or provision*))
S46	TI ((abortion or termination or ToP) N5 (provider* or provision*)) OR AB ((abortion or termination or ToP) N5 (provider* or provision*))
S45	(MM "Attitude of Health Personnel")
S44	(MM "Physician's Role") OR (MM "Nursing Role")
S43	(MM "Nurses+")
S42	(MM "Midwifery")
S41	(MM "Physician Assistants") OR (MM "Physicians")
S40	(MM "Medical Staff") OR (MM "Nursing Staff, Hospital")
S39	(MM "Faculty, Medical") OR (MM "Faculty, Nursing")
S38	(MM "Case Managers")
S37	(MM "Health Personnel")
S36	TI (training NEXT (program* or model*)) OR AB (training NEXT (program* or model*))
S35	TI ((opt-in or opting-in or opting in or opt-out or opting-out or opting out or elective or non-elective) N5 training) OR AB ((opt-in or opting-in or opting in or opt-out or opting-out or opting out or elective or non-elective) N5 training)
S34	TI (residen* NEXT training) OR AB (residen* NEXT training)
S33	TI ((abortion or termination or ToP) N3 (education* or training)) OR AB ((abortion or termination or ToP) N3 (education* or training))
S32	(MH "Clinical Competence")
S31	(MH "Curriculum")
S30	(MH "Students, Medical") OR (MH "Students, Nursing")
S29	(MH "Schools, Medical") OR (MH "Schools, Nursing")
S28	(MH "Education, Medical") OR (MH "Education, Nursing")
S27	(MH "Internship and Residency")
S26	TI (key worker* or key person or case worker* or case manager*) OR AB (key worker* or key person or case worker* or case manager*)
S25	TI (multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or

#	Searches
	transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 (communic* or network? or collaborat* or relation*)) OR AB (multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N3 (communic* or network? or collaborat* or relation*))
S24	TI (MDT*) OR AB (MDT*)
S23	TI ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N5 (clinic* or center* or centre* or service* or team* or group* or staff* or care or therap* or management or approach* or treat* or panel* or program* or system* or setting* or unit)) OR AB ((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) N5 (clinic* or center* or centre* or service* or team* or group* or staff* or care or therap* or management or approach* or treat* or panel* or program* or system* or setting* or unit))
S22	TI (((patient$ or medical or health) N1 care team) or healthcare team) OR AB (((patient$ or medical or health) N1 care team) or healthcare team)
S21	(MH "Multidisciplinary Care Team")
S20	TI (self refer* or self-refer* or selfrefer*) OR AB (self refer* or self-refer* or selfrefer*)
S19	TI ((GP or general practitioner*) NEXT refer*) OR AB ((GP or general practitioner*) NEXT refer*)
S18	TI ((GP or general practitioner*) NEXT refer*) OR AB ((GP or general practitioner*) NEXT refer*)
S17	TI ((abortion or termination or ToP) N3 referral*) OR AB ((abortion or termination or ToP) N3 referral*)
S16	(MH "Referral and Consultation+")
S15	TI (navigat* N3 health*) OR AB (navigat* N3 health*)
S14	TI ((streamlin* or centrali?ed) N3 (process* or procedure* or service* or pathway* or access* or program* or system* or refer* or appointment* or booking*)) OR AB ((streamlin* or centrali?ed) N3 (process* or procedure* or service* or pathway* or access* or program* or system* or refer* or appointment* or booking*))
S13	TI (educat* NEXT (program* or intervention*)) OR AB (educat* NEXT (program* or intervention*))
S12	TI ((provider* or trainee* or regional* or communit* or outreach* or value*) N3 workshop*) OR AB ((provider* or trainee* or regional* or communit* or outreach* or value*) N3 workshop*)
S11	TI (awareness* NEXT campaign*) OR AB (awareness* NEXT campaign*)
S10	TI ((rais* or increas* or improv* or promot* or expand* or spread* or creat*) N3 awareness*) OR AB ((rais* or increas* or improv* or promot* or expand* or spread* or creat*) N3 awareness*)
S9	TI ((reduc* or lower or decreas*) N3 stigma*) OR AB ((reduc* or lower or decreas*) N3 stigma*)
S8	TI ((abortion or termination or ToP) N3 stigma*) OR AB ((abortion or termination or ToP) N3 stigma*)
S7	(MH "Health Promotion/MT")
S6	(MH "Health Education/MT")
S5	(MH "Stigma")
S4	S1 OR S2 OR S3

#	Searches
S3	TI ((f?etal* or f?etus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*) OR AB ((f?etal* or f?etus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*)
S2	TI (abort* or postabort* or preabort*) OR AB (abort* or postabort* or preabort*)
S1	(MH "Abortion, Habitual") OR (MH "Abortion, Criminal") OR (MH "Abortion, Spontaneous") OR (MH "Abortion, Incomplete")

Database: Web of Science Core Collection

Timespan=2001-2018. Date of last search: 21st November 2018

#	Searches
# 33	#32 OR #29 Refined by: LANGUAGES: (ENGLISH) AND [excluding] DOCUMENT TYPES: (NEWS ITEM OR BOOK REVIEW OR EDITORIAL MATERIAL OR LETTER) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 32	#31 AND #30 AND #3 Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 31	TS=((hospital* or central* or in-clinic*) SAME (setting* or facilit* or unit* or delivery* or service* or context* or provider*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 30	TS=((community* or local* or remote* or rural*) SAME (setting* or facilit* or unit* or delivery* or service* or context* or provider*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 29	#28 AND #3 Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 28	#27 OR #26 OR #25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19 OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12 OR #11 OR #10 OR #9 OR #8 OR #7 OR #6 OR #5 OR #4 Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 27	TS=((remote* or distanc* or distant or audio or audio-visual or audiovisual or telephone* or phone* or video* or internet* or computer* or webcam or website* or electronic or smartphone* or email or e-mail) SAME (consult* or communicat* or assess* or examin* or evaluat*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 26	TS=(telemedicine or tele-medicine or telenurs* or tele-nurs* or telemedical or tele-medical or videoconsult* or video-consult* or teleconsult* or tele-consult* or e-consult*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 25	TS=(provider-led or physician-led or nurse-led or midwife-led or doctor-led) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 24	TS=((physician* or nurs* or midwife* or midwives* or doctor* or mid-level* or midlevel* or mid level*) SAME (provider* or provision*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 23	TS=((abortion or termination or ToP) SAME (provider* or provision*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 22	TS=(training NEAR (program* or model*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 21	TS=(residen* NEAR training) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 20	TS=((abortion or termination or ToP) SAME (education* or training))

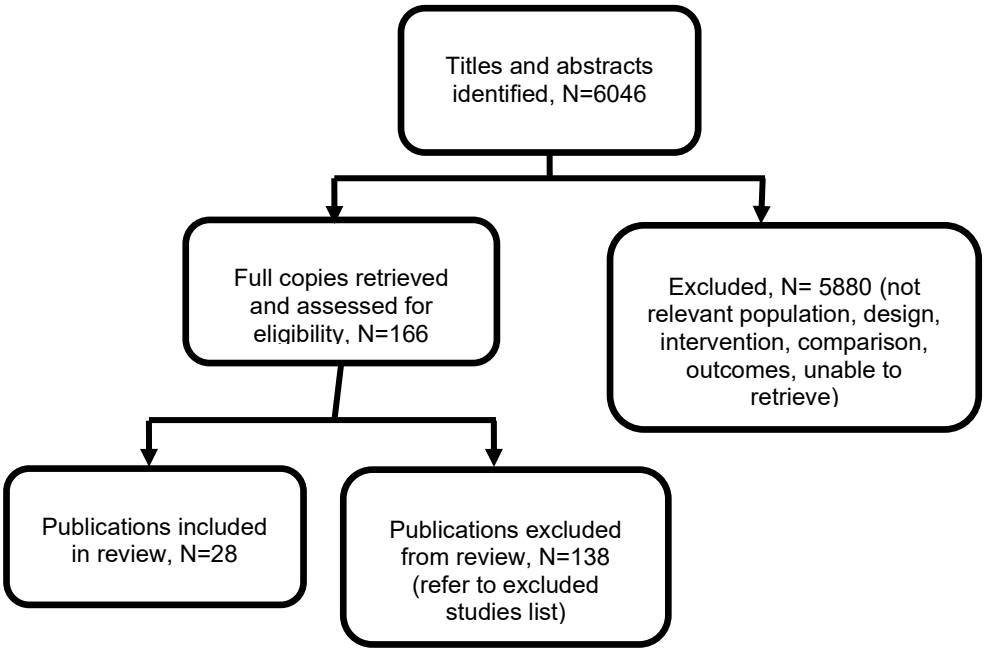
#	Searches
	Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 19	TS=(key worker* or key person or case worker* or case manager*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 18	TS=((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) SAME (communic* or network* or collaborat* or relation*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 17	TS=MDT* Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 16	TS=((multiprofess* or multi-profess* or interprofess* or inter-profess* or transprofess* or trans-profess* or multidisciplin* or multi-disciplin* or interdisciplin* or inter-disciplin* or transdisciplin* or trans-disciplin* or crossdisciplin* or cross-disciplin*) SAME (clinic* or center* or centre* or service* or team* or group* or staff* or care or therap* or management or approach* or treat* or panel* or program* or system* or setting* or unit)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 15	TS=(((patient* or medical or health) NEAR care team) or healthcare team) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 14	TS=(self refer* or self-refer* or selfrefer*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 13	TS=((GP or general practitioner*) SAME refer*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 12	TS=((abortion or termination or ToP) SAME referral*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 11	TS=(navigat* SAME health*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 10	TS=((streamlin* or centralised or centralized) SAME (process* or procedure* or service* or pathway* or access* or program* or system* or refer* or appointment* or booking*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 9	TS=(educat* NEAR (program* or intervention*)) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 8	TS=((provider* or trainee* or regional* or communit* or outreach* or value*) SAME workshop*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 7	TS=(awareness* NEAR campaign*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 6	TS=((rais* or increas* or improv* or promot* or expand* or spread* or creat*) SAME awareness*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 5	TS=((reduc* or lower or decreas*) SAME stigma*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 4	TS=((abortion or termination or ToP) SAME stigma*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 3	#2 OR #1 Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018
# 2	TI=((f?etal* or f?etus* or gestat* or midtrimester* or pregnan* or prenatal* or pre natal* or trimester*) and terminat*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018

#	Searches
# 1	TI=(abort* or postabort* or preabort*) Indexes=SCI-EXPANDED, SSCI Timespan=2001-2018

Appendix C – Clinical evidence study selection

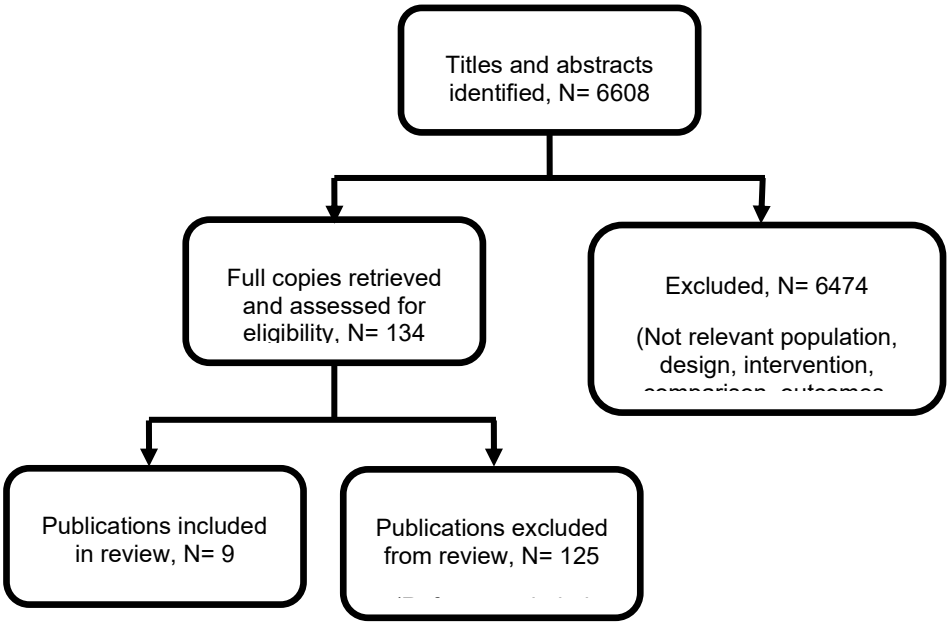
Clinical evidence study selection for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

Figure 2: Study selection flow chart



Clinical evidence study selection for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

Figure 3: Study selection flow chart



Appendix D – Clinical evidence tables

Clinical evidence tables for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Full citation Aiken, A. R. A., Broussard, K., Johnson, D. M., Padron, E., Motivations and Experiences of People Seeking Medication Abortion Online in the United States, Perspectives on Sexual & Reproductive HealthPerspect Sex Reprod Health, 11, 11, 2018 **Ref Id** 930127 **Country/ies where the study was carried out** **Study type** Data not extracted as data saturation had been reached	**Sample size** **Characteristics** **Inclusion criteria** **Exclusion criteria**	**Sampling and setting** **Data collection** **Data analysis**		**Limitations** **Other information**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Aim of the study **Study dates** **Source of funding**				
Full citation Aiken, A. R. A., Guthrie, K. A., Schellekens, M., Trussell, J., Gomperts, R., Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain, Contraception, 97, 177-183, 2018b **Ref Id** 831370 **Country/ies where the study was carried out** UK (England, Scotland and Wales) **Study type** Mixed-methods - online consultation form	**Sample size** n=519 women **Characteristics** Age in years - <20 (number; percentage in parentheses): 49 (9.4) Age in years - 20-24 (number; percentage in parentheses): 111 (21.4) Age in years - 25-29 (number; percentage in parentheses): 127 (24.5) Age in years - 30-34 (number; percentage in parentheses): 104 (20.0) Age in years - 35-39 (number; percentage in parentheses): 90 (17.3) Age in years - 40-44 (number; percentage in parentheses): 30 (5.8)	**Sampling and setting** All British women who requested medication for abortion through Women on Web (WoW) between 22nd November 2016 and 22nd March 2017. Women in the UK are not eligible for abortion services through WoW but, nonetheless, a number of women complete their online consultation forms and WoW have started a service which helps women to find abortion services in their local (and surrounding) area. **Data collection** Limited information reported but as part of completing the online consultation from women are asked to describe their reasons for requesting abortion outside of the formal healthcare setting	**Theme: barrier to accessing in-clinic care** • "..experiencing delays in accessing services, including waiting times of several weeks. Amelia, a 34-year-old woman living in England explained: 'I've been in touch with my doctor and have been referred but they can't see me for nearly three weeks. I cannot wait that long. I have nine children who need me and every day is feeling like torture at the minute. My marriage has ended and I cannot physically face another child on my own. I just want to get on with my life and raising the children I do have and who need me now.'" page 179 *(Service-*	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers do not state if they considered alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
containing both fixed (quantitative) and free-text (qualitative) options **Aim of the study** To determine reasons why women in the UK seek abortion services outside of the NHS **Study dates** November 2016 to March 2017 **Source of funding** Society of Family Planning; Eunice Kennedy Shriver National Institute of Child Health and Human Development; National Institutes of Health	Age in years - ≥45 (number; percentage in parentheses): 8 (1.5) Parity - 0 (number; percentage in parentheses): 358 (68.9) Parity - 1 (number; percentage in parentheses): 96 (18.5) Parity - 2 (number; percentage in parentheses): 37 (7.1) Parity - 3 (number; percentage in parentheses): 16 (3.0) Parity - ≥4 (number; percentage in parentheses): 13 (2.5) Gestation - <7 weeks (number; percentage in parentheses): 397 (76.5) Gestation - 7-10 weeks (number; percentage in parentheses): 122 (23.5) **Inclusion criteria** Women in Britain who requested medication for abortion through Women on Web (WoW) between 22nd November 2016 and 22nd March 2017 **Exclusion criteria** No additional criteria reported	**Data analysis** Two researchers independently analysed emails and coded them according to a coding guide that was developed iteratively. Differences were resolved via group discussion using a summative content analysis approach	*level barriers: long waiting times and delays)* • "Another common barrier was logistical difficulties getting to a clinic due to inability to get time away from work or childcare to attend one or more appointments. Linda, a 31-year-old working mother living in Scotland echoed many others when she explained: 'I am only 2 weeks pregnant, I already have 3 kids and I am a single working mum. I am unable to go to the hospital as I do not have the funds to pay for childcare while I would be in there. I am unable to take time off work and I can't tell my family so there is no one I can ask to look after the kids. I really need to do this in my own home.'" page 180 *(Logistical barriers: Difficulty arranging time off work; Logistical barriers: Difficulty arranging childcare)*	research issue? Can't tell, open-ended questions in the online consultation form provided the qualitative data, may not provide the necessary richness to address the research question. Data saturation not discussed. Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? Can't tell, insufficient discussion of evidence for and against

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			• "For other women, major barriers to clinic access were long travel distances or lack of transport. Rachel, a 30-year-old woman living in England explained: 'My nearest clinic is over 100 miles away and I have no idea how I would get there and back home after the abortion.'" page 180 *(Logistical barriers: additional expenses and delays caused by travel arrangements)* • "Women who are ineligible for free, non-emergency NHS services face particular barriers finding and paying for abortion care on their own. Most commonly, these women are either undocumented immigrants, or have been admitted under a visa program and are thus considered visitors to rather than naturalized ordinary residents of Great Britain. Leila, who is 22 years old and living in	the researchers' arguments How valuable is the research? Can't tell, women contacting WoW for medical abortion is unlikely to be representative of the wider population of women in Britain who want an abortion **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			England explained 'I completely lack the money for services and I am not a resident of UK. I am completely alone and really need help.'" page 180 *(Financial barriers: Funding for people ineligible for free NHS service)* • "Finally, some women reported prior negative experiences with clinical services or experienced judgmental attitudes from healthcare providers, and were afraid of encountering the same situation a second time. Jessica, who is 27 years old and living in England explained: 'I know what is available to me. I've had bad experiences in the past. I do not want to talk to anyone or go anywhere. I won't have a hospital abortion again. I find it ironic that it would be easier for me to get what I need in a country where abortion is illegal!'" page 180 *(Personal barriers:*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			Prior negative experiences) **Theme: privacy concerns, confidentiality concerns and privacy preferences** • "Many women wished to keep their abortion secret because of either perceived or experienced stigma around abortion. As Meera, who is 29 years old and lives in England explained: 'I'm ashamed and embarrassed to return to clinic as I've been for an abortion before and know I will be judged for having another one. The stigma of having to walk into any face-to-face setting is too much.'" page 180 *(Personal barriers: Perceived stigma)* • " Others feared breach of confidentiality if they accessed in-clinic services, sometimes due to working within the hospital or clinic themselves, or having friends or family working there." page 180 *(Privacy*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			and confidentiality concerns) • "For other women, issues such as severe anxiety made it hard for them to leave the house, leading to a strong preference or necessity for both consultations and procedures to take place in private at home. Tina, who is 35 years old and lives in England explained: 'I am on medication for the depression and anxiety and I struggle to leave the house. I do all my shopping online, my child is picked up and dropped off for school in a taxi. Simple things like leaving the house to take the bins out are an impossible task for me... I know I couldn't cope with this pregnancy and I certainly wouldn't be able to cope with a baby but I know I can't go outside to the doctors and I certainly wouldn't cope with a hospital visit.'" page 180 *(Personal barriers:*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			comorbid health conditions) • "For others, a change in law to decriminalize self-sourced and self-managed abortion was the clear solution." page 181 *(Legal and policy barriers)* **Theme: threat of violence or controlling circumstances** • "Just over 1 in 6 reasons (18%) involved a situation where women did not feel able to seek abortion services at a clinic or hospital because of the fear or threat of partner violence or a situation involving a controlling family. These circumstances ranged from fear of strong disapproval on religious grounds—leading to shunning or, in extreme circumstances, fear of honor killing—to inability to leave the house without permission from a partner and fear of physical violence from a	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			partner disapproving of abortion... Susan, who is 30 years old and lives in England, described her situation living with domestic violence and unable to seek care at a clinic or hospital for fear of partner intervention or retaliation: 'I'm in a controlling relationship, he watches my every move, I'm so scared he will find out, I believe he's trying to trap me and will hurt me. I can't breathe. If he finds out, he wouldn't let me go ahead, then I will be trapped forever. I cannot live my life like this.'" page 181 *(Personal barriers: Threat of violence)*	
Full citation Black, K. I., Douglas, H., De Costa, C., Women's access to abortion after 20 weeks gestation for fetal chromosomal abnormalities: Views and experiences of doctors in New South Wales and Queensland, Australian	**Sample size** n=22 physicians **Characteristics** Profession - maternal-fetal medicine specialists (number; percentage in parentheses): 4 (18) Profession - sexual health physician (number; percentage in parentheses): 4 (18)	**Sampling and setting** Healthcare professionals from the public and private sector that referred women to abortion services, exclusively provided abortion services, or worked across the broader area of obstetrics and gynaecology; unclear how they were	• "Eighteen doctors alluded to the difficulty they had in accessing private and public hospital abortion services for women with a fetal abnormality post 20 weeks' gestation. Twenty one of the 22 practitioners or their colleagues had to refer women interstate to	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
and New Zealand Journal of Obstetrics and Gynaecology, 55, 144-148, 2015 **Ref Id** 841372 **Country/ies where the study was carried out** Australia **Study type** Qualitative - thematic analysis **Aim of the study** To investigate barriers to abortion services for fetal anomaly beyond 20 weeks' gestation **Study dates** November 2011 to May 2012 **Source of funding** No sources reported	Profession - abortion provider in private clinic (number; percentage in parentheses): 10 (45) Profession - specialist obstetrician/gynaecologist (number; percentage in parentheses): 3 (14) Profession - family planning physician (number; percentage in parentheses): 1 (5) **Inclusion criteria** No criteria reported **Exclusion criteria** No criteria reported	recruited or who was deemed eligible. **Data collection** Interviewees asked respondents about the scope of their practice, their understanding of abortion laws and provided them with clinical scenarios and asked them to comment on the legality and availability of an abortion under these conditions. Not reported whether interviews were structured, how long they lasted, how they were conducted or whether they were recorded. **Data analysis** Thematic analysis was undertaken; no further details reported.	have an abortion because the ethics committee would take too long to convene: 'Well that's not the way it's supposed to be but in practice it seems extremely difficult to arrange. . .Apparently the X hospital should do this but they seem to have to constitute ethics committees at a drop of a hat to look at some of these issues, and by then, of course its 20, 21, 22 23, 24 weeks, no guarantee, incredibly stressful for the woman, So we try to arrange it privately or interstate. It's much less stressful for everyone.' (Interview 7, p5–6)" page 146 *(No theme applied by the authors; Legal and policy barriers)* • "...the decisions of ethics committees were viewed to some extent as representing personal beliefs and not necessarily based on the law or ethical implications: 'Because I think they tend to feel they	Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Can't tell, insufficient information reported Was the data collected in a way that addressed the research issue? Can't tell, asked about availability of services in response to specific clinical scenarios rather than based on their experience Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			can choose which women they can offer termination to or not, [based] on their own value judgment. . .,' (Interview 6, p7)" page 146 *(No theme applied by the authors; Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)*	Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? No, researchers did not present theme labels How valuable is the research? Researchers do not clearly discuss the contribution the study makes to existing literature **Other information** None
Full citation Blanchard, K., Meadows, J. L., Gutierrez, H. R., Hannum, C. P., Douglas-Durham, E. F., Dennis, A. J., Mixed-methods investigation of women's experiences with second-trimester abortion care in	**Sample size** **Characteristics** **Inclusion criteria** **Exclusion criteria**	**Sampling and setting** **Data collection** **Data analysis**		**Limitations** **Other information**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
the Midwest and Northeast United States, Contraception, 96, 401-410, 2017 **Ref Id** 841932 **Country/ies where the study was carried out** **Study type** Data not extracted as data saturation had been reached **Aim of the study** **Study dates** **Source of funding**				
Full citation Cano, J. K., Foster, A. M., "They made me go through like weeks of appointments and everything": Documenting women's experiences seeking abortion care in Yukon territory, Canada,	**Sample size** n=16 women **Characteristics** Age in years (average): 32 Ethnicity - White (number; percentage in parentheses): 9 (56)	**Sampling and setting** Women were recruited through email, study advertisements on online platforms and traditional and social media, and through circulating study information through local organisations. Yukon Territory only offers abortion services	**Theme: obtaining an abortion in the Yukon is complicated and the process is not transparent** • "Most women were unaware of what obtaining an abortion would entail and those without a family physician had difficulty	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Contraception, 94, 489-495, 2016 **Ref Id** 602056 **Country/ies where the study was carried out** Canada **Study type** Qualitative - deductive and inductive analysis **Aim of the study** To explore women's experiences of accessing abortion services in Yukon Territory of Canada **Study dates** June 2015 to January 2016 **Source of funding** Ministry of Health and Long-Term Care in Ontario	Gestational age in weeks at abortion (average): 9.4 **Inclusion criteria** English- or French-speaking women aged at least 18 years old who obtained an abortion, while a resident of Yukon Territory, from 1st January 2005 **Exclusion criteria** No additional criteria reported	twice a month in the capital city and does not perform abortions after 12^{+6} weeks' gestation. **Data collection** Interviews were audio-recorded, lasted approximately 1 hour and were conducted by telephone or over Skype. The interview guide consisted of open-ended questions about 1) the woman's background, 2) reproductive health history, 3) circumstances surrounding the abortion(s), 4) insights on future improvements to services, and 5) knowledge and opinion of mifepristone. Interviews were transcribed verbatim. **Data analysis** Data analysis had 4 phases: 1) development of a codebook using a priori codes based on the interview guide, study objective and findings from a larger qualitative study (Canada Abortion Study) that this study was part of, 2) addition of further codes developed through inductive	navigating where to go and who to contact. As Sofia, a 38-year-old woman who obtained her abortion in 2015, explained, 'So it took me a little bit of searching around, you know, I called different people, different places, and eventually I got in touch with the sexual clinic.' Even for participants that did have a family doctor, some reported difficulty getting an appointment in a timely manner or receiving inadequate information about the overarching process. Alyssa, a 26-year-old woman who obtained her abortion in 2012, described her uncertainty, 'Yeah they don't really lay it out clearly, like what's gonna happen, like you have no idea.'" page 491 *(Service-level barriers: Difficulty navigating the healthcare system)* • "Another participant waited over a month to get her ultrasound after her family	Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Yes (see Foster 2017) Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? yes Is there a clear statement of findings? Can't tell, insufficient discussion of evidence for and against

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
		analysis of the data, 3) identification of themes and relationships between themes and codes, and 4) checking for coherence between themes both within and between the researchers. Group meetings (including the wider CAS team) guided interpretations and were used to resolve discrepancies	doctor appointment. She suspects that the ultrasound department intentionally delayed her procedure; she was nearing the 12-week gestational age limit by the time her family doctor received the ultrasound results and was immediately scheduled for the next procedure date in-territory." page 492 *(Service-level barriers: Long waiting times and delays)* **Theme: Multiple appointments, significant travel and long wait times are financially and emotionally taxing and influence disclosure** • "Transportation challenges are further amplified for women living in remote communities, where there are few or no public transportation options available to travel to Whitehorse. Kristen, a 27-year-old woman, did not	the researchers' arguments How valuable is the research? Can't tell, researchers discuss limitations to the generalizability of the research **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			want anyone to know about her second abortion, 'Yeah, I drove myself actually because I didn't want to tell my mom…and they said I needed somebody to pick me up, but I said I had somebody to pick me up but I didn't, I just, I drove myself home afterwards'" page 493 *(Logistical barriers: Arranging drive home can cause delays and necessitate unwanted disclosure)* **Theme: A number of avenues exist for improving care** • "'So if they could somehow even just bundle those appointments? Like so that they're all on the same day…and make them more like just convenient.' (Heather, 29) When asked how services could be improved, participants made suggestions to streamline the service and decrease the wait times."	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			page 493 *(Service-level barriers: Difficulty navigating the healthcare system)* • "Women who accessed care through the new Yukon Sexual Health Clinic identified the need for expanded clinic hours and more providers offering care. As Karen explained, 'So there's one nurse practitioner and [the physician], but that's not enough, like they need other people working and supporting women.'" page 493 *(Service-level barriers: Insufficient resources and hours of operation)*	
Full citation Dawson, A. J., Nicolls, R., Bateson, D., Doab, A., Estoesta, J., Brassil, A., Sullivan, E. A., Medical termination of pregnancy in general practice in Australia: A descriptive-interpretive qualitative study, Reproductive Health, 14 (1) (no pagination), 2017	**Sample size** n=72 invited to participate n=32 interviewed (n=28 interviews; n=4 participated in focus group) **Characteristics** Gender - female (number; percentage in parentheses): 24 (75)	**Sampling and setting** Purposive maximum variation sampling; services in 8 areas were selected to reflect the diversity of community and general practice following stakeholder consultation and mapping the characteristics of primary health care services (metropolitan, inner and outer regional or remote or very remote areas; sole-	**Theme: MTOP demand, care and referral** *Subtheme: GP provider experience of demand for MTOP* • "One GP provider spoke about the importance of MTOP for Aboriginal women: 'I think it's certainly a more accessible option for them because it doesn't have a financial	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Can't tell, the aim does

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Ref Id 802280 **Country/ies where the study was carried out** Australia **Study type** Qualitative - thematic analysis **Aim of the study** To explore the provision and referral of medical abortions by general practitioners in New South Wales, Australia **Study dates** Not reported **Source of funding** Family Planning NSW (New South Wales)	Gender - male (number; percentage in parentheses): 9 (28)* Provider of medical abortion - yes (number; percentage in parentheses): 8 (25) Provider of medical abortion - no (number; percentage in parentheses): 24 (75) *Note. numbers do not add up to the number of women in the study **Inclusion criteria** Not reported **Exclusion criteria** Not reported	provider, 2-5 doctors or more than 5 areas). 72 GPs were sent letters and emails asking them to participate in the study; practice managers, receptionists and practice nurses were also contacted to distribute study information to GPs. Study adverts were also placed in electronic newsletters of local health districts and snowball sampling was used, such that recruited GPs provided details for potential participants. **Data collection** Semi-structured interviews lasting up to 1 hour were conducted either face-to-face or via telephone and one focus group was help with 4 GPs. Three sets of open-ended questions were identified based on domains of access to abortions identified in a previous systematic review. **Data analysis** NVivo10 was used to undertake thematic analysis; coding was completed by 3	barrier or a distance barrier...'." page 5 *(Community prescribing and telemedicine)* *Subtheme: referral and brokerage for abortion in general practice* • "One interviewee reported that she delayed referring women so that they could have more thinking time: 'Letting them know that they've actually got time in many situations to make a decision. It's not a decision that needs to be made straight away. I think that to me is so important. Any decision that is made at that point has the potential of affecting them forever… it's just whether they do go ahead with the termination or they don't go ahead with the termination, there are consequences either way. That to me in that first consultation is so important. We'll walk through this together making sure that they're safe at that moment in time	not explicitly state that it intended to capture views or experiences but additional information in the methods suggests that a qualitative methodology is appropriate Was the research design appropriate to address the aims of the research? Can't tell as the aim does not explicitly state that it intended to capture views or experiences but additional information in the methods suggests that a qualitative methodology is appropriate and that the study design was appropriate Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
		researchers and emerging themes were discussed among the researchers and with 2 medical doctors to reach agreement.	for them to go away and digest everything that was said and then coming back for review and follow up.' [GP non-provider, metropolitan]" page 6 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "Some GPs expressed confusion over appropriate places to refer their patients: 'I'm starting to question myself about whether I know all the possible referral avenues with regards to abortion. It's something I need to just go over, it might just be today. I think just having that information and having the right information and the appropriate information that we can pass on to our clients.' [GP non-provider, metropolitan]" page 7 *(Training and education)*	critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss limits to generalisability of the research **Other information** In the UK, GPs do not currently prescribe for medical abortion as women would not be able to collect prescriptions from community pharmacies (as medication is legally restricted and has to be issued on licensed premises). Therefore, only themes about barriers to access that are relevant to current UK practice, and themes saying GP prescribing for medical

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
				abortion improved access to abortion were extracted as additional themes (barriers to GPs prescribing for medical abortion) will not be applicable to the current UK setting.
Full citation Dennis, A., Manski, R., Blanchard, K., A Qualitative Exploration of Low-Income Women's Experiences Accessing Abortion in Massachusetts, Women's Health Issues, 25, 463-469, 2015 **Ref Id** 602156 **Country/ies where the study was carried out** **Study type** Data not extracted as data saturation had been reached	**Sample size** **Characteristics** **Inclusion criteria** **Exclusion criteria**	**Sampling and setting** **Data collection** **Data analysis**		**Limitations** **Other information**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Aim of the study **Study dates** **Source of funding**				
Full citation Doran, F. M., Hornibrook, J., Barriers around access to abortion experienced by rural women in New South Wales, Australia, Rural & Remote Health, 16, 3538, 2016 **Ref Id** 602168 **Country/ies where the study was carried out** Australia **Study type** Qualitative - thematic analysis **Aim of the study** To identify factors experienced by women in rural New South Wales	**Sample size** n=16 women contacted researcher (n=2 did not live in New South Wales; n=1 follow-up contact not possible) n=13 women interviewed **Characteristics** Age at abortion in years (mean; range reported in parentheses): 27.5 (18-46) Interview format - phone (number; percentage reported in parentheses): 12 (92) Interview format - face-to-face (number; percentage reported in parentheses): 1 (8) **Inclusion criteria** Sought access to abortion in the last 15 years; living in rural New South Wales (at the time of abortion); older than 18 years of age; able to speak English	**Sampling and setting** Women in rural New South Wales were recruited through flyers displayed in public places, media releases, word of mouth and through women's services. Women self-selected and contacted the researcher if interested. Informed consent was obtained to record the interviews. **Data collection** Four broad questions were designed to facilitate a conversation regarding women's experience of accessing abortion services: 1) how they found out about the abortion clinic, 2) logistics involved in getting to the clinic, 3) logistics involved in follow-up care, 4) how women could be better supported to access an abortion. Interviews were transcribed verbatim.	**Theme: Getting to the clinic: self-referral, doctors referrals and 'jumping through hoops'** • "Women's experiences of the GP process varied from being easy and supported (one participant) to very challenging. Challenges related to delays in seeing a rural GP, lack of willingness of GPs to refer" page 4 *(Service-level barriers: Long waiting times and delays; Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "lack of information provided about the procedure or the clinic, lack of information about	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Yes Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered?

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
accessing abortion services and suggestions about how women could be better supported **Study dates** Not reported **Source of funding** No sources reported	**Exclusion criteria** No additional criteria reported	**Data analysis** Anonymised transcripts were read by both authors and thematic analysis was undertaken following guidelines from Braun and Clark (2016). Five themes were identified, based on significance of results and diversity rather than number of responses, which comprehensively and accurately represented women's experiences.	medical abortion and the required follow-up visit" page 4 *(Service-level barriers: Difficulty navigating the healthcare system)* • "delays caused by the need for blood tests or ultrasounds" page 4 *(Service-level barriers: Long waiting lists and delays)* **Theme: Stigma, shame and secrecy** • "An emergent theme was of women's experiences of stigma, shame and secrecy. All women commented on the stigma they experienced surrounding abortion, which for some was particularly apparent in small rural towns. External stigma was exacerbated by protestors, and internalised stigma was linked to feelings of shame and secrecy. Some women discussed the consequences of stigma	Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Can't tell, insufficient discussion of evidence for and against the researchers' arguments How valuable is the research? Researchers discuss the contribution the study makes to existing literature **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			and the lack of respect for women to make reproductive decisions concerning their own bodies." page 4 *(Personal barriers: Perceived stigma)* **Theme: Logistics to access services** *Subtheme: Money* • "Not all women mentioned problems with money but several did. Some women's partners paid the abortion fee, even if they were separated. Some women commented that the abortion cost, whilst expensive in the short term, was not as expensive as raising a child. Many women borrowed money to help with petrol, abortion fees or accommodation... Molly commented that the fee in itself 'wasn't that much but it's all the associated costs' of getting to the clinic." page 5 *(Financial barriers: Patient expenses)* *Subtheme: Travel*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			• "Participants travelled 1–9 hours one way to reach a clinic and five women required overnight accommodation. All except one woman used private transport to travel to the clinic. Moira travelled on an overnight train to Brisbane. For Fern it was a 'harrowing day', requiring a 6-hour journey to the clinic and then the return journey home, all in one day. Clara, who had previously had an abortion in the city, compared the city/regional experience as 'chalk and cheese' and was 'gobsmacked' she had to travel 'all that way to another state' where she felt 'isolated and horrible driving over that border'." page 6 *(Logistical barriers: Additional expenses and delays caused by travel arrangements)* *Subtheme: Support* • "Support was discussed in relation to child care or a support person. Five	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			women required early morning child care, which was provided by either a formal childcare provider or by friends or family. The clinic requirements were for someone to drive them home. Moira suggested this could have been particularly challenging for young women, for women who had no one to accompany them and for women without a licence. Skye also wondered how challenging this could be for women with few social or personal resources to negotiate loans and deal with the stigma and challenges." page 6 *(Logistical barriers: Difficulty arranging childcare; Logistical barriers: Arranging drive home can cause delays and necessitate unwanted disclosure)* **Theme: Follow-up medical/surgical abortions**	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			• "All women commented that medical abortion was not a feasible option because of logistical factors that prevented them from returning for the required follow-up appointment. Some women did see their GP for recommended follow-up care whilst some did not see the need for it." page 6 *(Logistical barriers: More appointments needed for medical abortion is a barrier to choosing medical abortion)* **Theme: more affordable, local and mainstream services** • "Some thought access to medical abortion was a way to reduce a complicated process: 'If RU486 was prescribed by my doctor, I wouldn't have had to go through all that', commented June" page 7 *(Community prescribing and telemedicine introduce greater flexibility)*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			• "Different models including more integrated women's health care were suggested. Moira's idea was a 'one-stop shop where women could go for help to get pregnant or if they want to end their pregnancy', which could also potentially increase privacy and deter protestors. Fern proposed that abortion services needed to be 'part of proper women's health care: it still needs to be dragged out of the back alley'". page 7 *(Service-level barriers: Difficulty navigating the healthcare system)* • "Women commented on social barriers linked to women's rights and overly complicated systems that if addressed could improve access to abortion services for all women" page 7 *(Personal barriers: Perceived stigma)*	
Full citation	**Sample size** n=46 invited to participate in study	**Sampling and setting**	**Theme: hospital and logistical challenges**	**Limitations**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Dressler, J., Maughn, N., Soon, J. A., Norman, W. V., The Perspective of Rural Physicians Providing Abortion in Canada: Qualitative Findings of the BC Abortion Providers Survey (BCAPS), PLoS ONE, 8 (6) (no pagination), 2013 **Ref Id** 840544 **Country/ies where the study was carried out** Canada **Study type** Qualitative - thematic analysis **Aim of the study** To investigate the experiences of rural and urban physicians providing abortion services **Study dates**	n=29 agreed to participate n=23 interviewed n=20 recordings transcribed (four recordings were lost due to leaking battery acid; it was only possible to redo one interview) **Characteristics** Provider location - rural (number; percentage in parentheses): 13 (65) Provider location - urban (number; percentage in parentheses): 7 (35) **Inclusion criteria** Surgical abortion providers listed on the Pregnancy Options Service (POS) **Exclusion criteria** No additional criteria reported	Questionnaires inviting participation in a brief interview were distributed to all surgical abortion providers in British Columbia listed on the Pregnancy Options Service. **Data collection** Semi-structured interviews were conducted either face-to-face or by telephone and were audio-recorded. Interviewers asked short, closed-ended questions to gather basic demographic information and then asked questions about the challenges faced as abortion providers (particularly regarding administrative and personal barriers) and their intentions for future provision of abortion services. Interviews were transcribed by a confidential service. **Data analysis** Transcripts were analysed through thematic analysis independently by 2 researchers and discrepancies were discussed. The data was then reviewed by all authors for	• "In general, the urban abortion providers faced fewer or no barriers to provision... The challenges that did emerge for some of the urban providers included lack of operating room time for those providing hospital-based services, and increasing restrictions on the basic funding support for the urban purpose-specific clinics (‘‘abortion clinics’’). As one urban physician stated: '…not so much that the funding is going to be threatened to the service as a whole but it may be threatened to the organization where I work.'" page 2 *(Financial barriers: Lack of financial input to services)* • "Conversely, rural participants faced many challenges to provide abortion service in their communities... The barriers associated with this setting included lack of operating room time for abortions, a	The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
April 2011 to February 2012 **Source of funding** Women's Health Research Institute of the BC Women's Hospital and Health Centre; Canadian Institutes of Health Research (CIHR) Strategic Training Program; Michael Smith Foundation for Health Research		thematic saturation (does not report if saturation was achieved).	tendency to defer an abortion case for an ''urgent'' non-abortion case, and difficulties in logistically scheduling operating room staff (e.g., nurses and anesthesiologists) to accommodate staff who did not wish to participate in abortion care." page 3 *(Service-level barriers: Insufficient resources and hours of operation; Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "Several rural physicians faced logistical challenges when scheduling patients for counselling (occurring at their private practice offices), timely ultrasounds and for procedures... Typically, rural abortion providers are required to fit into their private practice office time the counseling and pre-operative	Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? Can't tell, researchers do not discuss evidence for and against their arguments How valuable is the research? Researchers discuss limitations to generalisability of the research **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			assessment that would be performed by allied health professionals in the interdisciplinary urban abortion clinics. For example, one participant stated, ‘‘You know, at a freestanding [urban] abortion clinic, they have counselors that do a lot of the counseling with the patients. So actually you [one physician] can provide a lot more care to a larger group of women.’’" page 3 *(Service-level barriers: Insufficient resources and hours of operation)* **Theme: isolation** • "Several physicians indicated feeling overwhelmed by their inability to meet local requirements for abortion service in a timely manner due to facility restrictions. Some noted waiting lists in excess of five weeks from first contact until the procedure could be	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			performed." page 3 *(Service-level barriers: Long waiting times and delays)* • "Two physicians described pressure to always be available as the sole abortion provider in their community. One participant discontinued his/her surgical abortion practice because s/he was unable to find another physician to assist in providing 24 hour availability for emergency care in case of a complication. Another participant discussed his/her frustration with the isolation as follows: 'Biggest barriers I see, and things that might see me stopping, is the sheer volume. And if it's only me trying to see everyone, with no breaks and, you know, to feel like you can't even take a week away because, either it'd pile up or people aren't going to be able to be seen…The biggest barrier is	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			just…keeping myself from getting burnt out, providing the services and feeling like I can't do as much as I want to.'" page 3 *(Training and education)* • "Additionally, physicians providing abortion service in rural communities lack professional support in the form of easily accessible continuing professional education events and camaraderie." page 3 *(Training and education)* **Theme: training and replacement** • "Many urban abortion providers described no concerns with the availability of other physicians to replace their services. One participant stated, 'I think in [urban facility], [my services] could easily be replaced, there are many physicians who would like to work at [urban facility] but there just is not the space at the time. So, in the [city name]	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			area I don't think it would be much of an issue.' This perceived availability of replacements was less pronounced in the smaller urban centers and among the urban providers who performed second trimester abortions. With respect to training new physician replacements, many urban providers described an established training program through the local university-based medical school, or having participated in the provision of abortion training for family practice or obstetrician-gynecology residents and rural physicians." page 3-4 *(Training and education)* • "Rural physicians perceived a lack of available replacements. One physician stated, 'Nobody would ever [provide abortion] here. I'm the only one. We approached other people, like the other physicians, and there's nobody	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			interested in doing it.' Rural physicians were less likely to train other physicians in skills for provision of abortion, in their communities. One participant described a feeling of insecurity in training another physician, particularly in light of the lack of specialist back up in the event of a complication. As well, two physicians described a lack of volume of abortion cases as a deterrent to the local training of new abortion providers. 'I was hoping to get this [physician] trained but I think [the physician] is going to have to go to a[n urban] clinic where there are several cases a day, so [the physician] can get [many] cases in … if it's going to have any chance of being successful.'" page 4 *(Training and education)*	
Full citation Freedman, L., Landy, U., Darney, P., Steinauer, J.,	**Sample size** n~150 invited to participate n=40 agreed to participate	**Sampling and setting** Opt-out training programs were selected to capture views from	**Theme: practice prohibitions**	**Limitations** The assessment of the quality of the study was

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Obstacles to the Integration of Abortion Into Obstetrics and Gynecology Practice, Perspectives on Sexual & Reproductive Health, 42, 146-151, 2010 **Ref Id** 830153 **Country/ies where the study was carried out** USA **Study type** Qualitative - grounded theory **Aim of the study** To investigate the barriers that recent obstetrics and gynaecology graduates face when they want to provide abortion services **Study dates** 2006 **Source of funding**	n=30 interviewed **Characteristics** Age in years (range): 34-50 Gender - female (number; percentage in parentheses): 22 (73) Current profession - O&G in private practice (number; percentage in parentheses): 20 (67) Current profession - O&G in academic institutions (number; percentage in parentheses): 6 (20) Current profession - Health Maintenance Organisations (number; percentage in parentheses): 3 (10) Current profession - Military (number; percentage in parentheses): 1 (3) Wanted to provide abortion after residency - yes, elective (number; percentage in parentheses): 18 (60) Wanted to provide abortion after residency - yes, in specific circumstance (number; percentage in parentheses): 5 (17)	physicians who had been trained in a medical setting where abortion training was considered a routine part of residency education. The 4 training programs in particular were selected because they had a strong history of abortion training that predated the 1996 American Council of Graduate Medical Education that mandated that abortion training is provided as part of obstetrics and gynaecology residency programs (with an exception for moral and religious beliefs), and because they each represented a different region of the USA (West, Midwest, Northeast and South). All graduates from these residency programs between 1996 and 2001 were sent information about the study by the director of the residency programs and asked to return consent forms to the researchers if interested. **Data collection** Semi-structured interviews lasting roughly 30 to 60	*Subtheme: prohibitions made explicit before hire* • "Dr. S had been directly threatened by an out going senior partner while interviewing for a position in an obstetrics and gynecology private practice in a large midwestern city. Dr. S remembered, 'He leaned across the desk and said, If I ever find out you did elective abortion any time in your professional life, you'll never practice medicine in [this state] again. Do you understand that?' In contrast, some groups communicated their abortion prohibitions in a more collegial way. For example, Dr. D, practicing in a small southern town, recalled the interview with his private group practice, in which they discussed his having participated in abortion training during residency. A senior member of the group with strong antiabortion views	performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration?

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
No sources reported	Wanted to provide abortion after residency - no (number; percentage in parentheses): 7 (23) Currently providing elective abortions (number; percentage in parentheses): 3 (10) **Inclusion criteria** Graduates from 4 obstetrics and gynaecology training programs with opt-out abortion training from 1996 to 2001 **Exclusion criteria** No additional criteria reported	minutes were conducted by telephone or face-to-face. An interview guide was used with required questions and optional prompts to allow flexibility, topics included: physicians' abortion training, professional paths since residency, and decision making regarding abortion provision. The interview guide was modified throughout the process to reflect emerging themes and questions that arose from early interviews. **Data analysis** Interviews were transcribed and data analysis was undertaken using ATLAS-ti 5.0. An inductive approach, based on grounded theory methods, was used to examine the data and note recurring themes without the use of an a priori theory or hypothesis. Theories were developed that connected the data to existing social theories to offer explanatory value.	pressed him to explain why he had participated. The partners told him during the interview, 'We're not going to be doing that.' And Dr. M, practicing in the Northeast, recounted: 'When I finished my residency, I went to [a northeastern state], and I was working in a small hospital. ... No one at the hospital would ever perform an abortion. ... It wasn't a religious hospital, but it was a very conservative town, and they just felt like they didn't want to be associated with doing terminations. And they told me that at the interview'" page 148 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* *Subtheme: restrictions discovered after hire* • "The committee, which includes physicians with	Can't tell, ethical approval not discussed Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section; no mention of double-coding or discussing emerging themes among the research team Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss the contribution the study makes to existing literature **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			different areas of specialization (e.g., family practice and pediatrics) and a chaplain, dis cusses every case under consideration. However, Dr. G said, 'the policy that we have is basically no elective abortions"; the committee approves abortions only for women whose fetus has a fatal anomaly or for whom the pregnancy may cause serious health risks, and refers other women elsewhere.' page 148 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "A few physicians attempted to moonlight while working in private practices where abortion provision was prohibited, and they were surprised to find out that their groups prohibited it outside the practice as well. Dr. K, from the Midwest said, 'I	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			brought it back to the group, and they nixed it and said absolutely not, just because they didn't want my name associated with the [abortion] clinic.'" page 148 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "In other instances, despite the absence of overt restrictions, participants found that the culture of their group practice or institution was to discourage abortion provision and refer women elsewhere for abortion services. For example, Dr. F, from a large southern city, said abortions are never done in her practice. She learned this shortly after being hired, when she noticed that abortion providers were listed in the referral book in the office. She casually asked a colleague about whether	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			practice members do abortions, and the colleague explained that because of one senior partner's opposition, patients were always referred elsewhere for abortions." page 148 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "Another physician, Dr. R, working in a suburb of a large western city, explained that she does not perform abortions because some staff at the public hospital where she performs surgery are opposed to abortion and refuse to assist in procedures. In Dr. R's view, the policies of her group practice are not prohibitive, but the culture of the practice makes it so: 'It's a big deal. I don't know if the nurses don't want to be part of it or they all just	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			like to band together ... because if you're the one that says you don't mind doing it, everyone else is going to look at you. So if there's an abortion procedure that needs to be done, I send [the woman] to Planned Parenthood. It's not worth my time and effort to jump through the hoops of the hospital to make that happen. ... Actually, in my first couple months in practice, the people that are in my office here told me, 'Don't even bother.'" page 148 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* *Subthemes: institutional restrictions:* • "Physicians working for large HMOs or health networks, both religiously affiliated and nonsectarian, can find themselves without the autonomy to	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			decide whether to provide abortions. Catholic health networks, which account for one-sixth of hospital beds and yearly hospital admissions in the United States, pose extensive restrictions on reproductive health care services provided within their properties and by their employees. One physician, who was on the faculty in her residency program at the time of the interview, remarked: "The majority of our residents stay in town, and we have a very strong [Catholic] health care system that has a lot of tentacles through the community. ... Even though you have an independent practice, they own the building, and they refuse to allow you to do abortions?even if it's in your own [private] practice. ... There're several private groups associated with that facility, and so it makes it really tough."	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			page 149 *(Legal and policy barriers)*	
Full citation Grindlay, K., Lane, K., Grossman, D., Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study, Women's Health Issues, 23, e117-e122, 2013 **Ref Id** 832040 **Country/ies where the study was carried out** USA **Study type** Qualitative - grounded theory **Aim of the study** To investigate women's and healthcare professional's experience of telemedicine for medical abortion	**Sample size** n=25 women n=15 staff **Characteristics** Characteristics of women: Age in years <25 (number; percentage in parentheses): 16 (64) Ethnicity - White (number; percentage in parentheses): 19 (76) Ethnicity - Black (number; percentage in parentheses): 3 (12) Received medical abortion through telemedicine (number; percentage in parentheses): 20 (80) Received medical abortion in-person (number; percentage in parentheses): 5 (20) Previous abortion (number; percentage in parentheses): 12 (48) Previous birth (number; percentage in parentheses): 11 (44) **Characteristics:**	**Sampling and setting** Planned Parenthood clinics in Iowa that provided medical abortion either through telemedicine or in-person. Fewer women were sampled from in-person settings due to a larger amount of published literature in this area. Women were invited to participate in the study at their initial clinic visit; unclear if all eligible women were invited. Clinic staff were invited to participate by a member of the research team; unclear if all eligible staff were invited. **Data collection** Interviews with women: Interviews were conducted at the end of the visit at a private location at the clinic. The interview were audio-recorded, lasted about 45 minutes to an hour, semi-structured and followed an interview guide including open-ended questions about access to health care services in	**Theme: staff Perceptions and Impact on Clinic Operations** • "Clinic staff cited numerous benefits to introducing telemedicine into their clinic system. This included the greater reach of the physicians, who could now be “in three places at once,” greater efficiency of resources with women and providers no longer having to travel such long distances, and fewer cancelations and delays related to travel in inclement weather. As one staff member reflected, 'To give choice to a lot more people is exciting, very fulfilling to me personally and professionally. The helplessness you feel about not being able to help people because they can’t get here - they don’t have a ride, they don’t have the money, they don’t have whatever, you know -	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers do not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Study dates October 2009 to February 2010 **Source of funding** Supported by a grant from an anonymous foundation	Profession - medical assistant (number; percentage in parentheses): 6 (40) Profession - clinic manager (number; percentage in parentheses): 5 (33) Profession - physician (number; percentage in parentheses): 2 (13) Profession - nurse (number; percentage in parentheses): 2 (13) **Inclusion criteria** Eligibility criteria for women: English-speaking women choosing medical abortion who were at least 18 years old, ≤63 days gestation and had no contraindications to medical abortion Eligibility criteria for staff: doctor, advance practice clinician, nurse, medical assistant or clinic manager working at a Planned Parenthood clinic **Exclusion criteria** No additional criteria reported	general, decision making surrounding the abortion and where to have it and their experience and opinion of the service. Clinic staff were also interviewed at a private location at the clinic, but it is unclear if the same interview guide was followed. **Data analysis** Interviews were transcribed verbatim and analysed in ATLAS-ti 6.2 using grounded theory methods to establish themes related to the acceptability of telemedicine. No further details were reported regarding analysis.	a lot of those problems have gone away so that I'm feeling very pleased.'" page e120-e121 *(Community prescribing and telemedicine introduce greater flexibility)* • "Another benefit that staff saw was the reduced number of visits that women had to make to outlying clinics. Before telemedicine, women typically had to come to the clinic over the course of 2 days because the doctor had a limited window in which to see patients at the outlying clinics, women would typically do their "pre-op" activities on one day, and then come back a second day to consult with the doctor. With telemedicine, patients at outlying clinics could typically complete their visit in 1 day." page e121 *(Community prescribing and telemedicine introduce greater flexibility)*	not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss limits to the generalisability of the research **Other information** In the UK, telemedicine does not occur as medication is legally restricted and has to be issued on licensed premises. Therefore, only themes about barriers to access that are relevant to current UK practice, and themes saying telemedicine prescribing

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			• "The greater flexibility of telemedicine also enabled clinics to offer services more frequently and with a wider range of times available to women. Whereas before patients at outlying clinics could only be seen on a particular day of the week or month that the doctor visited the clinic, telemedicine allowed them to potentially schedule any day of the week if needed. Staff found this to be of particular benefit to women who could only take a specific day off from work or school. It also made it possible for clinics to see patients earlier in pregnancy, and to ensure they had access to medical abortion by better accommodating women with a limited timeframe for eligibility. Before telemedicine, a patient might have had to wait up to 2 weeks for an appointment, which could put them out of the window of eligibility" page e121	for medical abortion improved access to abortion were extracted as additional themes (general experience of telemedicine for medical abortion) will not be applicable to the current UK setting.

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			(Community prescribing and telemedicine introduce greater flexibility)	
Full citation Grindlay, K., Grossman, D., Telemedicine provision of medical abortion in Alaska: Through the provider's lens, Journal of Telemedicine & TelecareJ Telemed Telecare, 23, 680-685, 2017 **Ref Id** 842015 **Country/ies where the study was carried out** USA **Study type** Qualitative - grounded theory **Aim of the study** To investigate healthcare professionals' experience with telemedicine	**Sample size** n=8 staff **Characteristics** Profession - physician (number; percentage in parentheses): 4 (50) Profession - clinic manager (number; percentage in parentheses): 2 (25) Profession - medical assistant/patient care coordinator (number; percentage in parentheses): 2 (25) **Inclusion criteria** Physicians, advance practice clinicians, nurses, medical assistant/patient care coordinators, clinic managers or counsellors working at a clinic that provided medical abortion through telemedicine **Exclusion criteria** No additional criteria reported	**Sampling and setting** Planned parenthood clinics in Alaska using telemedicine to prescribe for medical abortion; recruitment strategy not reported **Data collection** Interviews were semi-structured and focused on involvement with, and opinions of, using telemedicine services, associated benefits and challenges of the service, impact of telemedicine on women and healthcare professionals and areas for improvement. All interviews were recorded and transcribed verbatim. **Data analysis** Data were analysed independently by 2 researchers in ATLAS-ti 6.2 using grounded theory methods; regular meetings	**Theme: impact of telemedicine on patients** • "Respondents overwhelmingly reported the greatest impacts of telemedicine introduction in their clinics were for the patients, and that it facilitated a more patient centred approach to care where women were able to be seen sooner, with greater choice in abortion procedure type, and closer to their home." page 681 *(Community prescribing and telemedicine introduce greater flexibility)* • "Participants (n=8) uniformly noted the most significant gain from telemedicine was that clinics could schedule appointments on additional days and times that better meet patients' needs and in turn allow women to be seen at earlier gestational ages. Before telemedicine,	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Can't tell, insufficient information reported about recruitment Was the data collected in a way that addressed the research issue? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
provision of medical abortion **Study dates** October to November 2013 **Source of funding** The research was supported by a grant from an anonymous foundation		were held to discuss and resolve discrepancies	a physician would come to some facilities one or two times per month. This wait time could put women outside of the gestational age eligibility window for a medical abortion... 'We can see them much earlier than waiting for our next scheduled [in-person physician] day, which can be, you know, three and a half weeks in time. [For] women in that kind of situation, three weeks is a lot of time, you know—it can make a pretty big difference.' (Medical assistant/ patient care coordinator" page 682 *(Community prescribing and telemedicine introduce greater flexibility)* • "Participants (n=7) widely agreed that women were given greater choice in whether to have a medical or surgical abortion as a result of decreased wait times and the resulting lower gestational ages at which women could be seen, as well as the	Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? Can't tell, researchers do not discuss evidence for and against their arguments How valuable is the research? Researchers discuss limitations to the generalisability of the research **Other information** In the UK, telemedicine does not occur

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			increased availability of the service. They felt that prior to telemedicine, women did not always have a 'real' choice because of the time-sensitive nature of medical abortion. As a physician reported, 'I've had some patients that wanted the medication abortion, didn't want a surgical abortion, and by the time they could have gotten to us in another part of the state . . . or for me to come to them . . . they wouldn't have been eligible anymore.'" page 682 *(Community prescribing and telemedicine introduce greater flexibility)* • "Several providers (n=3) also noted that the expanded availability of medical abortion had rippling impacts on surgical abortion access. Because medical abortion could be shifted to a wider range of days, women could be more easily scheduled for surgical abortions on the few days a physician was	as medication is legally restricted and has to be issued on licensed premises. Therefore, only themes about barriers to access that are relevant to current UK practice, and themes saying telemedicine prescribing for medical abortion improved access to abortion were extracted as additional themes (general experience of telemedicine for medical abortion) will not be applicable to the current UK setting.

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			in the outlying clinic." page 682 *(Community prescribing and telemedicine introduce greater flexibility)* • "Participants (n=5) also described the impacts on women in terms of reduced travel. Prior to telemedicine, women either had to wait for the provider to come to their closest clinic, or they could drive or fly to another part of the state or for out-of-state care. Respondents noted that this disproportionately affected poor women and those living in rural areas who were not readily able to travel. As one participant said, 'I feel like it's vastly increased our access to the women that are most vulnerable. You know, our wealthier patients will get whatever they need, regardless of telemedicine, but in rural areas it's a lot more difficult'" page 682 *(Community prescribing*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			and telemedicine introduce greater flexibility) **Theme: impact of telemedicine on clinics and providers** • "... telemedicine enabled clinics to schedule physicians on an as-needed basis, rather than dedicate an entire day to clinical work. One physician stated, 'It gives us huge flexibility because . . . instead of having a doctor scheduled and having to fill an entire day to make it feasible for the doctor to come in, you know, I can be doing an administrative day and take an hour out of an administrative day and see three medication abortion patients.'" page 683 *(Community prescribing and telemedicine introduce greater flexibility)*	
Full citation Heller, R., Purcell, C., Mackay, L., Caird, L., Cameron, S. T., Barriers	**Sample size** **Characteristics**	**Sampling and setting** **Data collection**		**Limitations** **Other information**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
to accessing termination of pregnancy in a remote and rural setting: a qualitative study, Bjog-an International Journal of Obstetrics and Gynaecology, 123, 1684-1691, 2016 **Ref Id** 816075 **Country/ies where the study was carried out** **Study type** Data not extracted as data saturation had been reached **Aim of the study** **Study dates** **Source of funding**	**Inclusion criteria** **Exclusion criteria**	**Data analysis**		
Full citation Hulme, J., Dunn, S., Guilbert, E., Soon, J., Norman, W., Barriers and facilitators to family	**Sample size** n=72 **Characteristics**	**Sampling and setting** The goal was to collect a sample that incorporated a variety of professional viewpoints across Canada from	**Theme: cost barriers** • "The cost of travel and accommodation and the cost of therapeutic abortion itself in private abortion	**Limitations** The assessment of the quality of the study was performed using the

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
planning access in Canada, Healthcare Policy, 10, 48-63, 2015 **Ref Id** 770199 **Country/ies where the study was carried out** Canada **Study type** Qualitative - thematic analysis **Aim of the study** To explore healthcare professionals' and organisational stakeholders' views on barriers to contraception across Canada **Study dates** August 2011 to May 2012 **Source of funding** No sources reported	Profession - nurses, midwives and nurse practitioners (number; percentage in parentheses): 20 (28) Profession - family physicians and paediatricians (number; percentage in parentheses): 8 (11) Profession - physicians performing abortions (number; percentage in parentheses): 4 (6) Profession - health service administrators (number; percentage in parentheses): 8 (11) Profession - Managers of public health agencies (number; percentage in parentheses): 6 (8) Profession - university-based clinician researchers (number; percentage in parentheses): 4 (6) Profession - university-based medical/health professional educators (number; percentage in parentheses): 3 (4) Profession - directors of organisations representing women and vulnerable populations (number; percentage in parentheses): 7 (10) Profession - leaders of provincial and national reproductive health	providers working in sexual health, including people working with disadvantaged populations. Key stakeholders were recruited from government agencies, professional organisations (medicine, nursing and pharmacy), advocacy and non-profit groups; unclear how they were recruited. Additionally, participants in an online survey distributed to organisations dealing with women's health issues were asked if they consented to be contacted for a phone-interview for the purpose of this study. **Data collection** The interview guide was based on key domains of access to (cognitive, administrative, economic, geographical, psychosocial) and quality of (choice of contraceptive methods, information given to clients, technical competence, interpersonal relations, continuity and follow-up) family planning services from 2 theoretical frameworks;	clinics were reported as major barriers for Canadian women living outside of urban areas." page 55 *(Financial barriers: Patient expenses)* **Theme: negative physician attitudes and conflicts with personal belief** • "In Prince Edward Island, New Brunswick and the Yukon, where women require referrals for abortion services, as well as rural and Northern communities, informants described difficulty in finding a physician who will refer, with resulting delays in abortion care. 'She went to the walk-in clinic and the doctor there said – he said, 'Oh, well, you might as well keep the baby. Do you know how hard it is to get pregnant?' and she was crushed, terrified, upset, didn't know what to do. Because she went for help and this man told her that – 'You're lucky to be	CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Can't tell, insufficient information reported about recruitment Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
	organisations (number; percentage in parentheses): 4 (6) Profession - leaders of health professional organisations (number; percentage in parentheses): 6 (8) **Inclusion criteria** Not reported **Exclusion criteria** Not reported	questions were designed to elicit perspectives on key barriers and solutions to improving quality and access under these domains. Interviews were semi-structured, conducted either face-to-face or by phone and lasted 20 to 45 minutes. Interviews were recorded using handwritten notation. **Data analysis** TamsAnalyzer software was used for data analysis. One researcher coded the transcripts over multiple readings and noted discordant views; preliminary themes were discussed with the research team for refinement.	pregnant. Why would you want to get rid of it?'" (Family Physician, New Brunswick)" page 56-57 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* **Theme: special needs of vulnerable populations** • "Rural, Northern and Aboriginal communities face a unique set of challenges related to provider attitudes. These patients have very limited choice in healthcare providers and are not assured confidentiality in settings where they may know everyone working at the clinic." page 57 *(Privacy and confidentiality concerns)* **Theme: expand the range of family planning providers through task**	Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Can't tell, researchers do not discuss evidence for and against their arguments How valuable is the research? Researchers discuss the contribution the study makes to existing literature **Other information** Reported aim is to determine barriers to contraception across Canada, but methods talk about access to family planning services, which includes abortion. Therefore, some of the themes may not be relevant to abortion

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			sharing and expanded scope of practice of allied health professions • "Respondents advocated for broadening the scope of practice of nurse practitioners, registered nurses and pharmacists to help bypass access barriers to reproductive health services. 'There's no reason I see why nurse practitioners couldn't do medical abortions – we already do IUD insertions and we manage miscarriages within our scope of practice"'(Nurse Practitioner, British Columbia)." page 59 *(Service-level barriers: Insufficient resources and hours of operation)* **Theme: utilize telephone and virtual healthcare consultations** • "A few respondents also suggested piloting Skype and telephone consultations to expand access to medical abortion	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			care." page 60 *(Community prescribing and telemedicine introduce greater flexibility)* **Theme: improve public and healthcare provider education** • "Respondents called for expanded undergraduate and continuing education family planning training programs for physicians, nurses and midwives, including updated information on abortion." page 60 *(Training and education)*	
Full citation Hulme-Chambers, A., Temple-Smith, M., Davidson, A., Coelli, L., Orr, C., Tomnay, J. E., Australian women's experiences of a rural medical termination of pregnancy service: A qualitative study, Sexual and Reproductive Healthcare, 15, 23-27, 2018	**Sample size** n=59 women agreed to be contacted by research team (n=19 declined participation, n=22 did not respond to three attempts at contact) n=18 women interviewed **Characteristics** Age in years (median; range in parentheses): 25 (16-36) Gestational age in weeks at abortion (range): 5-9	**Sampling and setting** Women were recruited form Gateway Health sexual health clinic, which, at the time of the study was the only provider of bulk-billed (meaning there are no extraneous costs beyond the cost of ultrasound and medication) medical abortion in northeast Victoria. Women were provided with information about the study by a nurse at the clinic and contact details were passed to the research	**Theme: finding a rural MToP service and making an appointment** • "Almost all women said they were able to obtain an appointment with the clinic within a week. No one felt this was too long to wait." page 25 *(Service-level barriers: Long waiting times and delays)*	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Ref Id 839171 **Country/ies where the study was carried out** Australia **Study type** Qualitative - inductive analysis **Aim of the study** To understand women's experiences of accessing medical abortion through primary healthcare in a rural setting **Study dates** November 2016 to April 2017 **Source of funding** No sources of funding reported	**Inclusion criteria** Women aged at least 16 years old who had an abortion at Gateway Health sexual health clinic between February 2016 and February 2017 **Exclusion criteria** No additional criteria reported	team if the woman agreed to participate. **Data collection** Interviews were conducted following a guide that focused on women's experiences through the process of confirming pregnancy and obtaining a medical abortion, including suggestions for improvement. All interviews were audio recorded and transcribed. **Data analysis** Data analysis was conducted using NVivo and began after the first interview. The interview schedule was used as the framework from which initial themes were identified, but additional themes were added as they emerged. After 16 interviews, a third of transcripts were randomly selected and independently coded by 2 additional researchers. At this point, data saturation was deemed to have been reached but a further 2 women were interviewed as	**Theme: interactions with other health professionals associated with the MToP process** • "A small number of women reported feeling that their GP was obstructionist about MToP referral. Women described GPs staring blankly at them or giving them odd facial expressions, referring them to health professionals not directly associated with MToP, or being told they had find an abortion service themselves. 'She [GP] didn't really offer any sort of emotion at all…I couldn't really tell where she was standing on it [abortion] and she didn't – there was no offer of any information about anything, any options, when I went to her. As I had already made up my mind it would have been nice for her to talk to me about options and how those options would work. (Participant #10, age 26)'"	Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss limitations to the

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
		they had already agreed to participate. Themes were discussed and refined by a senior researcher and all members of the research team agreed with the final interpretation.	page 25 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* **Theme: most important aspects of the MToP service system and suggestions for improvement** • "Service improvement suggestions included improving access to MToP and the availability of the medication in rural areas. Travel distances were often seen as resolvable through more rurally-based services being available" page 26 *(Logistical barriers: Additional expenses and delays caused by travel arrangements)*	generalisability of the research **Other information** None
Full citation Jerman, J., Frohwirth, L., Kavanaugh, M. L., Blades, N., Barriers to Abortion Care and Their	**Sample size** n=29 women **Characteristics**	**Sampling and setting** Michigan and New Mexico were selected for this study as they have less restrictive abortion laws than at least one	**Theme: travel-related logistical issues** • "Involving unwanted persons in the abortion decision or travel	**Limitations** The assessment of the quality of the study was performed using the

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Consequences For Patients Traveling for Services: Qualitative Findings from Two States, Perspectives on Sexual and Reproductive Health, 49, 95-102, 2017 **Ref Id** 842040 **Country/ies where the study was carried out** USA **Study type** Qualitative **Aim of the study** To examine the barriers women face when having to travel to access abortion services and any consequences of these **Study dates** January to February 2015 **Source of funding** No sources reported	Age in years - 18-19 (number; percentage in parentheses): 2 (7) Age in years - 20-24 (number; percentage in parentheses): 11 (38) Age in years - 25-29 (number; percentage in parentheses): 8 (28) Age in years - 30-34 (number; percentage in parentheses): 4 (14) Age in years - 35-39 (number; percentage in parentheses): 3 (10) Age in years 40-44 (number; percentage in parentheses): 1 (3) Ethnicity - Hispanic (number; percentage in parentheses): 10 (34) Ethnicity - White (number; percentage in parentheses): 10 (34) Ethnicity - Black (number; percentage in parentheses): 7 (24) Gestational age in weeks - 0-7 (number; percentage in parentheses): 11 (38) Gestational age in weeks - 8-12 (number; percentage in parentheses): 7 (24) Gestational age in weeks - 13-19 (number; percentage in parentheses): 5 (17)	neighbouring state (e.g., Ohio and Texas) in order to capture women travelling to access services. Eligible women were identified by clinic staff during intake and details of interested women were passed to the research team. Those interviewed reflects nearly all women presenting to relevant services during the study period. **Data collection** Interviews were conducted at the clinic during times when the women would normally be waiting and therefore did not place much additional burden on the women. Interviews lasted roughly an hour and were audio-recorded. An interview guide was used which asked women to describe the time from when they found out about the pregnancy to when they arrived at the clinic; specific questions were then asked about how they chose the clinic, making the appointment, arranging travel and associated costs	arrangements" page 17 *(Privacy and confidentiality concerns)* • "Making arrangements after appointment was scheduled (e.g., for transportation, accommodations, child care and work schedule changes " page 17 *(Logistical barriers: Difficulty arranging time off work; Logistical barriers; Difficulty arranging childcare)* • "Requiring multiple means of transport to get to appointment" page 17 *(Logistical barriers: Additional expenses and delays caused by travel arrangements)* **Theme: system navigation issues** • "Hoop-jumping (logistics involved in securing an appointment" page 17 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can*	CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, the researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
	Gestational age in weeks - 20-23 (number; percentage in parentheses): 4 (14) Gestational age in weeks - 24-25 (number; percentage in parentheses): 2 (7) **Inclusion criteria** Women aged at least 18 years old that had travelled from outside state to access a abortion, or more than 100 miles within state **Exclusion criteria** No additional criteria reported	and the involvement of others in this process, reasons for any delays encountered, their knowledge and opinion of state laws and restrictions and any personal or anecdotal accounts of attempting (or succeeding) to terminate a pregnancy outside of the clinic setting. **Data analysis** An initial codebook was developed based on the interview guide and existing literature and this was amended and updated throughout the coding process. Data analysis was undertaken in NVivo; 16 transcripts were independently double-coded and any discrepancies were discussed by the research team.	*impact provision of services and obtaining referrals)* • "Lack of information, resources or referrals, including lack of transparency" page 17 *(Service-level barriers: Difficulty navigating the healthcare system)* • "Need to make multiple visits to the procedure clinic" page 17 *(Service-level barriers: Difficulty navigating the healthcare system)* • "Encountering crisis pregnancy centers that delayed abortion care" page 17 *(Service-level barriers: Difficulty navigating the healthcare system)* **Theme: limited clinic options** • "Unavailable appointment times at other clinics (e.g., because of overbooking or excessive demand)" page 17 *(Service-level barriers:*	Was the data analysis sufficiently rigorous? yes Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss limits to generalisability of the research **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			Insufficient resources and hours of operation) • "Limited or no options near home" page 17 *(Logistical barriers: Additional expenses and delays caused by travel arrangements)* • "Clinic closure in home state" page 17 *(Logistical barriers: Additional expenses and delays caused by travel arrangements)* **Theme: financial issues** • "Need to raise money for procedure and related costs e.g., travel, logistics" page 17 *(Financial barriers: Patient expenses)* **Theme: state or clinic restrictions** • "Waiting periods (state-imposed)" page 17 *(Legal and policy barriers)* • "Gestational limits (state- or clinic-imposed)" page 17 *(Legal and policy barriers)*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Full citation Kruss, J., Gridley, H., 'Country women are resilient but. ...': Family planning access in rural Victoria, The Australian journal of rural health, 22, 300-305, 2014 **Ref Id** 832341 **Country/ies where the study was carried out** Australia **Study type** Qualitative - thematic analysis within community and health psychology frameworks **Aim of the study** To examine barriers to accessing emergency contraception, abortion and options counselling in a rural setting **Study dates**	**Sample size** n=11 staff **Characteristics** Professions included politics, social work, general practice, psychology/counselling and nursing; n=9 women, n=2 men **Inclusion criteria** That professionals had experience of encountering women seeking emergency contraception, abortion or options counselling, and/or expertise regarding this area **Exclusion criteria** No additional criteria reported	**Sampling and setting** Professionals from the rural Grampians region of Victoria, Australia were recruited using snowball sampling, Women's Health Grampians emailed people from their list of service providers who suggested other possible contacts **Data collection** Interviews covered professionals' views of facilitators and barriers to accessing services in a rural setting but researchers do not state if an interview guide was used or if interviews were structured or semi-structured. **Data analysis** Themes were developed through thematic analysis following the process outlined by Braun and Clarke (2006). Limited information reported.	**Theme: barriers for women accessing family planning services in the Grampians region** *Subtheme: practical barriers* • "Financial and geographical barriers were frequently cited by participants... For rural women seeking a termination, costs can include the procedure itself, transportation and accommodation, calling metropolitan services for appointments, child care and loss of wages. Geographical barriers referred to limited rural services, waiting lists and less opportunity to see a female doctor, as well as the strain of leaving support systems behind when travelling to Melbourne." page 302 *(Financial barriers: Patient expenses; Logistical barriers: Difficulty arranging childcare; Service-level barriers: Long waiting times and*	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Can't tell, unclear what level of contact professionals had with women undergoing abortion and therefore whether they have the most relevant and up-to-date views on barriers and facilitators to access

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Not reported **Source of funding** No sources of funding reported			*delays; Service-level barriers: Insufficient resources and hours of operation)* *Subtheme: myths and misinformation* • "Myths about abortion leaving women infertile were still being spread, despite evidence to the contrary. While misinformation also occurs in metropolitan areas, the effects in a rural environment might be more significant because the limited pool of people a woman knows mean myths travel faster and 'stick' more in the absence of disconfirming information/ conversations." page 303 *(Training and education)* *Subtheme: confidentiality and privacy* • "Confidentiality and privacy were raised as access barriers to both EC and TOP and were often used interchangeably. It was reported that rural women have little choice but to see	Was the data collected in a way that addressed the research issue? Can't tell, no information was provided about structure of interview Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? Can't tell, insufficient discussion of evidence for and against the researchers' arguments How valuable is the research? Can't tell, inadequate discussion of

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			someone they might know socially, unless they travel some distance to access a service. They come from a rural town. . .they can't tell anyone what is happening . . . they are so nervous about somebody in the town finding out . . ." page 303 *(Privacy and confidentiality concerns)* *Subtheme: negative attitudes and judgements* • "One reported issue was a feeling of being 'judged' by health professionals, with some doctors refusing to make referrals" page 303 (Personal beliefs: Perceived stigma) • Some local doctors were suspected of deliberately delaying women's access to TOP, 'doing harm by withholding [information] . . .', forcing women to find their way to services by accident: 'We have become suspicious that GPs are actually delaying them accessing a service because of their own views	the contribution the study makes to existing literature **Other information** Aim of study, and focus of qualitative interviews, was not limited to abortion so some themes may not be relevant to this area

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			on abortion so they are sending them off to get multiple ultrasounds . . .'" page 303 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* *Subtheme: diversity* • "rural teenage women in the Grampians were noted as being particularly disadvantaged, with participants noting that teenagers are constrained more than other women regarding transportation to a service, confronting moralistic service providers wanting consent from parents, denial about a pregnancy and restrictions placed on services that can be provided by school nurses." page 303 *(Logistical barriers: Teenagers more affected by logistical barriers than other women)*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			Theme: what can be done • "Participants were invited to consider what could be done to reduce the access barriers they identified. While expanding services was considered essential (e.g. using a visiting model, increasing incentives to train in TOP, reducing the cost of EC), participants acknowledged that this might not always be possible or sufficient and advocated strategies to increase access to metropolitan services (e.g. travel assistance)." page 304 *(Service-level barriers: Insufficient resources and hours of operation; Logistical barriers: Additional expenses and delays caused by travel arrangements)*	
Full citation Kumar, U., Baraitser, P., Morton, S., Massil, H., Decision making and referral prior to abortion: A qualitative study of women's experiences,	**Sample size** n=64 women initially agreed to participate n=21 women interviewed (n=3 could not confirm admission for abortion, n=10 withdrew from the study after their abortion, n=14	**Sampling and setting** Convenience sampling; women were recruited at the time of their abortion consultation, following the appointment with the doctor. Unclear if all	**Theme: the referral process** • "Many women were keen to have the procedure done quickly and some commented on unnecessary delays during	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Journal of Family Planning and Reproductive Health Care, 30, 51-54, 2004 **Ref Id** 830476 **Country/ies where the study was carried out** UK (England) **Study type** Qualitative **Aim of the study** To investigate women's experiences of referral to abortion services **Study dates** September 2001 to August 2002 **Source of funding** Guy's and St Thomas' Charitable Foundation	could not be contacted despite multiple attempts, n=16 did not attend scheduled interviews) **Characteristics** Age in years (range): 16-40 Gestational age in weeks (range): 7-15 **Inclusion criteria** English-speaking women accessing abortion within the NHS and living within 1 of 3 inner city boroughs of London **Exclusion criteria** No additional criteria reported	eligible women were approached about the study. **Data collection** Interviews were conducted face-to-face, either in women's homes or in the offices of the Department of Sexual and Reproductive Health, 3-9 weeks after the abortion. Interviews were semi-structured, lasted 1-2 hours and were conducted using an interview guide; the guide including open-ended questions that covered events from when pregnancy was first suspected through to the post-abortion period. The interview guide was adapted during the interview process to seek additional information on emerging themes. All interviews were recorded and transcribed verbatim. **Data analysis** Two researchers reviewed transcripts and listed key ideas and emerging themes. These were agreed between the researchers and used to code	the referral process... Some women were asked by their GP to think about their decision and return another day, and some health professionals avoided discussing the options available following a positive pregnancy test... For women who had found the decision-making process difficult, such delays acted as a deterrent, making them think again about their decision and so causing further mental anguish. 'It was actually one of the most frustrating things, especially if you're dealing with, trying to make a difficult decision. I think that might actually deter other people and make them sort of say, 'Forget this, I've tried once, I've tried twice, I'm not gonna try this again'.'" page 53 *(Personal barrier: Negative physician attitudes and conflicts with personal beliefs can impact*	Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
		the transcripts. Hypotheses were generated from the emerging themes and these were tested by searching transcripts for deviant information and modifying or refuting the hypothesis. Analysis was completed independently by 2 researchers, who had high levels of agreement; data was rechecked and discussed to resolve any discrepancies.	*provision of services and obtaining referrals)* • "Further difficulties faced by women who had recently moved into the area included not being registered with a GP, difficulties finding a GP, and lack of awareness about alternative routes for referral. 'When I arrived here I went to the hospital emergency and he gave me a paper with a number. He said I need a doctor. When I called it was not possible in the area because all are full.'" page 53 *(Service-level barriers: Difficulty navigating the healthcare system)* • "Some women complained about the difficulty in getting urgent appointments with their GPs. 'The problem with the surgery is they no longer have a walk in, which I don't quite understand why that's happened because even though it's not a total emergency, it is. What do	Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss the contribution the study makes to existing literature **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			you take as an emergency?'" page 53 *(Service-level barriers: Long waiting times and delays)*	
Full citation Kung, S. A., Darney, B. G., Saavedra-Avendano, B., Lohr, P. A., Gil, L., Access to abortion under the heath exception: A comparative analysis in three countries, Reproductive Health, 15 (1) (no pagination), 2018 **Ref Id** 933662 **Country/ies where the study was carried out** UK, Colombia and Mexico **Study type** Qualitative **Aim of the study** To identify factors that affect how health exception laws for	**Sample size** n=17 healthcare professionals, academic scholars and NGO partners (only views from the UK [n=7] are of interest, but these are presented separately) **Characteristics** Not reported **Inclusion criteria** Providers who have experience of applying the health exception for abortion, academic scholars with knowledge of the health exception and NGO partners focused on expanding access to abortion **Exclusion criteria** No additional criteria reported	**Sampling and setting** Convenience sampling: no additional information reported **Data collection** Semi-structured interviews conducted using an interview guide that was based on findings from a document review conducted in an earlier phase of the study. Two key thematic areas were addressed: knowledge of the health exception and barriers to its use. Interviews were recorded and transcribed. **Data analysis** Analysis was conducted using Dedoose version 7.5.9. A codebook of a priori themes was established based on the document review and this was refined based on emerging themes.	**Theme: Barriers unique to abortion services in the public sector** • "Respondents in Britain discussed [NHS] hospital-based providers losing their clinical skills in abortion due to abortion services occurring overwhelmingly in independent sector clinics." page 6 *(Training and education)* **Theme: Dissemination of information about the law** • "Key informants largely echoed the view that poor dissemination of information is not a barrier to abortion access under the health exception in Britain. Only one respondent acknowledged minor difficulties in getting information to specific communities: “I think there	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers do not state if they considered alternative approaches Was the recruitment strategy appropriate to the aims of the research? Can't tell, insufficient information reported

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
abortion are applied in Great Britain, Colombia and Mexico **Study dates** Not reported **Source of funding** Society of Family Planning, Agency for Healthcare Research and Quality			is always going to be hard to reach communities and maybe the women in some ethnic communities, recent immigrants, women who don't have good English, there are probably problems of information"" page 8 *(Service-level barriers: Difficulty navigating the healthcare system)*	Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient information reported Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss the value of their research in terms of how it builds on previous research and makes recommendations for expanding access **Other information**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
				Convenience sample over-represented urban settings
Full citation Larsson, E. C., Fried, S., Essen, B., Klingberg-Allvin, M., Equitable abortion care - A challenge for health care providers. Experiences from abortion care encounters with immigrant women in Stockholm, Sweden, Sexual and Reproductive Healthcare, 10, 14-18, 2016 **Ref Id** 832371 **Country/ies where the study was carried out** Sweden **Study type** Qualitative - thematic analysis **Aim of the study**	**Sample size** n=13 staff **Characteristics** Gender = female (number; percentage in parentheses): 13 (100 Midwives n=10 Doctors n=3 **Inclusion criteria** Not reported **Exclusion criteria** Not reported	**Sampling and setting** Four of the largest abortion clinics (including public and private) in Stockholm County were selected as the setting for this study. A contact person from each clinic was asked to suggest professionals with experience of providing abortion care. **Data collection** Interviews were conducted either at the clinic or the researcher's office and were audio-recorded. An interview guide was used that contained open-ended questions; first, the background of the study including the hypothesis that immigrant women are at higher risk of having an abortion was explained and then the interviewees were asked about their thoughts regarding this and their experience of providing abortion care to this group. Interviews were	**Theme: striving to provide contraceptive counselling to immigrant women** • "One challenging experience, as brought up by several of the interviewees, was the encounters with abortion care-seeking women and girls/women with backgrounds in countries that accepted honour-based violence. These patients were either foreign-born or born in Sweden to immigrant parents. The main concern for these women and girls was, according to health care providers, the fear of their families finding out about them being pregnant or having boyfriends: 'There was this young woman who lived with protected ID, and she actually said that "If my family gets to know about this, then I'll be dead	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
To investigate healthcare providers' experience of providing abortion services to immigrant women **Study dates** Not reported **Source of funding** No sources of funding reported		transcribed verbatim by a research assistant. **Data analysis** Transcripts were read several times to gain an overview of the data before being grouped into a matrix and identifying themes. Provisional categories were then checked against initial extracts and transcripts before being organised into three themes. Provisional categories and themes were discussed and revised by the authors throughout the process.	tomorrow." And she was going to have an abortion. (…) The last thing she said when she walked from here was "If you read about a woman who's been killed in the newspapers tomorrow, you know it's me." She was so afraid. She was wearing clothes to cover herself up when she (left)… She was afraid to even be seen in this building.' (Midwife 6)" page 16 *(Personal barriers: Threat of violence)* **Theme: organizational barriers hindering patient-centred abortion care to immigrant women** • "Even though all interviewees agreed that foreign-born patients often demand more time, there were no routines or guidelines in the clinics that allowed for extended appointments for this purpose. However, the health care providers had	adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss the contribution the study makes to existing literature **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			their own means to acquire the time needed through cooperation, by planning or by scheduling patients for return visits: 'I think we, as colleagues, cooperate very well; for example, I know in advance which patient is coming here tomorrow, and then we know, we plan really well. If I have a patient with a professional interpreter, then someone else takes care of all the other patients /…/ You manage by planning in advance, we usually do that.' (Midwife 9)" page 17 *(Service-level barriers: Insufficient resources and hours of operation)*	
Full citation MacFarlane, K. A., O'Neil, M. L., Tekdemir, D., Foster, A. M., "It was as if society didn't want a woman to get an abortion": a qualitative study in Istanbul, Turkey, Contraception, 95, 154-160, 2017	**Sample size** n=14 women **Characteristics** Age in years (range): 21-44 **Inclusion criteria** English- or Turkish-speaking women who had an abortion in Istanbul from January 1st 2009	**Sampling and setting** Women were recruited through social media, gender studies, reproductive health organisations and referrals. **Data collection** Interviews were semi-structured, audio-recorded, and lasted 60-90 minutes. An interview guide was used that	**Theme: unmarried women face and fear** • "'There is no law that states that women can't be in a sexual relationship before marriage, but the moral, unwritten laws [make] it difficult to seek and receive reproductive health care. These already existed, but they have	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Ref Id 842077 **Country/ies where the study was carried out** Turkey **Study type** Qualitative **Aim of the study** To investigate women's experience of accessing abortions in Istanbul and to gain their views on the Turkish governments threat to restrict access to abortions **Study dates** 2015 **Source of funding** Mitacs Globalink Research Award; University of Ottawa Centre for Global and Community Engagement; Ministry of Health and	**Exclusion criteria** No additional criteria	asked questions related to the women's background and reproductive history, circumstances surrounding the abortion(s), the process of obtaining an abortion, how services could be improved and their opinion of the political climate in Turkey. **Data analysis** Data analysis was completed alongside data collection; interviews were analysed to develop themes using ATLAS.ti. An initial codebook was developed based on the study objectives and interview guide and new themes were added during the analytic process.	gotten worse with this current government.' (Melek, age 24) Notably, some of the unmarried women in our study discussed how their marital status influenced their decision to have an abortion. In addition, Yasemin felt that she was charged a higher price and received a lower quality of care because she was unmarried. Even though abortion care in the private sector was generally described as nonjudgmental, some unmarried women anticipated that they would be judged by providers, especially because of the recent negative publicity surrounding abortion in the media, and were surprised when they received nonjudgmental care." page 157 *(Personal barriers: Perceived stigma)* **Theme: women feel their rights are being violated**	Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Yes Was the recruitment strategy appropriate to the aims of the research? Can't tell, insufficient information provided Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers state that they reflected on participant-interviewer dynamics but do not report the outcome of this Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Can't tell, researchers do

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Long-Term Care in Ontario			**by government rhetoric and action** • "Melek felt that the government's rhetoric has created an antiabortion and anti-reproductive-health climate that impacts access to services. '[The political situation affects] my access to the pill, or just simply going to the Ob/Gyn. I get scared to go to the doctor. It takes away my right to access medical care…'" page 158 *(Personal barriers: Perceived stigma)*	not discuss evidence for and against their arguments How valuable is the research? Researchers discuss limitations to the generalisability of the research **Other information** None
Full citation Margo, J., McCloskey, L., Gupte, G., Zurek, M., Bhakta, S., Feinberg, E., Women's Pathways to Abortion Care in South Carolina: A Qualitative Study of Obstacles and Supports, Perspectives on Sexual & Reproductive Health, 48, 199-207, 2016 **Ref Id** 602562	**Sample size** n=45 women **Characteristics** Age in years - 18-25 (number; percentage in parentheses): 20 (44) Age in years - 26-35 (number; percentage in parentheses): 17 (38) Age in years - ≥36 (number; percentage in parentheses): 8 (18)	**Sampling and setting** Convenience sampling; interested women indicated their interest on a study form that was included in the registration paperwork on days that the researcher was at three abortion clinics in South Carolina (where most abortions in South Carolina took place). **Data collection** Interviews were recorded and lasted approximately 10-30 minutes. They were conducted	**Theme: learning about services** • "There was variation in whether health professionals discussed comprehensive pregnancy options with participants, whether they gave an abortion referral and how participants felt about their encounters. Of the 20 women who reported contact with a medical professional or crisis pregnancy center staff,	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Can't tell, there was not a clear statement of aims but the aim could be deduced Is a qualitative methodology appropriate? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Country/ies where the study was carried out USA **Study type** Qualitative - thematic analysis **Aim of the study** To obtain women's experiences of supportive and hindering conditions while accessing abortion services **Study dates** September 2014 to October 2014 **Source of funding** Maternal and Child Health Bureau, U.S. Department of Health and Human Services	Ethnicity - White (number; percentage in parentheses): 15 (33) Ethnicity - Black (number; percentage in parentheses): 25 (56) **Inclusion criteria** English speaking women aged at least 18 years old **Exclusion criteria** No additional criteria reported	using an interview guide that focused on 1) women's experience finding information about abortion services, 2) experience with health professionals while accessing abortion services, and 3) perceived barriers and facilitators of access to services. The guide was informed by theoretical frameworks in social support, healthcare utilisation and personal and systemic characteristics that may affect providers' abortion referral behaviour. Interviews were professionally transcribed. **Data analysis** Data analysis was conducted by 2 authors using NVivo. Initially, 3 interviews were read by both authors and a codebook was developed using thematic analysis and a priori domains specified based on a conceptual model, also allowing for unexpected themes; double coding was undertaken for 10 interviews to check inter-rater reliability.	seven were given a referral for abortion services. Of those who did not receive a referral, only four explicitly wished one had been offered, including one woman whose overtly antiabortion doctor recommended a crisis pregnancy center for "unbiased" counselling." page 202 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "Of the seven participants who were given referrals for abortion services, four reported feeling they were well treated and received nonjudgmental, thorough information. These women were seen in a family planning clinic, in an urgent care clinic, and by their usual gynecologist or primary care doctor. The interactions were characterized by direct communication and lack of	Was the research design appropriate to address the aims of the research? Yes Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Yes How valuable is the research? Can't tell, researchers discuss limitations to the generalizability of the research

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
		Data analysis was iterative in that earlier transcripts were re-read if new themes were identified.	judgment. One participant described her experience this way: 'We discussed all of the options, and he told me, ‘If you choose not to go forward with the pregnancy, you can go here,’ and explained what would be done [and] how the procedure would take place…. I’ve been with him for nine years, so the conversation was very easy'. The three women who described a negative or neutral referral experience received the requested information, but felt judged or were treated indifferently. An 18-yearold black woman who lived in an urban area told how an urgent care clinic doctor provided the requested abortion referral handwritten on a diabetes pamphlet, after which his demeanor changed from friendly to curt: 'After I said, ‘Well, maybe I don’t want to keep it,’ he was like, ‘Wait,’ and walked out of the room. And then he	**Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			gave me a brochure that somebody had written on 'Planned Parenthood,' and then he just left. I thought it was rude. You're a doctor, you're a professional.'" page 202 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* **Theme: contacting the clinic** • "Participant experience varied regarding appointment scheduling and timing. In two clinics, abortions could be booked only on certain days because of the rotating schedules of doctors. Limited availability made scheduling more difficult and sometimes resulted in delays in care." page 203 *(Service-level barriers: Insufficient resources and hours of operation)*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			• "Some women noted that their appointments at two clinics were delayed because of unexpected scheduling challenges. For example, one clinic introduced an electronic medical record system and scheduled fewer patients during the transition period. One participant reported that her appointment was postponed as a result of physician scheduling problems. Such delays could be caused by situations that commonly occur in many medical settings, but they highlight the precarious nature of abortion access in states with few providers." page 203 *(Service-level barriers: Long waiting lists and delays)* **Theme: preparing for the appointment** • "The greatest logistical barriers occurred as women prepared for their	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			abortion appointments. They described the financial burden of paying for the abortion, arranging transportation and negotiating time off work for the appointment and aftercare. Though the interviewer asked participants about child-care arrangements, they did not consider this aspect of preparation to be a major challenge." page 203 *(Logistical barriers: Additional expenses and delays caused by travel arrangements; Logistical barriers: difficulty arranging time off work)* • "Employed participants reported diverse experiences regarding taking time off for the appointment, the time needed for having a medication abortion at home and the suggested postabortion recovery period. Some participants managed their own schedules, and their concern was primarily over	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			lost work time. Others needed supervisor approval for time off. Some had supervisors with whom they felt comfortable explaining why they needed the time, and so anticipated a compassionate response; however, many participants feared judgment if their supervisor knew of the abortion... Several participants reported that their work schedules prevented them from scheduling the abortion as they truly wished. One woman had an aspiration abortion rather than the desired medication abortion because of work-related scheduling delays; another woman experienced delays that led to her having the abortion at a clinic that was not her first choice." page 204 *(Logistical barriers: difficulty arranging time off work)*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			• "Because of the scarcity of clinics, transportation was another obstacle. At all three clinics, oral or intravenous sedation is recommended as standard care for women receiving aspiration abortions, and many women agreed to this. These women required a ride home following their procedures. For some, securing a ride from their partner, friends or family was simple, but for others, this requirement presented a major challenge and may have necessitated unwanted disclosure." page 204 *(Logistical barriers: Arranging drive home can cause delays and necessitate unwanted disclosure)*	
Full citation O'Donnell, J., Goldberg, A., Lieberman, E., Betancourt, T., "I wouldn't even know where to start": unwanted pregnancy and abortion decision-making	**Sample size** n=31 women with unwanted pregnancies (n=15 who were in the process of obtaining, or had already obtained an abortion; n=16 who did not obtain an abortion; barriers and facilitators presented	**Sampling and setting** Stratified purposeful sampling: women were recruited from specialised and general reproductive health services and centres of commerce within rural counties and	**Theme: Social support (family/friends)** • ""I talked to my sister I live with. Actually, she's the only one I told about me coming here today. She was very supportive. No	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
in Central Appalachia, Reproductive Health Matters, 26, 16, 2018 **Ref Id** 931473 **Country/ies where the study was carried out** USA **Study type** Qualitative - inductive approach **Aim of the study** To determine barriers faced by women living in rural Central Appalachia seeking reproductive health care and what improves access to care **Study dates** December 2013 to September 2014 **Source of funding** No sources reported	separately for people who sought an abortion) **Characteristics** Age in years - 16-20 (number; percentage in parentheses): 4 (13) Age in years - 21-25 (number; percentage in parentheses): 8 (26) Age in years - 26-30 (number; percentage in parentheses): 5 (16) Age in years - 31-35 (number; percentage in parentheses): 6 (19) Age in years - 36-40 (number; percentage in parentheses): 4 (13) Age in years - 41-45 (number; percentage in parentheses): 3 (10) Children - 1 child (number; percentage in parentheses): 6 (19) Children - 2 children (number; percentage in parentheses): 6 (19) Children - 3 children (number; percentage in parentheses): 5 (16) Race - White (number; percentage in parentheses): 28 (90) Race - Black (number; percentage in parentheses): 3 (10) **Inclusion criteria**	stratified according to age (16-25 and 26-45). In the centres of commerce, women were approached by members of the study team using a recruitment script, and interviewed at a late time/date in a private setting. **Data collection** Women completed a brief questionnaire about demographic characteristics prior to a 20-45 minute semi-structured interview. The same interviewer conducted all interviews and interviews were recorded and transcribed verbatim. **Data analysis** Analysis was conducted using NVivo. First, a 3 phase inductive approach to analysis was undertaken: 1) open coding of transcripts to conceptualise themes, 2) applying categories and codes related to the research question, and 3) axial coding of the relationships between concepts. Thematic content analysis, using existing	matter what I do, she supports me and she'll be there. She just looked at me and she's like, 'Are you okay?' I'm like, 'Yeah, I'm fine.' She's like, 'I noticed you just looked really off lately.' I'm like, 'No, I'm good.' She looked at me and she's like, 'What's wrong?' I just kind of looked up at her and I told her, 'I'm pregnant,' and we just cried. She was my age when she was pregnant with her child. But she ended up having the baby. I already knew that she had been here for an abortion, because she told me, obviously." – Tennessee, early twenties, recruited at abortion facility" page 11 *(Personal barriers: Social support)* **Theme: Modelling** • ""My friend had actually been [to the clinic] before. She had gotten pregnant by a guy that was abusing her, and she went –	Was there a clear statement of the aims of the research? Ye Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers do not state if they considered alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Can't tell, insufficient information reported about structure of interview Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
	English-speaking women aged 16-45 years old; resident in Central Appalachia counties defined as rural on the US census **Exclusion criteria** No additional criteria reported	frameworks of pregnancy acceptability and help-seeking behaviours, was then used to refine the axial coding. Coding and analysis was undertaken by 1 author but additional authors reviewed codes for clarity and assisted with development of research questions and the emerging theme framework.	instead of telling him, she went and had it done. And me and her had been friends since high school. So I already knew that she had it done, and when I needed it, I called her and I said, 'Do you care to drive me? Since you already know where it's at, and it'll save me some stress that morning.'" – Kentucky, mid-twenties, recruited at centre of commerce" page 11 *(Personal barriers: Social support)* **Theme: Isolation from social support (family/friends)** • ""It was really scary, and just felt like, 'How did this happen to me?' I couldn't talk to my mom. It was really hard. He lives with his parents, and they didn't know. You couldn't really talk about it on the phone or anything. It just felt like I was having to keep such a huge secret, such a burden. It still is, even after	Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss the contribution the study makes to existing literature **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			all this is done." – Kentucky, late teens, recruited at abortion facility" page 11 *(Personal barriers: Social support)* **Theme: Isolation from social support (healthcare providers)** • ""[My doctor] is just the doctor my sister uses. It's really the only doctor [where I live]…He's nice. He's sweet. He's kind of more of a traditional person as well. My sister actually just had an abortion, and she had some complications. She couldn't even tell her doctor about it because he would have dropped her as a patient, because he's dropped a couple of his other patients for the same reason…[when she was pregnant with her first child], he was asking her if she was gonna keep the baby at first, and she said yes, and he said, 'Okay, good. I let go of a couple of	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			patients because they decided otherwise.' – Tennessee, early twenties, recruited at abortion facility" page 11 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* **Theme: Silence** • "“All I could do was look online, because I don't know anyone in my area that has had this done. Or anyone that would really admit to it.” – Kentucky, early twenties, recruited at abortion facility" page 11 *(Personal barriers: Perceived stigma)*	
Full citation Ostrach, Bayla, Cheyney, Melissa, Navigating social and institutional obstacles: Low-income women seeking abortion, Qualitative Health Research, 24, 1006-1017, 2014	**Sample size** n=11 women interviewed n=4 clinic staff interviewed **Characteristics** Not reported **Inclusion criteria**	**Sampling and setting** Women seeking an abortion at 1 Clinic in Oregon (which serves a diverse population from within state and neighbouring states) were approached by clinic staff to complete an optional survey and/or recruitment form for the	**Theme: The Medicaid Application Process: Financial and Logistical Obstacles** • "…concerns about being able to pay for food and gas during her trip to the clinic and back complicated her travel	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Ref Id 841276 **Country/ies where the study was carried out** USA **Study type** Mixed methods - qualitative component inductive approach in keeping with grounded theory (other components quantitative survey and clinic observation) **Aim of the study** To examine abortion-seeking experiences of women from Oregon and to identify key barriers and strategies women employed to overcome them **Study dates** Interviews conducted April to November 2009	Not reported **Exclusion criteria** Not reported	interviews. The clinic staff were selected based on their job roles (physician, clinic manager, medical assistants) but no detail is provided regarding how staff were selected. **Data collection** Interviews with the women ranged from 1 hour to several hours long and were semi-structured, using open-ended questions and minimal prompting from the interviewer. Women were asked to describe everything that happened in the time between confirming they were pregnant and arriving at the clinic for the abortion. The interview guide was revised after 3 interviews to contain explicit questions about preliminary themes that were emerging. Interviews were conducted until data saturation was reached (no details about how this was defined). No details are provided about data collection for staff interviews.	arrangements." page 1010 *(Financial barriers: Patient expenses)* • "…finding someone who could miss work to give her a ride to the clinic.. was a major obstacle" page 1010 *(Logistical barriers: Arranging drive home can cause delays and necessitate unwanted disclosure)* • "finding someone... who could also watch her children, was a major obstacle" page 1010 *(Logistical barriers: Difficulty arranging childcare)* • "the logistical hassles of waiting for... a boss to approve a time-off" page 1010 *(Logistical barriers: Difficulty arranging time off work)* **Theme: The role of social support** • "lack of support made it difficult for them to overcome obstacles." page 1010; "Conversely, when	Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Yes Was the recruitment strategy appropriate to the aims of the research? Yes for recruitment of women, can't tell for recruitment of staff as details not reported Was the data collected in a way that addressed the research issue? Yes for data collection with women, can't tell for data collection with staff as details not reported Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Source of funding No financial support was given for the research, authorship, and/or publication of this article		**Data analysis** Limited information about data analysis. A grounded theory approach was used and emerging themes were used to construct a theoretical framework.	women had a strong support network in place they tended to describe feeling “capable of managing other barriers” such as, for example, those associated with finding the needed financial resources and arranging time off from work." page 1011 *(Personal barriers: Social support)* • "She described worrying about having to ask for help with travel arrangements and costs, fearing family members would be judgmental or reluctant to help" page 1010 *(Personal barriers: Perceived stigma)* • "she described harassment by anti-abortion protesters routinely found at the clinic entrance as a major barrier" page 1010 *(Personal barriers: Perceived Stigma)* • "Multiple women and clinic staff discussed intimate partner violence as both a	Have ethical issues been taken into consideration? Can't tell, neither informed consent or ethical approval are mentioned Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss the contribution the study makes to existing literature **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			safety concern and a psychosocial obstacle... Clinic staff frequently mentioned intimate partner violence as a major barrier to access, or as a factor that compounded the impact of other obstacles." page 1011 *(Personal barriers: Threat of violence)*	
Full citation Purcell, C., Cameron, S., Caird, L., Flett, G., Laird, G., Melville, C., McDaid, L. M., Access to and experience of later abortion: accounts from women in Scotland, Perspectives on Sexual and Reproductive Health, 46, 101-108, 2014 **Ref Id** 832792 **Country/ies where the study was carried out** UK (Scotland) **Study type**	**Sample size** n=23 women **Characteristics** Not reported **Inclusion criteria** Women at ≥16 weeks' gestation seeking abortion **Exclusion criteria** Girls aged <16 years old; insufficient English to conduct interview; overly distressed when attending services	**Sampling and setting** Convenience sampling; specialist nurses at 5 NHS regions provided potential participants with information about the study, obtained informed consent (if the woman agreed to participate) and passed contact details to the researchers. The 5 NHS boards selected (Ayrshire and Arran, Greater Glasgow and Clyde, Grampian, Highland and Lothian) were chosen to cover both urban and rural women and because they anticipated roughly 2 thirds of women travelling to England for a later (≥16 weeks' gestation) abortion.	**Theme: considering options** • "The delay in asserting candidacy for services was also linked to fear of others' reactions. This fear was a factor in the delay that 17-year-old Melissa—who had an abortion locally—experienced between discovering her pregnancy at around four weeks and terminating at 18: 'I really didn't know how to handle it, I was just so confused, like, 'What do I do?' … I was just so scared,… I just didn't want [my mother] to be disappointed.'" page 103	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Can't tell, there is not a clear statement of aims; however, it was possible to deduce the aim Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Yes

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Qualitative - thematic analysis **Aim of the study** To compare experiences of Scottish women who used local abortion services, those who travelled to England for abortion and those that continued their pregnancy in ration to barriers to access **Study dates** January 2013 to July 2013 **Source of funding** Scottish Government; UK Medical Research Council		**Data collection** Interviews were semi-structured and began with the women being asked to talk about when they first thought they might be pregnant. The interviewer followed the woman's lead but used an interview guide to elicit responses for areas of interest. Interviews were audio recorded, transcribed and anonymised. **Data analysis** Transcripts were analysed thematically using NVivo by 2 authors; data analysis began while data collection was ongoing to identify emerging issues	*(Personal barriers: Perceived stigma)* • "Orla, who was 20 and had an abortion locally at 17 weeks, explained that she had “compartmentalized” her thinking, in part from fear of the procedure, which she had been through before: 'I think that was where the emotional block was, actually going and admitting it, and going through the procedure, because last time was fairly traumatic, and it was uncomfortable and painful, and I was upset and alone.... Having to go and do it again was hard, so putting it off was easier.'" page 104 *(Personal barriers: Prior negative experiences)* **Theme: navigating services** • "Some women expected that staff might be unreceptive to their request to have an abortion and therefore	Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section to deduce the framework for thematic analysis Is there a clear statement of findings? Yes How valuable is the research? Researchers discuss the contribution the study makes to existing literature

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			delayed their assertion of candidacy. However, only one participant met with any clear objection: A general practitioner advised Yvonne that at 17 weeks, she was 'too late" for a termination, as the fetus was "a baby now.'" page 105 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "It was more common for general practitioners to appear "confused" or "unclear" regarding the gestational limit of their NHS board, and to initially tell women that the limit was lower than the actual case, before having to seek clarification from their local abortion service." page 105 *(Training and education)* • "Once women requested an abortion and were referred to specialist	**Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			services, delays were uncommon, and most participants were satisfied in this respect... Natalie—who was 22 and eventually had an abortion in England at 21 weeks—experienced both personal and service-related problems that caused her to pass the local gestational limit:'[The general practitioner] booked me in, and I went to a clinic, and then it just took so long. I found out when I was 13 weeks, and it took three weeks for me to get an appointment [for abortion]. So, that was making me 16 weeks, and then I missed the appointment and thought it was the following week.… I had to go back to the doctor [and wait to be referred] again. And now I'm just back from [England].'" page 105 *(Long waiting times and delays)*	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			Theme: outcome of the candidacy process • "Women who did travel to England had to mobilize a range of resources, including financial, practical and emotional support, and access to these varied. Travel costs— train tickets or flights and 2–3 nights' accommodation, booked at short notice—were high. The women who travelled were in a range of socioeconomic positions, but none found it easy to obtain such funds, and none was clear on how to claim reimbursement from health services." page 105 *(Financial barriers: Patient expenses)* • "For women who were employed, another difficulty was taking time off work. Irregular work patterns and low autonomy positions left some women unsure of their rights to sick pay, and the need to explain their absence to	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			managers or colleagues was magnified for those who had to travel, since they had to account for a potentially longer absence." page 105 *(Logistical barriers: Difficulty arranging time off work; Privacy and confidentiality concerns)* • "In addition, women who traveled to England for an abortion were aware that services were less available in Scotland, and felt there was judgment implicit in this disparity. Vivienne was aware of and perplexed by the fact that if a fetal anomaly had been detected, she could have been treated within five miles of home, rather than several hundred miles away." page 105 *(Personal beliefs: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)*	
Full citation	**Sample size**	**Sampling and setting**	**Theme: individual factors**	**Limitations**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Say, L., Foy, R., Improving induced abortion care in Scotland: Enablers and constraints, Journal of Family Planning and Reproductive Health Care, 31, 20-23, 2005 **Ref Id** 840080 **Country/ies where the study was carried out** UK (Scotland) **Study type** Qualitative **Aim of the study** To examine factors that help or hinder the provision of high-quality abortion services in Scotland **Study dates** 2001 **Source of funding**	n=8 **Characteristics** Professions: consultant/director of family planning and well woman services in an NHS Primary Care Trust; programme co-coordinator of a national clinical effectiveness programme; consultant in public health medicine; 2 consultant gynaecologists; nurse; general practitioner; researcher from the Scottish Association of Local Health Councils **Inclusion criteria** Not reported **Exclusion criteria** Not reported	Eight interviewees were purposively selected to represent a range of perspectives on abortion services in Scotland; no further information reported - unclear how sample was selected or who was consider eligible **Data collection** A semi-structured interview guide was developed to cover factors that help or hinder the provision of abortion services, views on the general quality of care and what aspects of care require improvement. Interviews lasted approximately 45 minutes and were conducted face-to-face; interviews were not recorded but notes were taken and immediately written up following the interview. **Data analysis** Data were analysed by grouping themes under a pre-existing framework: factors related to the characteristics of the guideline (evidence), factors related to the	• "Negative attitudes of gynaecologists towards abortion care had significantly restrained service development in some hospitals. Such attitudes were rooted in different perceptions. Most gynaecologists did not prioritise abortion care; it was not 'real gynaecology'... 'They look at [abortion care] as a nuisance. Sometimes this is quite obstructive and acts as a barrier, not consciously, but by really being unhelpful.'" page 21 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "Abortion also created perceived ethical conflicts (e.g. between preserving and ending life) and justification for religious and moral objections. Some gynaecologists	The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Can't tell, aim did not explicitly state that it intended to capture experiences or views Was the research design appropriate to address the aims of the research? Can't tell, researchers did not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Can't tell, insufficient information provided; unclear how the purposive sampling was undertaken Was the data collected in a way that addressed the research issue? Can't tell, insufficient information

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Wellcome Trust Fellowship; Medical Research Council/Chief Scientist Office Special Training Fellowship in Health Services Research		characteristics of individuals who need to change, and factors related to the characteristics of the organisation or environment; no further details reported.	believed the problem was rooted in women's own faults, and were intolerant and judgmental towards women requesting abortion." page 21 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "Negative attitudes to abortion also existed amongst general practitioners (GPs), which hindered the speed or quality of referrals." page 21 *(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* • "There were arbitrary upper gestational age limits to perform abortions; some gynaecologists were performing abortions for gestations no later than	provided and interviews were not recorded and therefore not transcribed verbatim Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Can't tell, neither informed consent or ethical approval are discussed Was the data analysis sufficiently rigorous? Can't tell, insufficient detail in the analysis section; no mention of double-coding or discussion of themes among the research team Is there a clear statement of findings? Can't tell, researchers do not discuss evidence for and against their arguments and quotes from interviews are presented

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			15–16 weeks, or even 12 weeks. Individual preferences, 'without logic', caused variable access to care." page 21 *(Legal and policy barriers)* • "Lack of knowledge and skills among gynaecologists were barriers to performing certain procedures. For example, the near-universal use of general anaesthesia for surgical abortions partly reflected clinicians' unfamiliarity with local anaesthesia. The introduction of local anaesthesia was further constrained by uncertainties over its benefits and acceptability to women... '[Gynaecologists] do not see developing the necessary skills for abortion as a priority.'" page 21 *(Training and education)* • "The enhanced role of nurses could help expand services, but both the lack	separately form researchers' summaries. How valuable is the research? Researchers discuss the limits to generalisability of the research **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			of self confidence among nurses and the lack of doctors' confidence in nurses limited action on this opportunity." page 22 **Theme: organisational and environmental factors** • "...directly linking family planning services to abortion clinics was considered to have improved access to appointments. Such developments were dependent upon an 'organisational commitment', in particular the prioritisation of dedicated resources by health boards" page 22 *(Service-level barriers: Difficulty navigating the healthcare system)* • "..the expanded role of nursing staff in medical abortion was hindered by shortfalls in NHS training budgets to ensure education in the legal, technical and emotional aspects of abortion." page	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			22 *(Training and education)* • "'Those who control spending on health do not see abortion care as a priority.' [I4]" page 22 *(Financial barriers: Lack of financial input to services)* • "'There needs to be more financial input, we have done as much as we can.' [I8]" page 22 *(Financial barriers: Lack of financial input to services)*	
Full citation White, K., deMartelly, V., Grossman, D., Turan, J. M., Experiences Accessing Abortion Care in Alabama among Women Traveling for Services, Women's Health Issues, 26, 298-304, 2016 **Ref Id** 833235 **Country/ies where the study was carried out** USA	**Sample size** n=59 women agreed to be interviewed n=25 women interviewed (remainder not interviewed as thematic saturation had been reached) **Characteristics** Age in years - 19-24 (number; percentage in parentheses): 11 (44) Age in years - 25-29 (number; percentage in parentheses): 6 (24) Age in years - 30-34 (number; percentage in parentheses): 4 (16)	**Sampling and setting** Women were recruited from 2 clinics in Alabama that had the highest volume of patients; women attending the clinics for abortion-related appointments (consultation, procedure or follow-up) were referred by clinic staff to the researchers. At the time of the study, 2 clinics had suspended services leaving only 3 clinics providing abortion services in the state, 2 of which only operated 2 days a week. One clinic offered services up to 16 weeks' gestation and the other offered	**Theme: locating a clinic providing abortion care** • "About one half turned to the Internet to find a clinic and others talked to women in their social networks who previously had abortions. Approximately one-half of those who used these strategies commented that finding a clinic was easy because 'the place just popped up' when they searched online or they were referred through an organizational website... Seven women	**Limitations** The assessment of the quality of the study was performed using the CASP checklist for qualitative studies Was there a clear statement of the aims of the research? Yes Is a qualitative methodology appropriate? Yes Was the research design appropriate to address the aims of the research? Can't tell, researchers did

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Study type Qualitative - directed content analysis **Aim of the study** To examine women's' experiences of women travelling to access abortion services, particularly in relation to state regulations **Study dates** July 2014 to September 2014 **Source of funding** Society of Family Planning	Age in years - ≥35 (number; percentage in parentheses): 4 (16) Ethnicity - White (number; percentage in parentheses): 9 (36) Ethnicity - Black (number; percentage in parentheses): 14 (56) Parity - 0 (number; percentage in parentheses): 8 (32) Parity - 1 (number; percentage in parentheses): 11 (44) Parity - ≥2 (number; percentage in parentheses): 6 (24) Previous abortion (number; percentage in parentheses): 4 (17) **Inclusion criteria** English-speaking women aged at least 19 years (age of consent in Alabama) travelling at least 30 miles one way to abortion services **Exclusion criteria** No additional criteria reported	services up to 20 weeks' gestation. **Data collection** Semi-structured interviews were conducted by phone, lasted approximately 35 minutes and were audio recorded and transcribed. The interview guide included open-ended questions about 1) accessing general and reproductive health care in the community, 2) pregnancy and locating a abortion service, 3) experience of arranging appointments, and 4) plan for follow-up care (only themes related to locating services and experience of arranging appointments are relevant to the current review question). **Data analysis** Interview transcripts were reviewed for accuracy against the original recordings. Directed content analysis and NVivo software was used to code the transcripts and organise the data into themes. Two authors	found multiple clinics in their online searches, three of which did not identify the nearest facility. Additionally, six women stated that finding a clinic was difficult and confusing, and a 28-year-old woman who lived almost 80 miles away from the clinic where she obtained services said, 'the hardest thing was finding somewhere to go.'" page 300 *(Service-level barriers: Difficulty navigating the healthcare system)* • "One woman stated that the clinic staff simply made her an appointment for prenatal care noting that 'they do not really talk about that [abortion] there,' and another, age 28 and who suffered from several chronic health conditions, said her regular doctor 'was totally against the idea..He didn't want me to have any other options besides having [the baby],' and dismissed her request for information." page 300	not discuss alternative approaches Was the recruitment strategy appropriate to the aims of the research? Yes Was the data collected in a way that addressed the research issue? Yes Has the relationship between researcher and participants been adequately considered? Can't tell, researchers did not state whether they critically examined their own role in the research Have ethical issues been taken into consideration? Yes Was the data analysis sufficiently rigorous? Yes Is there a clear statement of findings? Yes How valuable is the research? Can't tell, researchers discuss limits of generalizability of the findings, particularly to younger women and those accessing abortions

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
		independently reviewed a sample of the transcripts and then discussed and developed a preliminary coding scheme; when new themes were identified, the previous transcripts were re-read to identify any relevant texts. The 2 authors met to review consistency and any discrepancies were resolved through discussion.	*(Personal barriers: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals)* **Theme: arranging for first trimester abortion visits** • "Because Clinic A offered services only once a week, women obtaining care at that location also waited more than 48 hours to have their abortion" page 301 *(Service-level barriers: Insufficient resources and hours of operation)* • "Women also were unable to return within 48 hours because they had to make multiple arrangements to accommodate the extended time needed for travel. For example, a 30-year-old woman, who returned to the clinic 60 miles away 5 days after her consultation visit, said that in addition to taking off work, 'I had to find a ride and make sure my dad	beyond 20 weeks' gestation **Other information** None

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			had to get my children for me.. [The clinic] isn't just a hop up the road.' page 301 *(Logistical barriers: Difficulty arranging time off work; Logistical barriers: Difficulty arranging childcare; Logistical barriers: Arranging drive home can cause delays and necessitate unwanted disclosure)* • "Women having first trimester aspiration abortions noted that clinic policy required them to have someone who could drive them home after their appointment. A 34-year-old woman explained that she would have been unable to get an abortion if her boyfriend had not already been off from work and could drive her more than 150 miles one way on the day of her procedure, 'If I didn't find anybody to go with me that means.I may have to keep the pregnancy.. I don't have any family here. So I [was] kind of like 'Lord, come	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			on,' but I made it.'" page 301 *(Logistical barriers: Arranging drive home can cause delays and necessitate unwanted disclosure)* • "Almost all women were able to make the necessary arrangements by relying on those who already knew about their decision to have an abortion. However, because they had recently taken time off for the consultation visit, two participants having first trimester abortions (as well as two having second trimester procedures) reported they reluctantly had to disclose to others why they needed additional coverage at work or for childcare." page 301 *(Privacy and confidentiality concerns)* • "The need to make a third visit led a 30-year-old woman to choose aspiration abortion at 6 weeks from LMP because	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			she lived more than 100 miles away, and it 'did not seem practical to me to spend more money to go that far, and take the time off.'" page 301 **Theme: accessing care in the second trimester** • "Compared with women obtaining first trimester procedures, the eight women who had second trimester abortions were more often delayed in scheduling the consultation visit because they did not initially recognize their pregnancy or needed additional time to save money or reach a decision about having an abortion... 'money had gotten messed up in between that week and so I had to wait a little bit longer,'" page 301-302 *(Financial barriers: Patient expenses)* • "…women obtaining abortions at 15 or more weeks from LMP had extended time away from home to accommodate	

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
			their need for cervical preparation before the abortion; they also reported extra out-of-pocket expenses, unrelated to the cost of the procedure. Two women having abortions at 16 or more weeks from LMP reported staying overnight in a hotel for their 2-day procedures. One of these women, a 23-year-old mother of three traveling more than 90 miles with her own mother, stated, 'I had to have someone to watch my kids, and I had to get in a hotel down there for a day, because I really could not leave [town]. I could not be too far.'" page 302 *(Financial barriers: Patient expenses; Personal barriers: Difficulty arranging childcare)*	
Full citation Wiebe, E. R., Sandhu, S., Access to Abortion: What Women Want From Abortion Services, Journal of Obstetrics and	**Sample size** **Characteristics** **Inclusion criteria**	**Sampling and setting** **Data collection** **Data analysis**		**Limitations** **Other information**

Study details	Participants	Methods	Themes *(information in italics is theme(s) applied after thematic synthesis)*	Comments
Gynaecology Canada, 30, 327-331, 2008 **Ref Id** 831249 **Country/ies where the study was carried out** **Study type** Data not extracted as data saturation had been reached **Aim of the study** **Study dates** **Source of funding**	**Exclusion criteria**			

CAS: Canada Abortion Study; CASP: Critical Appraisal Skills Programme; CIHR: Canadian Institutes of Health Research; EC: emergency contraception; GP: general practitioner; HMOs; health maintenance organisations; IUD: intrauterine device; LMP: last menstrual period; mToP: medical termination of pregnancy; NHS: National Health Service; NSW: New South Wales; O&G: obstetrics and gynaecology; POS: Pregnancy Options Service; ToP: termination of pregnancy; WoW: women on web

Clinical evidence tables for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Allen, R. H., Raker, C., Steinauer, J., Eastwood, K. L., Kacmar, J. E., Boardman, L. A., Future abortion provision among US graduating obstetrics and gynecology residents, 2004, Contraception, 81, 531-536, 2010 **Ref Id** 891324 **Country/ies where the study was carried out** USA **Study type** Survey - retrospective cohort **Aim of the study** To investigate factors that affect graduating obstetrics and gynaecology residents' decisions to provide abortion services in their professional careers **Study dates** April 2004 **Source of funding**	**Sample size** n=1,148 eligible n=494 responded to surveys (n=228 routine/opt-out; n=153 elective/opt-in; n=96 not available) **Characteristics** Age in years (mean; standard deviation in parentheses): 32.1 (3.6) Gender - female (number; percentage in parentheses): 375 (76) Gender - male (number; percentage in parentheses): 119 (24) Race/ethnicity - non-Hispanic Caucasian (number; percentage in parentheses): 327 (67) Race/ethnicity - non-Hispanic Black (number; percentage in parentheses): 46 (9) Race/ethnicity - Hispanic (number; percentage in parentheses): 38 (8)	Surveys were sent to all graduating residents (who were identified from the Council on Resident Education in Obstetrics and Gynecology; CREOG) in April 2004 and stamped, return envelopes were provided. Subsequent mailings were not attempted as contact information was not available after June 2004 (when residents graduated). Questionnaires consisted of 48 closed-ended, multiple choice question that collected information on demographics, residency program characteristics, whether residents felt competent in different abortion methods, and whether or not they intended to provide elective abortions after graduation. **Routine/opt-out training:** No specific details about training programs provided	**Outcome: Intending to provide ToP services after completing training (elective terminations)** Routine/opt-out: 123/228 Elective/opt-in: 38/153 Not available: 20/96	**Limitations** **Quality assessment:** Risk of bias assessed using the Newcastle-Ottawa scale for cohort studies Selection 1) Representativeness of the exposed cohort c) selected group (those who self-selected into the study by responding to survey) 2) Selection of the non-exposed cohort a) drawn from the same community as the exposed cohort (one star) 3) Ascertainment of exposure c) written self-report 4) Demonstration that outcome of interest was not present at start of study b) no - some residents intended to provide abortions pre-residency (38% first-trimester

Study details	Participants	Interventions	Outcomes and Results	Comments
No sources of funding reported	Race/ethnicity - Asian (number; percentage in parentheses): 52 (11) Religious affiliation - Catholic (number; percentage in parentheses): 135 (27) Religious affiliation - Protestant (number; percentage in parentheses): 128 (26) Religious affiliation - Other Christian (number; percentage in parentheses): 69 (14) Religious affiliation - Jewish (number; percentage in parentheses): 30 (6) Religious affiliation - Muslim (number; percentage in parentheses): 16 (3) Religious affiliation - Buddhist (number; percentage in parentheses): 8 (2) Religious affiliation - Hindu (number; percentage in parentheses): 17 (3)	but this category was defined as: all residents are trained to perform abortions unless they have a religious or moral objection **Elective/opt-in training:** No specific details about training programs provided but this category was defined as: residents elect to receive training **Not available:** Further details not applicable		abortions, 27% second-trimester abortions) Comparability 1) Comparability of cohorts on the basis of the design or analysis controlled for confounders no - primary comparison in study is between people who did and did not intend to provide elective abortions, not comparison of interest for this review question so unclear if groups are comparable Outcome 1) Assessment of outcome c) self-report 2) Was follow-up long enough for outcomes to occur a) Yes - intentions at the end of residency (one star) 3) Adequacy of follow-up cohorts c) follow up rate <50% (however, geographical and gender proportion similar to those in larger population) Overall quality Very low - only two stars

Study details	Participants	Interventions	Outcomes and Results	Comments
	Religious affiliation - Other (number; percentage in parentheses): 22 (5) Religious affiliation - atheist/agnostic/none (number; percentage in parentheses): 69 (14) Note. not reported separately based on training model as primary comparison in study was between people who did and did not intend to provide elective abortions **Inclusion criteria** All fourth-year residents from accredited obstetrics and gynaecology residency programs in the USA graduating in 2004. **Exclusion criteria** No additional criteria reported			**Other information** None
Full citation Amu, J., Kehinde, R., Amu, O., NHS abortion services: Referral pathways and outcomes, Journal of Obstetrics and Gynaecology, 30, 704-706, 2010	**Sample size** n=780 eligible (n=201 self-referral; n=570 formal referral)	**Self-referral:** Women who self-referred to 1 NHS general hospital via a dedicated telephone service and had surgical abortion; women could also	**Outcome: Time between referral and termination of pregnancy** Within 7 days	**Limitations** **Quality assessment:**

Study details	Participants	Interventions	Outcomes and Results	Comments
Ref Id 840329 **Country/ies where the study was carried out** UK (England) **Study type** Retrospective cohort study **Aim of the study** To determine the effectiveness of different referral pathways for abortion **Study dates** Not reported **Source of funding** No sources of funding reported	n=514 complete dataset and included in analysis (n=149 self-referral; n=365 formal referral) **Characteristics** Clinical and demographic characteristics not reported **Inclusion criteria** Women undergoing referral for abortion at 2 district hospitals; no further details reported **Exclusion criteria** No additional criteria reported	be formally referred to this hospital but these women were excluded from the study. **Formal-referral:** Women who were formally-referred to 1 NHS general hospital via healthcare providers (including family planning clinics and GPs); women could self-refer to this hospital but all women were formally-referred. Both surgical and medical abortion were available but the majority (92%) had surgical abortion.	Self-referral: 110/149 Formal referral: 135/365 Within 14 days Self-referral: 130/149 Formal referral: 277/365	Risk of bias assessed using the Newcastle-Ottawa scale for cohort studies Selection 1) Representativeness of the exposed cohort b) somewhat representative of women undergoing abortion at selected hospital (one star) 2) Selection of the non-exposed cohort b) drawn from a different source - different general hospital, unclear how comparable services are 3) Ascertainment of exposure a) Secure record (data drawn from hospital record) (one star) 4) Demonstration that outcome of interest was not present at start of study a) Yes; primary outcome waiting times for abortion (one star) Comparability 1) Comparability of cohorts on the basis of the design or analysis controlled for confounders

Study details	Participants	Interventions	Outcomes and Results	Comments
				No - gestational age is lower in the nurse-led cohort but this is likely a by-product of reduced waiting times (as it is gestational age at abortion, not at first presentation); only surgical abortion was available in the self-referral arm and both medical and surgical abortion was available in the formal referral arm but the majority (92%) had surgical abortion; demographic and additional clinical characteristics were not reported so unclear if they were comparable between arms Outcome 1) Assessment of outcome b) Record linkage (one star) 2) Was follow-up long enough for outcomes to occur a) Yes (retrospective cohort study; primary outcome waiting times between referral and abortion; one star) 3) Adequacy of follow-up of cohorts

Study details	Participants	Interventions	Outcomes and Results	Comments
				c) follow up rate <75% and no description of those lost Overall quality Low - no stars in comparability domain, inadequate follow-up and cohorts drawn from different sources **Other information** Indirectness due to comparison: Serious - formal referral included referral from healthcare providers other than GPs
Full citation Cameron, S. T., Glasier, A., Johnstone, A., Shifting abortion care from a hospital to a community sexual and reproductive health care setting, Journal of Family Planning & Reproductive Health CareJ Fam Plann Reprod Health Care, 42, 127-32, 2016 **Ref Id** 815815 **Country/ies where the study was carried out** UK (Scotland)	**Sample size** n=1,342 women for safety data and time between referral and assessment (n=601 hospital; n=741 community) n=305 for satisfaction study (n=151 hospital; n=152 community; n=2 did not complete questionnaire [1 at each site]) **Characteristics** Age in years (mean; standard deviation in parentheses):	Both services used the same centralised referral service and provided clinics on 2 days a week. Nursing staff were unique to each site, whereas some doctors worked at both sites. The clinical lead was the same for both services and the same protocols and laboratories were used. All women received 200mg oral mifepristone followed by 800micrograms misoprostol self-administered vaginally at home 24-48 hours later. Women were instructed to	**Outcome: Patient satisfaction** Satisfaction with care received (10-point scale) Hospital: N=148, M=9.2, SD=1.1 Community: N=149, M=9.6, SD=0.7 Care received rated as 10/10 Hospital: 85/148 Community: 115/149 Contraception discussion was helpful/very helpful	**Limitations** **Quality assessment:** Risk of bias assessed using the Newcastle-Ottawa scale for cohort studies Selection 1) Representativeness of the exposed cohort a) Truly representative of the population of women undergoing outpatient early medical abortion in geographical area (one star)

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type Retrospective cohort study for chart review of safety; prospective cohort study for satisfaction study **Aim of the study** To compare the safety of, and patient satisfaction with, outpatient early medical abortion conducted at community sexual and reproductive health services and hospitals. **Study dates** September 2012 to August 2013 for retrospective review; January 2013 to March 2013 for satisfaction study **Source of funding** Scottish Department of Sexual Health and Blood Borne Viruses	Hospital: 26.0 (6.7) Community: 26.6 (6.0) Previous birth (number; percentage in parentheses): Hospital: 282 (46.9) Community: 333 (44.9) Previous abortion (number; percentage in parentheses): Hospital: 203 (33.7) Community: 240 (32.3) Previous miscarriage (number; percentage in parentheses): Hospital: 60 (9.9) Community: 66 (8.9) Previous ectopic pregnancy (number; percentage in parentheses): Hospital: 10 (1.6) Community: 14 (1.8) Gestational age in days - ≤42 (number; percentage in parentheses): Hospital: 227 (37.7) Community: 356 (48.0) Gestational age in days - 43-49 (number; percentage in parentheses):	complete a low-sensitivity urine pregnancy test 2 weeks after the abortion and contact the service if the test was positive or there were signs of ongoing pregnancy. **Satisfaction study:** Women were given an anonymous questionnaire upon arrival at the clinic (on days where the research nurse was present) and instructed to complete it after consultation with the doctor/nurse. The questionnaire assessed level of satisfaction with care, information and contraceptive advice received, and overall satisfaction. **Hospital setting:** No further information provided. **Community setting:** The Chalmers Sexual Health Centre in Edinburgh provided counselling for	Hospital: 140/148 Community: 143/147 Did not feel under pressure to choose a particular contraceptive method Hospital: 140/151 Community: 145/152 Felt quite/very prepared for abortion (based on information received) Hospital: 140/150 Community: 149/149 Felt quite/very clear what would happen/what abortion would involve (based on information received) Hospital: 148/149 Community: 148/148 **Outcome: Time between referral and termination of pregnancy (time between referral and assessment in days)** Hospital: N=601, M=7.0, SD=3.2	2) Selection of the non-exposed cohort a) Drawn from the same community as the exposed cohort - allocation based on next available appointment (one star) 3) Ascertainment of exposure a) Secure record (data drawn from hospital record) (one star) 4) Demonstration that outcome of interest was not present at start of study a) Yes; waiting times for abortion, safety data and satisfaction with care and information received Comparability 1) Comparability of cohorts on the basis of the design or analysis controlled for confounders No - gestational age was younger in the community arm and this was not controlled for Outcome 1) Assessment of outcome b) Record linkage for waiting times data (one star)

Study details	Participants	Interventions	Outcomes and Results	Comments
	Hospital: 108 (17.9) Community: 153 (20.6) Gestational age in days - 50-56 (number; percentage in parentheses): Hospital: 151 (25.1) Community: 142 (19.1) Gestational age in days 57-63 (number; percentage in parentheses): Hospital: 114 (18.9) Community: 89 (12.0) Gestational age in days ≥63 (number; percentage in parentheses): Hospital: 1 (0.1) Community: 1 (0.1) **Inclusion criteria** Women aged ≥16 years old with pregnancy ≤9 weeks' gestation and no contraindications to medical abortion; lived within 40 minutes of hospital/community and had adult support at home; no cause for concern (e.g., child protection or domestic violence issues); did not require interpreter	abortion, referral and post-abortion care until 2012. After this date, half of the abortions conducted in Edinburgh were shifted from Royal Infirmary of Edinburgh (where previously all abortions in Edinburgh were conducted) to the Chalmers Sexual Health Centre.	Community: N=741, M=5.9, SD=3.4	c) self-report for satisfaction data 2) Was follow-up long enough for outcomes to occur a) Yes (retrospective cohort study for waiting times data and satisfaction was completed immediately after consultation; one star) 3) Adequacy of follow-up of cohorts a) complete follow up for waiting times data - all subjects accounted for (one star) b) subjects lost to follow up unlikely to introduce bias - small number lost - >99% follow up for satisfaction data (one star) Overall quality Moderate - no stars in comparability domain **Other information** Indirectness due to outcome: Serious - time between referral and assessment, not abortion

Study details	Participants	Interventions	Outcomes and Results	Comments
	Exclusion criteria No additional criteria reported			
Full citation Grossman, D., Grindlay, K., Buchacker, T., Lane, K., Blanchard, K., Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine, Obstetrics and gynecology, 118, 296-303, 2011 **Ref Id** 816046 **Country/ies where the study was carried out** USA **Study type** Prospective cohort study **Aim of the study** To compare the effectiveness and acceptability of medical abortion delivered through face-to-face visits and telemedicine **Study dates** November 2008 to October 2009	**Sample size** n=1,117 screen for eligibility (n=64 <18 years of age; n=468 declined participation or not invited) n=585 enrolled (n=284 telemedicine [n=1 decided to continue pregnancy; n=1 withdrew from study; n=1 gestational age >63 days]; n=301 face-to-face [n=3 did not give consent; n=1 <18 years of age]) n=578 included in study (n=281 telemedicine [n=58 lost to follow-up]; n=277 face-to-face [n=71 lost to follow-up]) n=449 included in analysis (n=223 telemedicine; n=229 face-to-face) **Characteristics** Age in years (mean; standard deviation not reported) Telemedicine: 24.9	All women attended Planned Parenthood clinics, had an ultrasound by a trained technician to confirm gestational age and received information about medical abortion; physical examinations were not done routinely. All women were observed taking 200mg oral mifepristone at the clinic and were given 800mcg misoprostol and instructed to take this bucally at home 24-48 hours later. A follow-up visit, with pelvic ultrasound, was undertaken within 2 weeks to confirm completion of the abortion; ongoing pregnancies were managed with vacuum aspiration and women with incomplete abortions were given the options of expectant management, additional misoprostol or vacuum aspiration. At the follow-up visit, women were	**Outcome: Patient satisfaction** Overall satisfaction: very satisfied Telemedicine: 201/214 Face-to-face: 191/217 Overall satisfaction: somewhat satisfied Telemedicine: 10/214 Face-to-face: 21/217 Overall satisfaction: somewhat or very dissatisfied Telemedicine: 1/214 Face-to-face: 1/217 Would recommend a medical abortion in this clinic to a friend Telemedicine: 192/214 Face-to-face: 180/217 Information received: very helpful Telemedicine: 195/214 Face-to-face: 202/217	**Limitations** **Quality assessment:** Risk of bias assessed using the Newcastle-Ottawa scale for cohort studies Selection 1) Representativeness of the exposed cohort b) somewhat representative of women undergoing medical abortion but authors note participants were more likely to be better educated and Latina compared with general medical abortion population (one star) 2) Selection of the non-exposed cohort a) Drawn from the same community as the exposed cohort (one star) 3) Ascertainment of exposure

Study details	Participants	Interventions	Outcomes and Results	Comments
Source of funding Anonymous donor	Face-to-face: 25.7 Race/ethnicity - Latina/Hispanic (number; percentage in parentheses): Telemedicine: 5 (2) Face-to-face: 12 (5) Race/ethnicity - Caucasian (number; percentage in parentheses): Telemedicine: 179 (82) Face-to-face: 182 (85) Race/ethnicity - African American (number; percentage in parentheses): Telemedicine: 28 (13) Face-to-face: 22 (10) Race/ethnicity - Asian American (number; percentage in parentheses): Telemedicine: 5 (2) Face-to-face: 4 (2) Parity - parous (number; percentage in parentheses): Telemedicine: 112 (50) Face-to-face: 133 (59)	given a questionnaire measuring adverse events and satisfaction with the service; if women did not attend the follow-up appointment they were contacted at least 3 times by phone and once by post to arrange either a face-to-face follow-up visit or a telephone interview to complete the questionnaire. **Telemedicine:** Medical history and ultrasound images were uploaded to a secure server by clinic staff for the physician to review. One of 2 physicians then had a brief discussion with the women via videoconference and entered a password that remotely unlocked a drawer in front of the women containing the mifepristone and misoprostol; final instructions were given via videoconference. **Face-to-face:**	<u>Information received: somewhat helpful or not helpful</u> Telemedicine: 16/214 Face-to-face: 13/217 <u>Satisfaction with conversation with doctor: very satisfied</u> Telemedicine: 163/214 Face-to-face: 164/217 <u>Satisfaction with conversation with doctor: somewhat satisfied</u> Telemedicine: 34/214 Face-to-face: 36/217 <u>Satisfaction with doctor: somewhat or very dissatisfied</u> Telemedicine: 11/214 Face-to-face: 6/217	a) Secure record (data drawn from hospital record) (one star) 4) Demonstration that outcome of interest was not present at start of study a) Yes - satisfaction with service (one star) Comparability 1) Comparability of cohorts on the basis of the design or analysis controlled for confounders No - but authors note that no covariates met the multivariable model inclusion criteria Outcome 1) Assessment of outcome c) self-report 2) Was follow-up long enough for outcomes to occur a) Yes - satisfaction with service measured within two weeks of abortion (one star) 3) Adequacy of follow-up of cohorts c) follow up rate <80% and no description of those lost Overall quality

Study details	Participants	Interventions	Outcomes and Results	Comments
	Prior abortion (number; percentage in parentheses): Telemedicine: 58 (26) Face-to-face: 86 (38) Gestational age in days (mean; standard deviation not reported): Telemedicine: 46.7 Face-to-face: 47.1 **Inclusion criteria** Women aged at least 18 years of age requesting medical abortion at or before 63 days gestation; no contraindications to medical abortion; spoke English; able to give informed consent **Exclusion criteria** No additional criteria reported	Medical history and ultrasound images were reviewed by 1 of 2 physicians (same as those in telemedicine arm) who had a brief discussion with the women, gave them both the mifepristone and misoprostol and final instructions.		Low - no stars in comparability domain and only one star in outcome domain **Other information** None
Full citation Harvey, N., Gaudoin, M., Effectiveness of a nurse-led pregnancy termination clinic, Nursing Times, 101, 34-36, 2005 **Ref Id** 839726	**Sample size** n=236 (n=41 physician-led [n=5 did not undergo abortion]; n=195 nurse-led [n=22 failed to attend; n=45 did not undergo abortion, of those who attended])	No details reported for physician led clinic. **Nurse-led clinic:** A new, nurse-led clinic, led by a senior staff nurse with a certificate in family	**Outcome: Time between referral and termination of pregnancy (time between referral and being seen at clinic in days)**	**Limitations** **Quality assessment:** Risk of bias assessed using the Newcastle-Ottawa scale for cohort studies Selection

Study details	Participants	Interventions	Outcomes and Results	Comments
Country/ies where the study was carried out UK (Scotland) **Study type** Retrospective cohort study **Aim of the study** To compare a standard medical abortion clinic with a new nurse-led clinic **Study dates** March 2004 to June 2004 **Source of funding** No sources of funding reported	**Characteristics** Gestational age in days (mean; standard deviation in parentheses): Nurse-led: 58.2 (19.0) Physician-led: 66.6 (23.8) **Inclusion criteria** All women undergoing medical abortion (up to 9 weeks' gestation and between 13 and 17 weeks' gestation) or surgical abortion (from 7 to 13 weeks' gestation) in one hospital in Scotland **Exclusion criteria** No additional criteria reported	planning was established April 2004; there are 4 clinics a week, each with the capacity to see 4 women. All women undergo detailed sexual health history, a urine screen for chlamydia, and an ultrasound to determine gestational age. Women who wish to continue with abortion are then given counselling regarding available methods and risks and have a blood test for haemoglobin concentration and rhesus status. Consent for medical abortion can be obtained by a nurse, but the referring doctor and ward physician has to sign the abortion certificate; the ward physician also signs the medication forms. For women undergoing surgical abortion, the nurse sees the women approximately 3 hours prior to surgery to administer vaginal misoprostol, but written consent is obtained, and the abortion certificate and drug forms are completed, by the surgeon.	<u>Mean waiting time in days</u> Nurse-led: N=195, M=6.6, SD=5.1 Physician-led: N=41, M=11.8, SD=5.3 <u>Seen within 5 days of referral</u> Nurse-led: 104/195 Physician-led: 5/41 <u>Seen within 14 days of referral</u> Nurse-led: 171/195 Physician-led: 30/41 Note. figures/percentages in nurse-led arm do not take into account those that did not attend appointments; presumably the authors have included data based on when appointments were scheduled if the woman did not attend	1) Representativeness of the exposed cohort a) Truly representative of the population of women undergoing abortion at selected hospital (one star) 2) Selection of the non-exposed cohort a) Drawn from the same community as the exposed cohort (one star) 3) Ascertainment of exposure a) Secure record (data drawn from hospital record) (one star) 4) Demonstration that outcome of interest was not present at start of study a) Yes; primary outcome waiting times for abortion Comparability 1) Comparability of cohorts on the basis of the design or analysis controlled for confounders No - no mention of controlling for any differences in cohorts and limited clinical and demographic information reported; gestational age is

Study details	Participants	Interventions	Outcomes and Results	Comments
				lower in the nurse-led cohort but this is likely a by-product of reduced waiting times (as it is gestational age at clinic, not at first presentation) Outcome 1) Assessment of outcome b) Record linkage (one star) 2) Was follow-up long enough for outcomes to occur a) Yes (retrospective cohort study; primary outcome waiting times between first contact, being seen at the clinic and abortion; one star) 3) Adequacy of follow-up of cohorts a) complete follow up - all subjects that had an abortion accounted for (one star) Overall quality Moderate - no stars in comparability domain **Other information** Indirectness due to outcome: Serious - time between referral and assessment, not abortion

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Kopp Kallner, H., Gomperts, R., Salomonsson, E., Johansson, M., Marions, L., Gemzell-Danielsson, K., The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by doctors or by nurse-midwives: A randomised controlled equivalence trial, BJOG: An International Journal of Obstetrics and Gynaecology, 122, 510-517, 2014 **Ref Id** 802123 **Country/ies where the study was carried out** Sweden **Study type** RCT **Aim of the study** To determine if nurse-midwives can provide early medical abortion as effectively as doctors **Study dates** February 2011 to July 2012	**Sample size** n=1,220 assessed for eligibility (n=28 declined participation; n=12 excluded due to language) n=1,180 randomised (n=597 nurse-midwife; n=583 doctor) n=938 analysed (n=481 nurse-midwife [n=62 did not have medical abortion; n=54 lost to follow-up]; n=457 doctor [n=43 did not have medical abortion; n=7 did not receive allocated intervention; n=76 lost to follow-up])* *Note. loss to follow-up reported here is for outcome of continuing pregnancy, which is not of interest for this review **Characteristics** Age in years (median; range in parentheses): Nurse-midwife: 27 (18-47) Doctor: 27 (18-46) Gestational age in days (median; range in parentheses):	In both arms, further information and the medication for abortion were given by a nurse-midwife. Women received 200mg mifepristone and had the option to self-administer 800mcg vaginal misoprostol at home or at the clinic 24-48 hours after the mifepristone; women were told to take an additional 400mcg misoprostol orally if no bleeding had occurred within 3 hours of the first dose of misoprostol. **Nurse-midwife:** The examination, ultrasound dating of the pregnancy and contraceptive counselling was provided by 1 of 2 nurse-midwives who had prior experience of contraceptive counselling and medical abortion and received training in vaginal ultrasound of early pregnancy. **Doctor:**	**Outcome: Patient satisfaction (defined as women preferring their allocated provider)** Nurse-midwife: 200/535 Doctor: 12/533	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane risk of bias tool Random sequence generation: low risk, computer-generated blocks of 10 Allocation concealment: low risk, sequentially numbered sealed opaque envelopes Blinding of participants and personnel: no blinding, but blinding impractical/unethical; low risk Blinding of outcome assessment: no blinding, but blinding impractical/unethical; low risk Attrition: low risk; small amounts of missing data for outcomes of interest; slightly higher loss to follow-up for continuing pregnancy in doctor arm (76/533 versus 54/535) but this was not an outcome of interest for this review

Study details	Participants	Interventions	Outcomes and Results	Comments
Source of funding Swedish Research Council; Swedish Council for Working Life and Social Research; Stockholm County Council; Karolinska Institutet	Nurse-midwife: 45 (30-63) Doctor: 45 (28-63) Gravidity (median; range in parentheses): Nurse-midwife: 2 (0-13) Doctor: 2 (0-14) Parity (median; range in parentheses): Nurse-midwife: 0 (0-5) Doctor: 0 (0-6) Previous medical abortion (median; range in parentheses): Nurse-midwife: 0 (0-4) Doctor: 0 (0-5) Previous surgical abortion (median; range in parentheses): Nurse-midwife: 0 (0-3) Doctor: 0 (0-5) Previous vaginal delivery (median; range in parentheses): Nurse-midwife: 0 (0-5) Doctor: 0 (0-6) Previous caesarean section (median; range in parentheses): Nurse-midwife: 0 (0-3) Doctor: 0 (0-3)	The examination, ultrasound dating of the pregnancy and contraceptive counselling was provided by a doctor. There was a total of 34 doctors providing this service, with a range of experience from only a few months of training to senior consultants.		Selective reporting: low risk, all outcomes reported in sufficient detail for analysis **Other information** None

Study details	Participants	Interventions	Outcomes and Results	Comments
	Inclusion criteria Women aged at least 18 years old in good general health; wanted and had no contraindications to medical abortion; gestational age ≤63 days **Exclusion criteria** On medication for chronic disease; evidence of pathological pregnancy; adnexal mass			
Full citation Martin, L. A., Debbink, M., Hassinger, J., Youatt, E., Eagen-Torkko, M., Harris, L. H., Measuring stigma among abortion providers: assessing the Abortion Provider Stigma Survey instrument, Women & HealthWomen Health, 54, 641-661, 2014 **Ref Id** 832486 **Country/ies where the study was carried out** USA	**Sample size** n=135 eligible to participate (from sites participating in the workshop) n=55 participated in workshops n=52 completed survey at both time points **Characteristics** Gender - female (number; percentage in parentheses): 55 (100)	Seven sites participated in the workshop program and were diverse in terms of geographical, demographic and instructional factors (e.g., private, public and non-profit hospitals and clinics, states with and without Medicaid funding for abortion. All eligible staff at participating sites were invited to participate by a site-liaison through emails, flyers and announcements at staff meetings.	**Outcome: Professional quality of life** Abortion Provider Stigma Survey (APSS) total score Pre-workshop: N=55, M=32.5, SD=6.0 Pre-post difference: N=52, M=1.1, 95% CI=-0.6-2.8 APSS Disclosure subscale Pre-workshop: N=55, M=17.8, SD=5.7	**Limitations** **Quality assessment:** Risk of bias assessed using the Effective Practice and Organisation of Care (EPOC) RoB Tool (for studies with a control group) Random sequence generation: High risk, controlled before-after study - no randomisation Allocation concealment: High risk, controlled before-after study - no randomisation

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type Before-and-after study **Aim of the study** To develop an Abortion Provider Stigma Survey to evaluate the extent to which abortion providers experience stigma as a result of their work and the impact this has on the personal and professional lives; to determine the utility of this instrument in monitoring change in stigma over time (and as a result of provider workshops) **Study dates** Not reported **Source of funding** No sources reported	Age in years - 23-39 (number; percentage in parentheses): 20 (36) Age in years - 30-39 (number; percentage in parentheses): 21 (38) Age in years - 40-49 (number; percentage in parentheses): 9 (16) Age in years - 50-59 (number; percentage in parentheses): 5 (9) Race/ethnicity - White (number; percentage in parentheses): 27 (56) Race/ethnicity - Black (number; percentage in parentheses): 7 (15) Race/ethnicity - Hispanic (number; percentage in parentheses): 9 (19) Race/ethnicity - Asian (number; percentage in parentheses): 2 (4) Race/ethnicity - Mixed race (number; percentage in parentheses): 2 (4) Job role - Counsellor (number; percentage in parentheses): 18 (24)	**Providers Share Workshop:** The workshop consisted of 5 sessions, each lasting 1-2 hours, over an 8-12 week period. Topics covered were: 1) what abortion work means to me, 2) memorable stories, 3) abortion and identity, 4) abortion politics, and 5) strategies for self-care. The goal of the workshop was to provide a safe space for abortion providers to discuss their work and strengthen providers' resilience. **Abortion Provider Stigma Survey (APSS):** A survey, including the APSS, was administered via a secure website prior to the first workshop session and within 3 weeks of the final workshop session. Surveys took approximately 45 to 60 minutes to complete on each occasion.	Pre-post difference: N=52, M=0.3, 95% CI=-1.1-1.7 APSS Resistance and Resilience subscale Pre-workshop: N=55, M=8.1, SD=3.3 Pre-post difference: N=52, M=0.3, 95% CI=-0.5-1.1 APSS Discrimination subscale Pre-workshop: N=55, M=6.3, SD=1.9 Pre-post difference: N=52, M=-0.3, 95% CI=-1.0-0.5	Baseline outcome measurements similar: Unclear risk, only one baseline measurement was taken and it is unclear how much time elapsed between baseline measurements and start of intervention Baseline characteristics similar: Unclear risk, only one baseline measurement was taken and it is unclear how much time elapsed between baseline measurements and start of intervention Incomplete outcome data: Low risk, amount of missing data is small (5%) Knowledge of the allocated interventions adequately prevented during the study: Low risk, no blinding but blinding was not feasible due to nature of intervention Protection against contamination: Low risk, controlled before-after study so control group was pre-intervention Selective outcome reporting: Low risk, all

Study details	Participants	Interventions	Outcomes and Results	Comments
	Job role - Nurse (number; percentage in parentheses): 11 (15) Job role - Physician (number; percentage in parentheses): 4 (5) Job role - Recovery room assistant (number; percentage in parentheses): 2 (3) Job role - Manager (number; percentage in parentheses): 7 (9) Job role - Surgical assistant (number; percentage in parentheses): 12 (16) Job role - Prep/clean-up (number; percentage in parentheses): 2 (3) **Inclusion criteria** Eligibility criteria for workshop sites: minimum of 6 participants; able to accommodate the workshop schedule; no administrative or leadership changes in previous 6 months. Eligibility criteria for individual participation: any			outcomes reported sufficiently Other risks of bias: High risk, no separate control group (pre-intervention scores act as control group for post-intervention scores) **Other information** Small sample size; may not be sufficiently powered to detect differences between pre- and post-workshop scores but power analysis was not undertaken.

Study details	Participants	Interventions	Outcomes and Results	Comments
	employee with direct abortion care responsibilities. **Exclusion criteria** No additional criteria reported			
Full citation Olavarrieta, C. D., Ganatra, B., Sorhaindo, A., Karver, T. S., Seuc, A., Villalobos, A., Garcia, S. G., Perez, M., Bousieguez, M., Sanhueza, P., Nurse versus physician-provision of early medical abortion in Mexico: A randomized controlled non-inferiority trial, Bulletin of the world health organization, 93, 249-258, 2015 **Ref Id** 770439 **Country/ies where the study was carried out** Mexico (Mexico city) **Study type** Randomised controlled trial **Aim of the study** To determine the effectiveness, safety and acceptability of nurse-led early	**Sample size** n=1028 screened for eligibility (n=9 had taken mifepristone or misoprostol before coming to the clinic; n=1 declined participation; n=1 did not meet cell phone criterion [not mentioned anywhere else in article]) n=1017 randomised (n=503 nurse-led [n=12 required hCG test; n=28 passed gestational limit based on confirmatory ultrasound; n=1 wanted manual vacuum aspiration]; n=514 physician led [n=11 required hCG test; n=28 passed gestational limit based on confirmatory ultrasound; n=1 wanted manual vacuum aspiration; n=2 decided to continue	All physicians and nurses received training on medical abortion, including 20 hours of abdominal and transvaginal ultrasound training, Women were screened for eligibility by a nurse participating in the study and then were randomised to study arm and received clinical care (vaginal and pelvic exam and abdominal ultrasound) according to treatment assignment (nurse-led or physician-led) and initiated medical abortion at the first visit. Women were given 200mg oral mifepristone under supervision and instructed to take 800mcg misoprostol bucally 24 hours later. Women also received contraceptive counselling, were given details of	**Outcome: Patient satisfaction** Very satisfied with provider Nurse-led: 343/434 Physician-led: 342/450 Satisfied with provider Nurse-led: 90/434 Physician-led: 106/450 Dissatisfied with provider Nurse-led: 1/434 Physician-led: 1/450 Could have done more to control pain Nurse-led: 43/434 Physician-led: 53/450 Did enough to control pain Nurse-led: 348/434 Physician-led: 366/450 Did not experience pain Nurse-led: 43/434	**Limitations** **Quality of study:** Risk of bias assessed using Cochrane risk of bias tool Random sequence generation: low risk, computer-generated randomisation Allocation concealment: low risk, sequentially numbered sealed envelopes Blinding of participants and personnel: no blinding, but blinding impractical/unethical; low risk Blinding of outcome assessment: no blinding, but blinding impractical/unethical; low risk Attrition: low risk for all outcomes; rates of, and reasons for, attrition were

Study details	Participants	Interventions	Outcomes and Results	Comments
medical abortion compared with physician-led early medical abortion **Study dates** November 2012 to January 2013 **Source of funding** "The study was funded by the department of Reproductive Health and Research which includes UNDP/UNFPA/UNICEF/WHO/the World Bank Special Programme of Research, Development and Research Training in Human Reproduction." page 256	pregnancy; n=1 not pregnant]) n=933 received medical abortion counselling (n=462 nurse-led [n=28 did not return for follow-up to confirm completed regimen]; n=471 physician-led [n=21 did not return for follow-up to confirm completed regimen]) n=884 intention to treat analysis (n=434 nurse-led [n=12 did not take misoprostol 24 hours after mifepristone; n=25 returned to clinic before 7 days; n=1 did not have ultrasound at follow-up; n=1 unclear if took mifepristone]; n=450 physician-led [n=15 did not take misoprostol 24 hours after mifepristone; n=26 returned to clinic before 7 days; n=1 did not have ultrasound at follow-up; n=1 decided to continue pregnancy; n=1 went to hospital for adverse event]) n=801 per protocol analysis (n=395 nurse-led; n=406 physician-led)	expected side-effects and who to contact if they had any questions or concerns and told to return to the clinic 7-15 days later. At the follow-up visit, completion of abortion was determined via clinical symptoms, history of bleeding and ultrasound and women were provided with contraception or information on where contraception could be obtained. Following this, women completed a survey measuring satisfaction with care received.	Physician-led: 31/450 Would recommend to friend: yes Nurse-led: 427/434 Physician-led: 444/450 Would recommend to friend: maybe Nurse-led: 7/434 Physician-led: 5/450 Would recommend to friend: no Nurse-led: 0/434 Physician-led: 1/450 Medical care received: better than expected Nurse-led: 408/434 Physician-led: 431/450 Medical care received: as expected Nurse-led: 25/434 Physician-led: 19/450	small and similar between arms Selective reporting: low risk, all outcomes reported in sufficient detail for analysis **Other information** None

Study details	Participants	Interventions	Outcomes and Results	Comments
	Characteristics Age in years (mean; standard deviation in parentheses): Nurse-led: 26.3 (6.3) Physician-led: 25.7 (6.0) Gestational age in days, measured by ultrasound (mean; standard deviation in parentheses): Nurse-led: 49.7 (14.0) Physician-led: 49.7 (13.3) **Inclusion criteria** Women aged at least 18 years old, reporting LMP of <70 days, who wanted a medical abortion; willing to provide contact information for follow-up. **Exclusion criteria** Allergy to mifepristone or misoprostol; chronic systemic corticosteroid use; chronic adrenal failure; coagulopathy or current anticoagulant therapy; inherited porphyria; heart disease;			

Study details	Participants	Interventions	Outcomes and Results	Comments
	severe hepatic or renal disease; severe anaemia; previous legal medical abortion in Mexico City			
Full citation Steinauer, J., Landy, U., Filippone, H., Laube, D., Darney, P. D., Jackson, R. A., Predictors of abortion provision among practicing obstetrician-gynecologists: A national survey, American Journal of Obstetrics and Gynecology, 198, 39.e1-39.e6, 2008 **Ref Id** 891206 **Country/ies where the study was carried out** USA **Study type** Survey - retrospective cohort **Aim of the study** To determine factors that affect whether or not physicians provide abortion services **Study dates** 2002 to 2003	**Sample size** n=5,005 eligible n=2,309 responded to surveys (n=130 graduated before 1990; n=10 graduated after 1998; n=3 not currently practicing medicine; n=14 missing key training information; n=3 blank surveys) n=2,149 surveys analysed (n=517 routine/opt-out; n=678 elective/opt-in; n=589 not available) Note. arms of interest for this review question do not add up to total number of surveys analysed in study; presumably missing data on training models (for programs where training was available) **Characteristics** Gender - female (number; percentage in parentheses): 1,336 (62)	Surveys were mailed in 2002-2003 to all obstetrician-gynaecologists that became board certified in the USA between 1998 and 2001; identical surveys were sent on 2 occasions to increase response rate and respondents were informed that surveys were anonymous. The survey was 2 pages and asked questions about demographics, careers, attitudes towards abortion, intention to provide abortions before residency, abortion training during residency, and abortion provision in the previous year. No details provided about the different types of training program.	**Outcome: Providing ToP services after completing training (during the last year)** Routine/opt-out: 176/517 Elective/opt-in: 140/678 Not available: 54/589	**Limitations** **Quality assessment:** Risk of bias assessed using the Newcastle-Ottawa scale for cohort studies Selection 1) Representativeness of the exposed cohort c) selected group (those who self-selected into the study by responding to survey) 2) Selection of the non-exposed cohort a) drawn from the same community as the exposed cohort (one star) 3) Ascertainment of exposure c) written self-report 4) Demonstration that outcome of interest was not present at start of study b) no - some residents intended to provide

Study details	Participants	Interventions	Outcomes and Results	Comments
Source of funding Anonymous foundation	Gender - male (number; percentage in parentheses): 813 (38) Religious - yes (number; percentage in parentheses): 1,424 (66) Religious - no (number; percentage in parentheses): 725 (34) Hospital restrictions/prohibit abortions (number; percentage in parentheses): 728 (34) Practice restrictions/prohibit abortions (number; percentage in parentheses): 347 (16) Note. not reported separately based on training model as primary comparison in study was between people who were and were not providing abortions **Inclusion criteria** All obstetrician-gynaecologists that became board certified in			abortions of pregnancy pre-residency (33%) Comparability 1) Comparability of cohorts on the basis of the design or analysis controlled for confounders no - primary comparison in study is between people who are and are not providing abortions of pregnancy, not comparison of interest for this review question so unclear if groups are comparable Outcome 1) Assessment of outcome c) self-report 2) Was follow-up long enough for outcomes to occur a) Yes - retrospective outcome; provision of abortions in the past year (one star) 3) Adequacy of follow-up cohorts c) follow up rate <50% (however gender and abortion provision proportions similar to those in larger population)

Study details	Participants	Interventions	Outcomes and Results	Comments
	the USA between 1998 and 2001 **Exclusion criteria** Graduated before 1990 or after 1998; not currently practicing medicine			Overall quality Very low - only two stars **Other information** None

APSS: Abortion Provider Stigma Survey; CREOG: Council on Resident Education in Obstetrics and Gynecology; EPOC: Effective Practice and Organisation of Care; GP: general practitioner; hCG: human chorionic gonadotrophin; LMP: last menstrual period; mcg: micrograms; NHS: National Health Service; RoB: risk of bias; ToP: termination of pregnancy; UNDP: United Nations Development Programme; UNFPA: United Nations Population Fund; UNICEF: United Nations International Children's Emergency Fund; WHO: World Health Organisation

Appendix E – Forest plots

Forest plots for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

No meta-analysis was undertaken for this review.

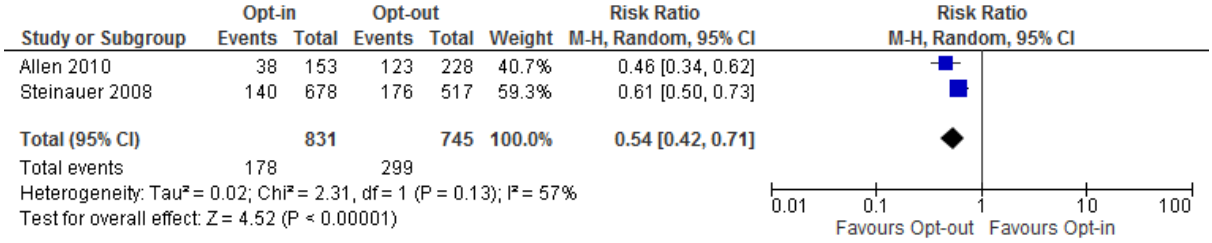
Forest plots for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

Comparison 5. Routine integration of termination training into core curriculum versus termination training not integrated into core curriculum

Figure 4: Providing/intending to provide ToP services after training

Comparison 6. Opt-in termination training versus opt-out termination training

Figure 5: Providing/intending to provide ToP services after training



Appendix F – GRADE tables

GRADE CERQual tables for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

Table 5: Clinical evidence profile: Theme 1. Service-level barriers

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 1.1: Service-level barriers – long waiting times and delays					
9 (Aiken 2018b; Cano 2016; Doran 2016; Dressler 2013; Hulme-Chambers 2018; Kruss 2014; Kumar 2004; Margo 2016; Purcell 2014) n=686	8 qualitative studies using semi-structured interviews; 1 mixed methods study (qualitative part open-ended questions on online consultation form)	**Mixed populations and remote locations:** 7 studies conducted in Australia, Canada, the UK and the USA with women and staff reported that there were long waiting times and delays in getting GP appointments, blood tests and ultrasounds, and appointments for the abortion. **Mixed population:** 1 study conducted in the UK with women reported that long waiting times were uncommon after a referral had been obtained. **Remote locations:** 1 study conducted in Australia with women reported that long waiting times were not an issue. **Remote locations:** 1 study conducted in Canada with women reported that decreasing waiting times was an important avenue for improving care.	Methodological limitations	None or very minor concerns	High
			Relevance	Minor concerns[1]	
			Coherence	Minor concerns[2]	
			Adequacy	None or very minor concerns	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 1.2: Service-level barriers – difficulty navigating the healthcare system					
7 (Cano 2016; Doran 2016; Jerman 2017; Kumar 2004; Kung 2018; Say 2005; White 2016) n=119	7 qualitative studies using semi-structured interviews	**Mixed populations and remote locations:** 5 studies conducted in Australia, Canada, the UK and the USA with women reported that the process to obtain an abortion is complicated and is not transparent and that there is a lack of information. **Mixed populations and remote locations:** 3 studies conducted in Australia, Canada and the UK with women and staff reported that streamlined services, more integrated healthcare and centralised referral would improve access to abortion services. **Mixed populations and women with communication difficulties:** 1 study conducted in the UK with staff, academics and NGO partners reported that poor dissemination of information was not a barrier to accessing abortion for most women, but was for some communities and women with communication difficulties.	Methodological limitations	None or very minor concerns	High
			Relevance	Minor concerns[1]	
			Coherence	Minor concerns[3]	
			Adequacy	None or very minor concerns	
Sub-theme 1.3: Service-level barriers – insufficient resources and hours of operation					
8 (Cano 2016; Dressler 2013; Hulme 2015; Jerman 2017; Kruss 2014; Larsson 2016; Margo 2016; White 2016) n=231	8 qualitative studies using semi-structured interviews	**Mixed populations and remote locations:** 5 studies conducted in Australia, Canada and the UK with women and staff reported that there were insufficient resources and/or appointment times available for abortion services. **Mixed populations and remote locations:**	Methodological limitations	None or very minor concerns	Moderate
			Relevance	Moderate concerns[4]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
		3 studies conducted in Australia and Canada, with women and staff reported that expanding services, in terms of both increased staffing and hours, would improve access to abortion services. **Women with communication difficulties:** 1 study conducted in Sweden with staff reported that there were no routines or guidelines that allowed for extended appointments for foreign born patients.			

GP: general practitioner; NGO, non-governmental organisation
[1]There were minor concerns with the relevance of the data as the majority of the studies were not from the UK; however, it was agreed that this theme also applied to the UK setting
[2]There were minor concerns with the coherence of the data as two studies (Hulme-Chambers 2018; Purcell 2014) reported that waiting times were uncommon or not an issue which contradicts data from the remaining seven studies
[3]There were minor concerns with the coherence of the data as one study (Kung 2018) reported that dissemination of information was not a barrier to accessing abortion for most women which contradicts data from the remaining six studies
[4]There were moderate concerns with the relevance of the data as none of the studies were conducted in the UK; however, it was agreed that this theme also applied to the UK setting

Table 6: Clinical evidence profile: Theme 2. Financial barriers

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 2.1: Financial barriers – funding for people ineligible for free NHS services					
1 (Aiken 2018b) n=519	1 mixed methods study (qualitative part open-ended questions on online consultation form)	**Mixed population:** 1 study conducted in the UK with women reported that there was insufficient funding for abortion care for women ineligible for free NHS services.	Methodological limitations	Moderate concerns[1]	Very low
			Relevance	Moderate concerns[2]	
			Coherence	None or very minor concerns	
			Adequacy	Moderate concerns[3]	
Sub-theme 2.2: Financial barriers – patient expenses					
7 (Doran 2016; Hulme 2015; Jerman 2017; Kruss 2014; Ostrach 2014; Purcell 2014; White 2016) n=188	6 qualitative studies using semi-structured interviews; 1 mixed methods study (qualitative part interviews)	**Mixed populations and remote locations:** 7 studies conducted in Australia, Canada, the UK and the USA with women and staff reported that raising funds for travel and accommodation can cause difficulty accessing abortion services and cause delays while funds are raised, particularly for women living in rural locations.	Methodological limitations	None or very minor concerns	Moderate
			Relevance	Moderate concerns[4]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	
Sub-theme: 2.3: Financial barriers – lack of financial input to services					
2 (Dressler 2013; Say 2005) n=28	2 qualitative studies using semi-structured interviews	**Mixed populations:** 2 studies conducted in Canada and the UK with staff reported that there is insufficient financial input and support for abortion services which affects the service that can be provided.	Methodological limitations	Serious concerns[5]	Very low
			Relevance	None or very minor concerns	
			Coherence	None or very minor concerns	

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
			Adequacy	Moderate[6] concerns	

NHS: National Health Service
[1]There were moderate concerns with the methodological quality of the study as the qualitative data came from open-ended questions in an online consultation form as opposed to interviews, data saturation was not discussed and there was insufficient information about data analysis
[2]There were moderate concerns with the relevance of the data as women trying to obtain a medical abortion through the online service (WoW) is unlikely to be representative of the wider population of women in Britain who want an abortion
[3]There were moderate concerns with the adequacy of the data as only 1 study reported this theme
[4]There were moderate concerns with the relevance of the data as the majority of the studies were not from the UK; this theme is likely to be more applicable to women living in rural locations who may have to travel greater distances to access abortion service and women in Scotland who may have to travel to England for abortion services at later gestational ages
[5]There were serious concerns with the methodological quality of the data as one study reported insufficient information about recruitment and data collection; both studies reported insufficient information about data analysis
[6]There were moderate concerns about the adequacy of the data as only 2 studies reported this theme

Table 7: Clinical evidence profile: Theme 3. Logistical barriers

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
Sub-theme 3.1: Logistical barriers – difficulty arranging time off work					
6 (Aiken 2018b; Jerman 2017; Margo 2016; Ostrach 2014; Purcell 2014; White 2016) n=656	4 qualitative studies using semi-structured interviews; 2 mixed methods study (1 qualitative part open-ended questions on online	**Mixed populations:** 6 studies conducted in the UK and the USA with women reported that arranging time off work can cause delays to accessing abortion services.	Methodological limitations	None or very minor concerns	High
			Relevance	Minor concerns[1]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
	consultation form; 1 qualitative part interviews)				
Sub-theme 3.2: Logistical barriers – difficulty arranging childcare					
6 (Aiken 2018b; Doran 2016; Jerman 2017; Kruss 2014; Ostrach 2014; White 2016) n=612	4 qualitative studies using semi-structured interviews; 2 mixed methods study (1 qualitative part open-ended questions on online consultation form; 1 qualitative part interviews)	**Mixed populations and remote locations:** 6 studies conducted in the UK and the USA with women and staff reported that arranging childcare can cause delays to accessing abortion services.	Methodological limitations	None or very minor concerns	High
			Relevance	Minor concerns[1]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	
Sub-theme 3.3: Logistical barriers – additional expenses and delays caused by travel arrangements					
6 (Aiken 2018b; Doran 2016; Hulme-Chambers 2018; Jerman 2017; Kruss 2014; Margo 2016) n=635	5 qualitative studies using semi-structured interviews; 1 mixed methods study (qualitative part open-ended	**Mixed populations and remote locations:** 4 studies conducted in Australia, the UK and the USA with women reported that long travel distances causes additional expenses and making arrangements can delay access to abortion services. **Remote locations:**	Methodological limitations	None or very minor concerns	High
			Relevance	Minor concerns[1]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
	questions on online consultation form)	2 studies conducted in Australia with women reported that local service provision and improved access to medical abortion would improve access to abortion services. **Remote locations:** 1 study conducted in Australia with staff reported that providing travel assistance would increase access to abortion services.			
Sub-theme 3.4: Logistical barriers – arranging drive home can cause delays and necessitate unwanted disclosure					
5 (Cano 2016; Doran 2016; Margo 2016; Ostrach 2014; White 2016) n=114	4 qualitative studies using semi-structured interviews; 1 mixed methods study (qualitative part interviews)	**Mixed populations and remote locations:** 5 studies conducted in Australia, Canada and the USA with women reported that arranging a drive home after the abortion can cause delays and necessitate unwanted disclosure.	Methodological limitations	None or very minor concerns	Moderate
			Relevance	Moderate concerns[2]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	
Sub-theme 3.5: Logistical barriers – teenagers more affected by logistical barriers than other women					
1 (Kruss 2014) n=11	1 qualitative study using semi-structured interviews	**Girls and younger women:** 1 study conducted in Australia with staff reported that teenagers are more affected by logistical barriers than other women and, therefore, will experience more issues accessing abortion services.	Methodological limitations	Serious concerns[3]	Very low
			Relevance	Moderate concerns[2]	
			Coherence	None or very minor concerns	
			Adequacy	Moderate concerns[4]	
Sub-theme 3.6: Logistical barriers – more appointments needed for medical abortion is a barrier to choosing medical abortion					

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
1 (Doran 2016) n=13	1 qualitative study using semi-structured interviews	**Remote locations:** 1 study conducted in Australia with women reported that the greater number of appointments that are needed for a medical abortion compared with a surgical abortion is a barrier to women choosing a medical abortion, which may be easier to access.	Methodological limitations	None or very minor concerns	Low
			Relevance	Moderate concerns[2]	
			Coherence	None or very minor concerns	
			Adequacy	Moderate concerns[4]	

[1]There were minor concerns with the relevance as the majority of the studies were not from the UK; however, it was agreed that this theme also applied to the UK setting
[2]There were moderate concerns with the relevance of the data as none of the studies were conducted in the UK; however, it was agreed that this theme also applied to the UK setting
[3]There were serious concerns with the methodological quality of the study as it is unclear whether the method of recruitment was appropriate and there was insufficient information reported about data collection or analysis
[4]There were moderate concerns with the adequacy of the data as only 1 study reported this theme

Table 8: Clinical evidence profile: Theme 4. Personal barriers

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
Sub-theme 4.1: Personal barriers – prior negative experiences					
2 (Aiken 2018b; Purcell 2014) n=542	1 qualitative study using semi-structured interviews; 1 mixed methods study (qualitative part open-ended questions on online consultation form)	**Mixed populations:** 2 studies conducted in the UK with women reported that prior negative experiences with staff and the abortion procedure itself may put women off having another abortion and/or cause delays in women seeking abortion procedures.	Methodological limitations	Moderate concerns[1]	Low
			Relevance	None or very minor concerns	
			Coherence	None or very minor concerns	
			Adequacy	Moderate concerns[2]	
Sub-theme 4.2: Personal barriers – perceived stigma					
7 (Aiken 2018b; Doran 2016; Kruss 2014; MacFarlane 2017; O'Donnell 2018; Ostrach 2014; Purcell 2014) n=610	5 qualitative studies using semi-structured interviews; 2 mixed methods study (1 qualitative part open-ended questions on online consultation form; 1	**Mixed populations and remote locations:** 7 studies conducted in Australia, Turkey, the UK and the USA with women and staff reported that there is a perceived stigma associated with abortions, that women fear reactions and judgments from others and that there is an anti-abortion climate.	Methodological limitations	None or very minor concerns	High
			Relevance	Minor concerns[3]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
	qualitative part interviews)				
Sub-theme 4.3: Personal barriers – comorbid medical conditions					
1 (Aiken 2018b) n=519	1 mixed methods study (qualitative part open-ended questions on online consultation form)	**Coexisting mental health problems:** 1 study conducted in the UK with women reported that severe anxiety was a barrier to seeking an abortion because of fear of leaving the house.	Methodological limitations	Moderate concerns[4]	Very low
			Relevance	Moderate concerns[5]	
			Coherence	None or very minor concerns	
			Adequacy	Moderate concerns[6]	
Sub-theme 4.4: Personal barriers – threat of violence					
3 (Aiken 2018b; Larsson 2016; Ostrach 2014) n=547	1 qualitative study using semi-structured interviews; 2 mixed methods study (1 qualitative part open-ended questions on online consultation form; 1 qualitative part interviews)	**Women with communication difficulties and vulnerable women** 3 studies conducted in Sweden, the UK and the USA with women and staff reported that the threat of violence, controlling circumstances and cultural background that accepts honour based violence can be a barrier to seeking and accessing abortion services.	Methodological limitations	None or very minor concerns	Moderate
			Relevance	Moderate concerns[7]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	
Sub-theme 4.5: Personal barriers – negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals					
15 (Black 2015; Dawson 2017;	14 qualitative studies using	**Mixed populations, remote locations and fetal anomaly:**	Methodological limitations	None or very minor concerns	High

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	**Design**		**Criteria**	**Level of concern**	**Overall quality**
Doran 2016; Dressler 2013; Freedman 2010; Hulme 2015; Hulme-Chambers 2018; Jerman 2017; Kruss 2014; Kumar 2004; Margo 2016; O'Donnell 2018; Purcell 2014; Say 2005; White 2016) n=384	semi-structured interviews; 1 qualitative study using semi-structured interviews and a focus group	13 studies conducted in Australia, Canada, the UK and the USA with women and staff reported difficulty in obtaining a referral for an abortion due to negative attitudes regarding abortions and physicians personal beliefs. **Mixed populations:** 2 studies conducted in Canada and the USA with staff reported that staff refusing to participate in abortion procedures can cause delays and impact the delivery of services. **Mixed populations:** 2 studies conducted in the UK and the USA with women and staff reported that physicians' personal beliefs, particularly those of senior staff, can create a barrier to delivering abortion services at a service-level.	Relevance	Minor concerns[3]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	
Sub-theme 4.6. Personal barriers – social support					
2 (O'Donnell 2018; Ostrach 2014) n=30	1 mixed methods study (qualitative part interviews)	**Mixed population and remote locations:** 2 studies conducted in the USA with women and staff reported that lack of social support is a barrier to accessing abortion services in itself and also makes it difficult to overcome other barriers. In contrast, good social support can help women to overcome barriers.	Methodological limitations	None or very minor concerns	Low
			Relevance	Moderate concerns[8]	
			Coherence	None or very minor concerns	
			Adequacy	Moderate concerns[2]	

[1]There were moderate concerns with the methodological quality of the data as the qualitative data for one study came from open-ended questions in an online consultation form as opposed to interviews, data saturation was not discussed and there was insufficient information about data analysis
[2]There were moderate concerns with the adequacy of the data as only 2 studies reported this theme
[3]There were minor concerns with the relevance as the majority of the studies were not from the UK; however, it was agreed that this theme also applied to the UK setting

[4]There were moderate concerns with the methodological quality of the study as the qualitative data came from open-ended questions in an online consultation form as opposed to interviews, data saturation was not discussed and there was insufficient information about data analysis
[5]There were moderate concerns with the relevance of the data as women trying to obtain a medical abortion through the online service (WoW) is unlikely to be representative of the wider population of women in Britain who want an abortion
[6]There were moderate concerns with the adequacy of the data as only 1 study reported this theme
[7]There were moderate concerns with the relevance of the data as only one of the studies was from the UK but the sample was women trying to obtain a medical abortion through an online service (WoW), which is unlikely to be representative of the wider population of women in Britain who want an abortion
[8]There were moderate concerns with the relevance of the data as none of the studies were conducted in the UK; however, it was agreed that this theme also applied to the UK setting

Table 9: Clinical evidence profile: Theme 5. Legal and policy barriers

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
5 (Aiken 2018b; Black 2015; Freedman 2010; Jerman 2017; Say 2005) n=608	4 qualitative study using semi-structured interviews; 1 mixed methods study (qualitative part open-ended questions on online consultation form)	**Fetal anomaly:** 1 study conducted in Australia with staff reported that decision making by ethics committee cause delays to accessing abortion services. **Mixed population:** 1 study conducted in the USA with staff reported that Catholic health networks pose extensive restrictions on reproductive health care services provided within their properties and by their employees and that this impacts the delivery of abortion services. **Mixed population:** 1 study conducted in the USA with women reported that state imposed waiting periods and gestational limits cause delays to accessing abortion services, is a barrier to accessing abortion at later gestational ages and can increase the need to travel to have an abortion. **Mixed population:**	Methodological limitations	Moderate concerns[1]	Very low
			Relevance	Serious concerns[2]	
			Coherence	None or very minor concerns	
			Adequacy	Moderate concerns[3]	

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
		1 study conducted in the UK with women reported that arbitrary gestational age limits in Scotland causes variable access to abortion services. **Mixed population:** 1 study conducted in the UK with women reported that de-criminalising self-sourced and self-managed abortions would improve access to abortion services.			

[1]*There were moderate concerns with the methodological quality of the study as insufficient information was reported across studies about recruitment, data collection and data analysis*
[2]*There were serious concerns with the relevance of the data as the majority of the studies were not from the UK and a number of the legal and policy barriers that arose under this theme are not applicable to the UK setting*
[3]*There were moderate concerns with the adequacy of the data as each of the barriers that arose under this theme were only reported by one study*

Table 10: Clinical evidence profile: Theme 6. Privacy and confidentiality concerns

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
6 (Aiken 2018b; Hulme 2015; Jerman 2017; Kruss 2014; Purcell 2014; White 2016) n=679	5 qualitative study using semi-structured interviews; 1 mixed methods study (qualitative part open-ended questions on online	**Mixed populations and remote locations:** 3 studies conducted in Australia, Canada and the UK with women and staff reported that women, particularly in rural locations, have concerns about seeing someone that they know personally when accessing abortion services unless they travel some distance. **Mixed populations:**	Methodological limitations	None or very minor concerns	High
			Relevance	Minor concerns[1]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
	consultation form)	3 studies conducted in the UK and the USA with women reported that women may need to disclose their abortion to unwanted people in order to overcome logistical barriers.			

[1]*There were minor concerns with the relevance as the majority of the studies were not from the UK; however, it was agreed that this theme also applied to the UK setting*

Table 11: Clinical evidence profile: Theme 7. Training and education

Study information		Description of theme or finding	CERQual assessment of the evidence		
Number of studies	Design		Criteria	Level of concern	Overall quality
7 (Dawson 2017; Dressler 2013; Hulme 2015; Kruss 2014; Kung 2018; Purcell 2014; Say 2005) n=173	6 qualitative studies using semi-structured interviews; 1 qualitative study using semi-structured interviews and a focus group	**Mixed populations:** 2 studies conducted in Australia and the UK with women and staff reported that general practitioners were confused or unclear regarding details of services such as routes for referral and gestational limits. **Mixed populations and remote locations:** 2 studies conducted in Australia and Canada with staff reported that further education was needed for the public and healthcare providers. **Remote locations:** 1 study conducted in Canada with staff reported that rural physicians lack professional support, the opportunity for continued professional education and appropriate replacements if they were not available to delivery services. **Remote locations:**	Methodological limitations	Moderate concerns[1]	Moderate
			Relevance	Minor concerns[2]	
			Coherence	None or very minor concerns	
			Adequacy	Minor concerns[3]	

Study information			CERQual assessment of the evidence		
Number of studies	Design	Description of theme or finding	Criteria	Level of concern	Overall quality
		1 study conducted in Canada with staff reported that the lack of volume of abortions in the rural setting was a deterrent to the local training of abortion providers. **Mixed population:** 1 study conducted in the UK with staff reported that a lack of knowledge and skills among healthcare providers is a barrier to performing certain abortion procedures. **Mixed population:** 1 study conducted in the UK with staff reported that expanding the role of nursing staff in medical abortion would improve access but is hindered by shortfalls in the NHS training budgets. **Mixed population:** 1 study conducted in the UK with staff, academics and NGO partners reported that [NHS] hospital-based providers are losing their clinical skills due to abortions occurring mainly in independent sector clinics.			

NGO: non-governmental organisations; NHS: National Health Service
[1]There were moderate concerns with the methodological quality of the study as insufficient information was reported across studies about recruitment, data collection and data analysis
[2]There were minor concerns with the relevance as the majority of the studies were not from the UK; however, it was agreed that this theme also applied to the UK setting
[3]There were minor concerns with the adequacy of the data as some of the details that arose under this theme were only reported by a small number of studies; however, there was a commonality of need for further training and education across studies

Table 12: Clinical evidence profile: Theme 8. Community prescribing and telemedicine introduce greater flexibility

Study information			CERQual assessment of the evidence		
Number of studies	**Design**	**Description of theme or finding**	**Criteria**	**Level of concern**	**Overall quality**
5 (Dawson 2017; Doran 2016; Grindlay 2013; Grindlay 2017; Hulme 2015) n=165	4 qualitative studies using semi-structured interviews; 1 qualitative study using semi-structured interviews and a focus group	**Mixed populations and remote locations:** 5 studies conducted in Australia, Canada and the USA with women and staff reported that community prescribing for medical abortion and telemedicine either has, or would, improve access to abortion services, increase flexibility and facilitate a more woman-centred approach to care.	Methodological limitations	None or very minor concerns	Moderate
			Relevance	Moderate concerns[1]	
			Coherence	None or very minor concerns	
			Adequacy	None or very minor concerns	

[1]*There were moderate concerns with the relevance of the data as none of the studies were conducted in the UK; however, it was agreed that whilst community prescribing and telemedicine does not currently happen in the UK as medication is restricted and has to be delivered on licensed premises, this theme also applied to the UK setting as it has the potential to improve access in the UK*

See Appendix M for all relevant quotes related to each theme applied after thematic synthesis.

GRADE tables for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

Table 13: Clinical evidence profile: Comparison 1. Community services versus hospital services

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Community services	Hospital services	Relative (95% CI)	Absolute	Quality	Importance
Patient satisfaction: Overall satisfaction with care received (10-point scale; better indicated by higher values)												
1 (Cameron 2016)	Observational studies	Serious[1]	No serious inconsistency	No serious indirectness	Serious[2]	None	149	148	Not relevant	MD 0.4 higher (0.19 to 0.61 higher)	VERY LOW	CRITICAL
Patient satisfaction: Overall satisfaction with care received rated as 10/10												
1 (Cameron 2016)	Observational studies	Serious[1]	No serious inconsistency	No serious indirectness	Serious[2]	None	115/149 (77.2%)	85/148 (57.4%)	RR 1.34 (1.14 to 1.58)	195 more per 1000 (from 80 more to 333 more)	VERY LOW	CRITICAL
Patient satisfaction: Contraception discussion was helpful/very helpful												
1 (Cameron 2016)	Observational studies	Serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	143/147 (97.3%)	140/148 (94.6%)	RR 1.03 (0.98 to 1.08)	28 more per 1000 (from 19 fewer to 76 more)	VERY LOW	CRITICAL
Patient satisfaction: Did not feel under pressure to choose a particular contraceptive method												
1 (Cameron 2016)	Observational studies	Serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	145/152 (95.4%)	140/151 (92.7%)	RR 1.03 (0.97 to 1.09)	28 more per 1000 (from 28 fewer to 83 more)	VERY LOW	CRITICAL
Patient satisfaction: Felt quite/very prepared for termination (based on information received)												

1 (Cameron 2016)	Observational studies	Serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	149/149 (100%)	140/150 (93.3%)	RR 1.07 (1.02 to 1.12)	65 more per 1000 (from 19 more to 112 more)	VERY LOW	CRITICAL
Patient satisfaction: Felt quite/very clear what would happen/what termination would involve (based on information received)												
1 (Cameron 2016)	Observational studies	Serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	148/148 (100%)	148/149 (99.3%)	RR 1.01 (0.99 to 1.03)	10 more per 1000 (from 10 fewer to 30 more)	VERY LOW	CRITICAL
Time (days) between referral and assessment												
1 (Cameron 2016)	Observational studies	Serious[1]	No serious inconsistency	Serious[3]	No serious imprecision	None	741	601	Not relevant	MD 1.1 lower (1.45 to 0.75 lower)	VERY LOW	CRITICAL

CI: confidence interval; MD: mean difference; MID: minimally important difference; RR: relative risk
[1] The quality of evidence was downgraded 1 level as differences between cohorts were not controlled for
[2] The quality of evidence was downgraded by 1 as the 95% confidence interval crossed 1 MID
[3] The quality of evidence was downgraded 1 level as the outcomes measures time between referral and assessment, not referral and abortion

Table 14: Clinical evidence profile: Comparison 2. Community or hospital services versus telemedicine

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Community or hospital**	**Telemedicine**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Patient satisfaction: Overall - Very satisfied												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	201/214 (93.9%)	191/217 (88%)	RR 1.07 (1.01 to 1.13)	62 more per 1000 (from 9 more to 114 more)	VERY LOW	CRITICAL
Patient satisfaction: Overall - Somewhat satisfied												

1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	Serious[2]	None	10/214 (4.7%)	21/217 (9.7%)	RR 0.48 (0.23 to 1)	50 fewer per 1000 (from 75 fewer to 0 more)	VERY LOW	CRITICAL
Patient satisfaction: Overall - Somewhat or very dissatisfied												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	Very serious[3]	None	1/214 (0.47%)	1/217 (0.46%)	RR 1.01 (0.06 to 16.11)	0 more per 1000 (from 4 fewer to 70 more)	VERY LOW	CRITICAL
Patient satisfaction: Would recommend a medical ToP in this clinic to a friend												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	192/214 (89.7%)	180/217 (82.9%)	RR 1.08 (1 to 1.17)	66 more per 1000 (from 0 more to 141 more)	VERY LOW	CRITICAL
Patient satisfaction: Information received - Very helpful												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	195/214 (91.1%)	202/217 (93.1%)	RR 0.98 (0.93 to 1.03)	19 fewer per 1000 (from 65 fewer to 28 more)	VERY LOW	CRITICAL
Patient satisfaction: Information received - Somewhat helpful or not helpful												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	Very serious[3]	None	16/214 (7.5%)	13/217 (6%)	RR 1.25 (0.62 to 2.53)	15 more per 1000 (from 23 fewer to 92 more)	VERY LOW	CRITICAL
Patient satisfaction: Conversation with doctor - Very satisfied												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	163/214 (76.2%)	164/217 (75.6%)	RR 1.01 (0.91 to 1.12)	8 more per 1000 (from 68 fewer to 91 more)	VERY LOW	CRITICAL

Patient satisfaction: Conversation with doctor - Somewhat satisfied												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	Very serious[3]	None	34/214 (15.9%)	36/217 (16.6%)	RR 0.96 (0.62 to 1.47)	7 fewer per 1000 (from 63 fewer to 78 more)	VERY LOW	CRITICAL
Patient satisfaction: Conversation with doctor - Somewhat or very dissatisfied												
1 (Grossman 2011)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	Very serious[3]	None	11/214 (5.1%)	6/217 (2.8%)	RR 1.86 (0.7 to 4.94)	24 more per 1000 (from 8 fewer to 109 more)	VERY LOW	CRITICAL

CI: confidence interval; MID: minimally important difference; RR: relative risk
[1] The quality of evidence was downgraded 2 levels as differences between cohorts were not controlled for and follow up rate <80% with no description of those lost
[2] The quality of evidence was downgraded by 1 as the 95% confidence interval crossed 1 MID
[3] The quality of evidence was downgraded by 2 as the 95% confidence interval crossed 2 MIDs

Table 15: Clinical evidence profile: Comparison 3. Mid-level provider-led services versus physician-led services

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Mid-level provider-led services**	**Physician-led services**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Patient satisfaction: Satisfaction with provider - Preferred allocated provider												
1 (Koop Kallner 2014)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	No serious imprecision	None	200/535 (37.4%)	12/533 (2.3%)	RR 16.6 (9.39 to 29.36)	351 more per 1000 (from 189 more to 638 more)	HIGH	CRITICAL
Patient satisfaction: Satisfaction with provider - Very satisfied												
1 (Olavarri	Randomised trials	No serious	No serious inconsistency	No serious indirectness	No serious imprecision	None	343/434 (79%)	342/450 (76%)	RR 1.04 (0.97 to 1.12)	30 more per 1000 (from 23	HIGH	CRITICAL

eta 2015)		risk of bias								fewer to 91 more)		
Patient satisfaction: Satisfaction with provider - Satisfied												
1 (Olavarri eta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Serious[1]	None	90/434 (20.7%)	106/450 (23.6%)	RR 0.88 (0.69 to 1.13)	28 fewer per 1000 (from 73 fewer to 31 more)	MODERATE	CRITICAL
Patient satisfaction: Satisfaction with provider - Dissatisfied												
1 (Olavarri eta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Very serious[2]	None	1/434 (0.23%)	1/450 (0.22%)	RR 1.04 (0.07 to 16.52)	0 more per 1000 (from 2 fewer to 34 more)	LOW	CRITICAL
Patient satisfaction: Pain control - Did not experience pain												
1 (Olavarri eta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Serious[1]	None	43/434 (9.9%)	31/450 (6.9%)	RR 1.44 (0.92 to 2.24)	30 more per 1000 (from 6 fewer to 85 more)	MODERATE	CRITICAL
Patient satisfaction: Pain control - Did enough to control pain												
1 (Olavarri eta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	No serious imprecision	None	348/434 (80.2%)	366/450 (81.3%)	RR 0.99 (0.92 to 1.05)	8 fewer per 1000 (from 65 fewer to 41 more)	HIGH	CRITICAL
Patient satisfaction: Pain control - Could have done more to control pain												
1 (Olavarri eta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Serious[1]	None	43/434 (9.9%)	53/450 (11.8%)	RR 0.84 (0.58 to 1.23)	19 fewer per 1000 (from 49 fewer to 27 more)	MODERATE	CRITICAL
Patient satisfaction: Would recommend to a friend - Yes												

1 (Olavarrieta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	No serious imprecision	None	427/434 (98.4%)	444/450 (98.7%)	RR 1 (0.98 to 1.01)	0 fewer per 1000 (from 20 fewer to 10 more)	HIGH	CRITICAL
Patient satisfaction: Would recommend to a friend - Maybe												
1 (Olavarrieta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Very serious[2]	None	7/434 (1.6%)	5/450 (1.1%)	RR 1.45 (0.46 to 4.54)	5 more per 1000 (from 6 fewer to 39 more)	LOW	CRITICAL
Patient satisfaction: Would recommend to a friend - No												
1 (Olavarrieta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Very serious[2]	None	0/434 (0%)	1/450 (0.22%)	RR 0.35 (0.01 to 8.46)	1 fewer per 1000 (from 2 fewer to 17 more)	LOW	CRITICAL
Patient satisfaction: Medical care received - Better than expected												
1 (Olavarrieta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	No serious imprecision	None	408/434 (94%)	431/450 (95.8%)	RR 0.98 (0.95 to 1.01)	19 fewer per 1000 (from 48 fewer to 10 more)	HIGH	CRITICAL
Patient satisfaction: Medical care received - As expected												
1 (Olavarrieta 2015)	Randomised trials	No serious risk of bias	No serious inconsistency	No serious indirectness	Very serious[2]	None	25/434 (5.8%)	19/450 (4.2%)	RR 1.36 (0.76 to 2.44)	15 more per 1000 (from 10 fewer to 61 more)	LOW	CRITICAL
Time (days) between referral and assessment												
1 (Harvey 2005)	Observational studies	Serious[3]	No serious inconsistency	Serious[4]	No serious imprecision	None	195	41	Not relevant	MD 5.2 lower (6.97 to 3.43 lower)	VERY LOW	CRITICAL

Time (days) between referral and assessment - Seen within 5 days												
1 (Harvey 2005)	Observational studies	Serious[3]	No serious inconsistency	Serious[4]	No serious imprecision	None	104/195 (53.3%)	5/41 (12.2%)	RR 4.37 (1.9 to 10.05)	411 more per 1000 (from 110 more to 1000 more)	VERY LOW	CRITICAL
Time (days) between referral and assessment - Seen within 14 days												
1 (Harvey 2005)	Observational studies	Serious[3]	No serious inconsistency	Serious[4]	Serious[1]	None	171/195 (87.7%)	30/41 (73.2%)	RR 1.2 (0.99 to 1.45)	146 more per 1000 (from 7 fewer to 329 more)	VERY LOW	CRITICAL

CI: confidence interval; MD: mean difference; MID: minimally important difference; RR: relative risk
[1] The quality of evidence was downgraded by 1 as the 95% confidence interval crossed 1 MID
[2] The quality of evidence was downgraded by 2 as the 95% confidence interval crossed 2 MIDs
[3] The quality of evidence was downgraded 1 level as differences between cohorts were not controlled for
[4] The quality of evidence was downgraded 1 level as the outcome measures time between referral and assessment, not time between referral and abortion

Table 16: Clinical evidence profile: Comparison 4. Self-referral versus GP referral

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-referral	GP referral	Relative (95% CI)	Absolute		
Time (days) between referral and ToP - ToP within 7 days												
1 (Amu 2010)	Observational studies	Very serious[1]	No serious inconsistency	Serious[2]	No serious imprecision	None	110/149 (73.8%)	135/365 (37%)	RR 2 (1.69 to 2.35)	370 more per 1000 (from 255 more to 499 more)	VERY LOW	CRITICAL
Time (days) between referral and ToP - ToP within 14 days												
1 (Amu 2010)	Observational studies	Very serious[1]	No serious inconsistency	Serious[2]	Serious[3]	None	130/149 (87.2%)	277/365 (75.9%)	RR 1.15 (1.06 to 1.25)	114 more per 1000 (from 46 more to 190 more)	VERY LOW	CRITICAL

CI: confidence interval; GP: general practitioner; MID: minimally important difference; RR: relative risk; ToP: termination of pregnancy

[1] The quality of evidence was downgraded 2 levels as differences between cohorts were not controlled for and follow-up rate <75% with no description of those lost

[2] The quality of evidence was downgraded 1 level as the comparison includes referrals from healthcare providers other than GPs

[3] The quality of evidence was downgraded by 1 as the 95% confidence interval crossed 1 MID

Table 17: Clinical evidence profile: Comparison 5. Routine integration of termination training into core curriculum versus termination training not integrated into core curriculum

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Routine training	Training not available	Relative (95% CI)	Absolute		
Providing/intending to provide ToP services after training												
2 (Allen 2010; Steinauer 2008)	Observational studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	299/799 (37.4%)	74/685 (10.8%)	RR 3.09 (2.45 to 3.9)	226 more per 1000 (from 157 more to 313 more)	VERY LOW	CRITICAL

CI: confidence interval; RR: relative risk; ToP: termination of pregnancy
[1] The quality of evidence was downgraded 2 levels as both studies only received 2 stars on the Newcastle-Ottawa scale for cohort studies

Table 18: Clinical evidence profile: Comparison 6. Opt-in training versus opt-out training

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Opt-in termination training	Opt-out termination training	Relative (95% CI)	Absolute		
Providing/intending to provide ToP services after training												
2 (Allen 2010; Steinauer 2008)	Observational studies	Very serious[1]	Serious[2]	No serious indirectness	No serious imprecision	None	178/831 (21.4%)	299/745 (40.1%)	RR 0.54 (0.42 to 0.71)	185 fewer per 1000 (from 116 fewer to 233 fewer)	VERY LOW	CRITICAL

CI: confidence interval; RR: relative risk; ToP: termination of pregnancy
[1] The quality of evidence was downgraded 2 levels as both studies only received 2 stars on the Newcastle-Ottawa scale for cohort studies
[2] The quality of evidence was downgraded 1 level as there were high rates of unexplained heterogeneity (57%)

Table 19: Clinical evidence profile: Comparison 7. Provider and/or trainee workshops versus no provider and/or trainee workshops

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Workshop	No workshop	Relative (95% CI)	Absolute		
Professional quality of life - Abortion Provider Stigma Survey (APSS) total (Better indicated by lower values)												
1 (Martin 2014)	Before-after studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	52	55[2]	Not relevant	MD 1.1 lower (2.8 lower to 0.6 higher)	LOW	IMPORTANT
Professional quality of life - APSS Disclosure subscale (Better indicated by lower values)												
1 (Martin 2014)	Before-after studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	52	55[2]	Not relevant	MD 0.3 lower (1.7 lower to 1.1 higher)	LOW	IMPORTANT
Professional quality of life - APSS Resistance and Resilience subscale (Better indicated by lower values)												
1 (Martin 2014)	Before-after studies	Very serious[1]	No serious inconsistency	No serious indirectness	No serious imprecision	None	52	55[2]	Not relevant	MD 0.3 lower (1.1 lower to 0.5 higher)	LOW	IMPORTANT
Professional quality of life - APSS Discrimination subscale (Better indicated by lower values)												
1 (Martin 2014)	Before-after studies	Very serious[1]	No serious inconsistency	No serious indirectness	Serious[2]	None	52	55[2]	Not relevant	MD 0.3 higher (0.4 lower to 1 higher)	VERY LOW	IMPORTANT

APSS: Abortion Provider Stigma Survey; CI: confidence interval; MD: mean difference; MID: minimally important difference
[1] The quality of evidence was downgraded 2 levels as there was no random allocation and no separate control group
[2] 55 participants completed pre-workshop questionnaires but only 52/55 participants completed post-workshop questionnaires
[3] The quality of evidence was downgraded by 1 as the 95% confidence interval crossed 1 MID (0.5x1.9 [baseline SD] =0.95)

Appendix G – Economic evidence study selection

Economic evidence for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

No economic evidence was identified which was applicable to this review question.

Economic evidence for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

No economic evidence was identified which was applicable to this review question.

Appendix H – Economic evidence tables

Economic evidence tables for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

No economic evidence was identified which was applicable to this review question.

Economic evidence tables for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

No economic evidence was identified which was applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

No economic evidence was identified which was applicable to this review question.

Economic evidence profiles for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

No economic evidence was identified which was applicable to this review question.

Appendix J – Economic analysis

Economic analysis for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

No economic analysis was conducted for this review question.

Economic analysis for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

The potential cost savings from reductions in the time from initial request to abortion.

Introduction

There will always be a period of time between a woman requesting an abortion and the procedure being performed. Current guidance from the Royal College of Obstetricians and Gynaecologists (RCOG 2011) recommends that assessment must be offered by abortion providers within 5 days of referral and that the total time from initial contact with the abortion provider to the procedure being performed should not exceed 10 working days. This recommendation was not based on strong economic evidence or evidence of clinical benefit and adherence to this target varies widely across England.

By reducing the time between initial presentation and the abortion procedure, women could have a greater choice between type of procedure (medical or surgical) and expulsion at home or in a clinical setting (for medical abortion). Further, procedures may be less intensive and the number and severity of adverse events should be reduced. All of these could lead to cost savings and may increase quality of life.

This economic model aims to estimate the cost savings associated with the reduction in time between initial presentation and procedure. For reasons presented below, the model does not attempt to estimate the cost of interventions to achieve these reductions, but the costs associated with these could be significant. The estimated cost savings are presented under a number of alternative assumptions.

Methods

Population

The economic model covers all women who receive an abortion up to and including 23^{+6} weeks' gestation. Women with pregnancies after 23^{+6} weeks' gestation were excluded from the analysis as abortion after this time period will almost exclusively be as a result of fetal anomalies where there is very little chance of survival outside the womb or they would have very serious disabilities if they did survive (ground E of the Abortion Act 1967). It is not believed that recommendations made are likely to impact upon the timing of these abortions due to the timing of diagnoses of anomalies. Further, abortion after 23^{+6} weeks' gestation account for 0.001% of all abortions performed in England and Wales (Department of Health 2018) and the inclusion or exclusion of these are unlikely to alter conclusions of the economic model. It is acknowledged that some abortions occurring up to and including 23^{+6} weeks will be due to fetal anomaly and the data used in the model does not allow for these women to be removed from the analysis. However, as with abortions occurring after 23^{+6} weeks, the timing of these abortions are unlikely to be affected by the recommendations. Further, abortions that conducted for reasons other than ground C (physical and mental harm to the mother) make up just over 2% of all abortions and their inclusion or exclusion again unlikely to impact upon results or conclusions of the economic model.

Model Structure

An economic model was created to estimate the potential cost savings from a reduction in the time between initial presentation and the abortion. Costs were estimated for potential factors that would change from a reduction in this time: change in the method of abortion, change in the timing of abortion, difference in adverse events and, in a sensitivity analysis,

the setting of the abortion. The model explicitly did not consider any potential costs from interventions for achieving a reduction in these times.

The base-case in the economic model uses Abortion Statistics for England and Wales: 2017 (Department of Health 2018). These statistics cover all abortions of pregnancy carried out in England and Wales in 2017, the most recent year available at the time of modelling. All medical and surgical abortions up to and including 23^{+6} weeks' gestation were included in the model. Costs were assigned to all abortions for both the procedure and adverse events as discussed below.

The comparator was the same number of abortions of pregnancy performed a defined number of days earlier, representing a reduction in time from initial presentation to procedure. The reduction in days was altered between 1 day and 21 days and the model made the explicit assumption that this would result in the same reduction in gestational age at the time of abortion of pregnancy. For example, all abortions performed at 7^{+2} weeks' gestation in the base-case would be performed at 7^{+0} weeks' gestation in the comparator if a reduction of 2 days was assumed. The implications of relaxing this assumption are explored and discussed.

The Abortion Statistics for England and Wales: 2017 are reported by gestational age in week bandings. (Table 20) This was converted into days by assuming a uniform distribution across the 7 days included in each band. The lowest band reported in the statistics was for a gestational age of 3^{+0} to 4^{+6} weeks. The model assumed that nobody would have an abortion before 3^{+0} weeks regardless of the number of days' reduction. The model also assumed that abortions performed after 23^{+6} weeks would not enter the model even if the reduction in waiting times made them eligible for inclusion (by reducing the gestational age to less than 24^{+0} weeks).

The model was run under two differing assumptions:

- **Assumption 1:** The method of abortion (surgical or medical) would not change as a result of the reduction in gestational age and consequently the overall proportion of both methods of abortion would remain the same between the base case and the comparator.
- **Assumption 2:** The method of abortion (surgical or medical) between the comparator and base-case would change in line with the proportions reported in the Abortion Statistics for England and Wales: 2017 if the reduction in gestational age resulted in movement between the week bandings.

The model did not consider increases in the time between initial presentation and procedure between the comparator and base-case.

Model Parameters

Number of abortions of pregnancy

The total annual number of abortions of pregnancy were taken from The Abortion Statistics for England and Wales: 2017 (Department of Health 2018). In 2017, 189,859 abortions of pregnancy were recorded in England and Wales; 189,614 of these were performed before 24 weeks' gestation and were eligible for inclusion in the economic model. Table 20 presents the number of abortions performed in England and Wales in 2017, by gestational age. Over half of abortions of pregnancy were performed before the end of the 7^{th} week of pregnancy and over 90% were performed before the end of the 12^{th} week. The total number of abortions of pregnancy has remained between 190,000 and 200,000 per year since 2009 and there is no anticipation that these numbers would change significantly in future years.

Table 20: Number of abortions performed in 2017 by gestational age

Gestational age (weeks)	Number of abortions
3-4	1,028
5	18,146
6	42,313
7	36,745
8	30,774
9	16,760
10	10,028
11	8,416
12	6,301
13	5,046
14	2,673
15	2,146
16	2,043
17	1,822
18	1,262
19	852
20	737
21	895
22	830
23	797

Method of abortion

Figure 6 shows the percentage of abortions of pregnancy by gestational week and method of procedure. As all abortions were carried out either surgically or medically the data lines are inversions of each other. Medical abortion is the most popular method up to and including 10^{+0} weeks' gestation with over 90% of abortions before 7 weeks' gestation being medical abortions. After 10^{+0} weeks' gestation, surgical abortions are more common than medical and the percentage of surgical abortions continues to rise up to a gestational age of 19^{+0} weeks. After 19^{+0} weeks, surgery as a percentage of all abortions decreases but remains the predominant method. There is a 20 percentage point increase in medical abortions between 18^{+0} and 20^{+0} weeks' gestation. This is most likely as a result of abortion on grounds other than ground C (which make up a larger proportion of abortions in later gestational weeks) which are often performed medically to allow for examination of the fetus.

Figure 6: Percentage of abortions of pregnancy by method and gestational week

Given that the proportion of medical abortions increases as gestational age is reduced, under assumption 2 of the model, any decrease in the time between initial presentation and procedure will lead to an increase in the overall proportion of medical abortions.

Adverse events

The number of adverse events (Table 21) were taken from The Abortion Statistics for England and Wales: 2017. The complications were reported in aggregated form and primarily consisted of haemorrhage, uterine perforation and sepsis, reported up to the time of discharge from the abortion provider. From the data, only a small proportion of abortions resulted in adverse events with a combined percentage of 0.12% and 0.18% for medical and surgical abortions, respectively. The percentage of adverse events increases as gestational age increases; therefore, decreasing the time between initial presentation and procedure will result in a reduction in the number of adverse events.

Table 21: Percentage of adverse events by method of abortion and gestational age

Gestational age (weeks)	Medical	Surgical
3-9	0.06%	0.05%
10-12	0.14%	0.74%
13-20	0.19%	2.55%
20+	0.30%	4.94%

It is likely that the true number of adverse events will be underestimated in these figures given the narrow definition and tight timeframe for reporting. Carlsson 2018 considered complication rates at one Swedish hospital between 2008 and 2015 and estimated that complications occurred in 6.7% of all abortions. However, this study included incomplete abortion as a complication and recorded any visits up to 2 months after discharge. Other Scandinavian studies (Larsson 1992, Charonis 2006) with similar definitions of complications have reported complication rates of between 2.8% and 4.9%. A UK study of 28,901 women undergoing a medical abortion at a British Pregnancy Advisory Service (BPAS) clinic between May 2015 and April 2016 reported an adverse event, excluding incomplete abortions, in 0.2% of abortions occurring up to and including 9^{+0} weeks' gestation, which is higher than the number of events estimated above (Lohr 2018). However, this definition of adverse events (hospital admission, haemorrhage and intravenous antibiotic administration)

was very narrow. When need for surgical intervention for an incomplete abortion is considered, this adverse event rate rises to figures similar to the Scandinavian studies.

As the number of complications reported in The Abortion Statistics for England and Wales: 2017 are potential underestimates, and do not include costs associated with surgical intervention, the proportion of any cost savings associated with adverse events was explored.

Mortality is an extremely rare adverse event with abortions and was not considered by the economic model. No deaths were reported in 2017 and only 2 deaths occurred in the previous 5 years, during which there were over 1 million abortions (Department of Health 2018).

Costs and resource use

Cost of abortion

In the base case all costs for the abortion procedure were taken from NHS Reference Costs 2016/2017. NHS Reference Costs may not estimate the true costs of the abortions as only a minority of NHS funded abortions are performed in NHS settings. The majority, especially in the first trimester of pregnancy, are performed in the independent sector which do not feed into the cost estimates (Department of Health 2018). Clinical Commissioning Groups in England negotiate their own contracts with the independent and charity sector to provide abortion services. These contracts and costs, especially on the individual level, are commercially sensitive and are not publically available. It is almost certain that the cost of abortions in the independent sector is significantly below that of NHS settings as they can take advantage of expertise and economies of scale in specially designed clinics and theatres. It is also intuitive that Clinical Commissioning Groups would not 'contract out' services at a higher price than they couple provide themselves. It is almost certain that these cost savings would be realised for all methods of abortion at any stage of pregnancy and is likely that the costs in the economic model are an overestimate of the true costs.

NHS Reference Costs provide currency descriptions for three gestational week bandings:

- Less than 14 weeks
- 14 to 20 weeks.
- Over 20 weeks

Before 20 weeks these were further stratified by medical abortion and two types of surgical abortion 'dilatation and evacuation' and 'vacuum aspiration with cannula'. These were reported for four different settings:

- Elective inpatient
- Non-elective short stay
- Non-elective long stay
- Day case

Costs for medical and surgical abortion in the model for gestational ages less than 14^{+0} weeks (Table 22), 14^{+0} to 20^{+0} weeks (Table 23) and over 20^{+0} weeks (Table 24) were estimated by taking a mean cost of all NHS reference costs weighted by the number of full consultant episodes (FCE). Costs for surgical abortion were further weighted by the proportion of 'vacuum aspirations' and 'dilatation and evacuations' reported at the different gestational bands in The Abortion Statistics for England and Wales: 2017 (Department of Health 2018). As only tariff was reported for abortions over 20 weeks, the cost of abortion for this group was identical regardless of the method used. As the model does not exclude any abortions, all cost tariffs were included even when the FCEs reported were in small numbers.

Table 22: NHS Reference Costs 2016/2017 for abortions before 14 weeks

Setting	Currency code and description	Number of FCEs	National average unit cost
Elective Inpatient	MA18C Medical Abortion, less than 14 weeks' gestation	3,390	£731
Elective Inpatient	MA17C Dilatation and Evacuation, less than 14 weeks' gestation	807	£1,555
Elective Inpatient	MA19A Vacuum Aspiration with Cannula, less than 14 weeks' gestation	3,118	£1,415
Non elective Long Stay	MA18C Medical Abortion less than 14 weeks' gestation	1,089	£1,630
Non elective Long Stay	MA17C Dilatation and Evacuation, less than 14 weeks' gestation	769	£2,423
Non elective Long Stay	MA19A Vacuum Aspiration with Cannula, less than 14 weeks' gestation	1,999	£2,268
Non elective Short Stay	MA18C Medical Abortion, less than 14 weeks' gestation	5,564	£643
Non elective Short Stay	MA17C Dilatation and Evacuation, less than 14 weeks' gestation	2,485	£1,189
Non elective Short Stay	MA19A Vacuum Aspiration with Cannula, less than 14 weeks' gestation	8,677	£1,245
Day Case	MA18C Medical Abortion, less than 14 weeks' gestation	30,046	£479
Day Case	MA17C Dilatation and Evacuation, less than 14 weeks' gestation	4,066	£977
Day Case	MA19A Vacuum Aspiration with Cannula, less than 14 weeks' gestation	26,676	£870
Mean Cost Medical Abortions	**Number of FCEs * National average unit cost**		**£555**
Mean Cost Surgical Abortion	**Number of FCEs * National average unit cost*weighted proportion MA17D (92%) & MA19B (8%)**		**£1,223**

FCE: Full Consultant Episode; NHS: National Health Service

Table 23: NHS Reference Costs 2016/2017 for abortions between 14 and 20 weeks

Setting	Currency code and description	Number of FCEs	National Average Unit Cost
Elective Inpatient	MA18D Medical Abortion, 14 to 20 weeks' gestation	571	£839
Elective Inpatient	MA17D Dilatation and Evacuation, 14 to 20 weeks' gestation	90	£2,005
Elective Inpatient	MA19B Vacuum Aspiration with Cannula, 14 to 20 weeks' gestation	178	£1,763

Setting	Currency code and description	Number of FCEs	National Average Unit Cost
Non elective Long Stay	MA18D Medical Abortion, 14 to 20 weeks' gestation	409	£2,564
Non elective Long Stay	MA17D Dilatation and Evacuation, 14 to 20 weeks' gestation	266	£3,300
Non elective Long Stay	MA19B Vacuum Aspiration with Cannula, 14 to 20 weeks' gestation	281	£2,940
Non elective Short Stay	MA18D Medical Abortion, 14 to 20 weeks' gestation	1,237	£1,022
Non elective Short Stay	MA17D Dilatation and Evacuation, 14 to 20 weeks' gestation	290	£1,595
Non elective Short Stay	MA19B Vacuum Aspiration with Cannula, 14 to 20 weeks' gestation	413	£1,499
Day Case	MA18D Medical Abortion, 14 to 20 weeks' gestation	834	£441
Day Case	MA17D Dilatation and Evacuation, 14 to 20 weeks' gestation	448	£736
Day Case	MA19B Vacuum Aspiration with Cannula, 14 to 20 weeks' gestation	862	£904
Mean Cost Medical Abortions	**Number of FCEs * National average unit cost**		**£1,036**
Mean Cost Surgical Abortion	**Number of FCEs * National average unit cost*weighted proportion MA17D (4%) & MA19B (96%)**		**£1,473**

FCE: Full Consultant Episode; NHS: National Health Service

Table 24: NHS Reference Costs 2016/2017 for abortions over 20 weeks

Setting	Currency Code and description	Number of FCEs	National Average Unit Cost
Elective Inpatient	MA20Z Medical or Surgical Abortion, over 20 weeks' gestation	50	£1,372
Non elective Long Stay	MA20Z Medical or Surgical Abortion, over 20 weeks' gestation	572	£3,608
Non elective Short Stay	MA20Z Medical or Surgical Abortion, over 20 weeks' gestation	939	£1,414
Day Case	MA20Z Medical or Surgical Abortion, over 20 weeks' gestation	217	£822
Mean Cost Medical and Surgical Abortions	**Number of FCEs * National average unit cost**		**£2,047**

FCE: Full Consultant Episode; NHS: National Health Service

Medical abortions performed in an outpatient setting were also reported in the NHS reference costs. Typically, women with pregnancies up to 9 weeks' gestation are able to have a medical abortion in an outpatient setting. There is the potential for large cost differences between inpatient and outpatient care and, therefore, the potential for large cost savings if abortions are performed earlier and women are able to select an outpatient setting for their abortion. However, it was not possible to ascertain from the data the number of abortions performed in an outpatient setting so this was not considered in the base case analysis. Given the potential for large cost savings, a sensitivity analysis was performed where it was assumed that all medical abortions performed before 9 weeks' gestation would be carried out on an outpatient basis. Costs for these were taken from NHS Reference Costs for the 2 services (obstetrics and gynaecology) who reported the most activity for medical abortion under 14 weeks' gestation (Table 25). A weighted average based on the number of FCEs was used for this sensitivity analysis.

Table 25: NHS Reference Costs 2016/2017 for abortion less than 14 weeks performed in an outpatient setting

Setting	Currency code and description	Number of FCEs	National average unit cost
Obstetrics	MA18C Medical Abortion, less than 14 weeks' gestation	799	£245
Gynaecology	MA18C Medical Abortion, less than 14 weeks' gestation	4130	£133
	Number of FCEs * National average unit cost		£151

FCE: Full Consultant Episode; NHS: National Health Service

Cost of adverse events

It was difficult to estimate the cost of adverse events given that they are likely to differ widely in terms of both severity and costs and the identified clinical evidence did not sufficiently report them in a disaggregated form. The evidence also did not stratify adverse events by gestational age and method of abortion. The cost of managing and treating adverse events will vary widely, with the most severe requiring surgical intervention and an overnight stay in hospital. However, adverse events of abortions almost never result in long term problems requiring ongoing management, with associated costs to the NHS. Therefore, costs for adverse events were only included for the period immediately after the abortion.

Due to the uncertainty around the cost of adverse events, 3 assumptions were investigated by the economic model. The first assumed that all adverse event costs were covered by the NHS Reference Costs, which may be the case for the more frequent adverse events, and no additional cost savings were estimated by the economic model as a result of reducing adverse events. The second estimated that the cost of an adverse event would equal that of the cost of giving 1 blood transfusion for a haemorrhage. The cost of a haemorrhage was taken from the health economic model for the NICE (2015) blood transfusion guideline (NG24) and inflated to 2016/17 price using the hospital & community health services (HCHS) index (Curtis 2017); this results in an estimated cost of £178.54 per adverse event. Other adverse events, such as infection and surgical injury, were not used as cost estimates. It was assumed that these would be treated and diagnosed as part of follow-up after an abortion, would not incur any additional time for health care professionals and would only require limited additional resources with a likely upper cost equivalent to 1 course of oral antibiotics.

The third assumption estimated the cost of an adverse event as the cost of an overnight stay. The cost of an overnight hospital stay was costed using the non-elective excess bed day for the NHS reference cost currency descriptions considered by the model. The different reported methods of surgical abortions were weighted identically to the methods used to estimate the costs of the abortion procedures (Table 26).

Table 26: Costs of one excess bed day

Currency Code and description	National Average Unit Cost
MA17C Dilatation and Evacuation, less than 14 weeks' gestation	£403.61
MA17D Dilatation and Evacuation, 14 to 20 weeks' gestation	£690.67
MA18C Medical Abortion, less than 14 weeks' gestation	£571.83
MA18D Medical Abortion, 14 to 20 weeks' gestation	£749.68
MA19A Vacuum Aspiration with Cannula, less than 14 weeks' gestation	£395.47
MA19B Vacuum Aspiration with Cannula, 14 to 20 weeks' gestation	£573.22
MA20Z Medical or Surgical Abortion, over 20 weeks' gestation	£720.95
Weighted mean cost of overnight stay for medical abortion, less than 14 weeks' gestation	£571.83
Weighted mean cost of overnight stay for medical abortion, 14 to 20 weeks' gestation	£749.68
Weighted mean cost of overnight stay for medical abortion, over 20 weeks' gestation	£720.95
Weighted mean cost of overnight stay for surgical abortion, less than 14 weeks' gestation	£396.09
Weighted mean cost of overnight stay for surgical abortion, 14 to 20 weeks' gestation	£685.93
Weighted mean cost of overnight stay for surgical abortion, over 20 weeks' gestation	£720.95

The vast majority of adverse events will not require an overnight stay in hospital and these costs should be considered as an upper estimate of the true costs of adverse events resulting from abortions. Any cost savings from reducing adverse events under this assumption should represent an upper estimate.

Cost of unwanted pregnancies resulting in births

It was hypothesised that by reducing waiting times that there may be some women with unwanted pregnancies who would be able to access abortions of pregnancy who otherwise would have missed legal time limits. The guideline committee however thought that groups near these legal limits, and also limits set by individual settings, were already prioritised for procedures. Therefore, the committee agreed that reduction in times between initial presentation and procedure were unlikely to increase the number of abortions. Even if this was the case, the total increase would likely be very small as only 0.2% of abortions were performed between 20 and 24 weeks in 2017 (Department of Health 2018). These costs were therefore not explored by the model.

Cost of interventions to reduce the time between initial presentation and procedure

Interventions to reduce the time between initial presentation and procedure, such as increasing the capacity and frequency of clinics and increasing the availability of procedures locally, could potentially have a significant resource impact to the NHS. There is also likely to be wide variability of implementing interventions across England with large cities able to increase capacity at a lower cost per head (due to a larger number of people attending) than

rural areas. The accompanying clinical evidence review did not identify any study which investigated any intervention primarily aimed at reducing time between initial presentation and procedure and therefore any link between an intervention and reduction in the model would have been based solely on assumptions.

Given the 2 difficulties highlighted above, the model did not look at either costing or estimating the impact of potential interventions. The cost savings estimated by this economic model, therefore, need to be considered in the context that there will be some initial, as well as potential ongoing, cost increase from achieving a reduction in time. Whilst these upfront costs may be relatively expensive, it also considered that many potential interventions are structural in nature and any impact upon cost savings would certainly go beyond the time horizon that this economic model considers.

Quality of life

The economic model did not attempt to make any quantitative estimations around changes in quality of life. Regardless, no evidence was identified which compared quality of life between abortions at different gestational ages. However, the committee agreed that any reduction in time between initial presentation and procedure would improve quality of life, as long as this timing was the preference of the woman and care was taken that they were not unduly rushed. This is because women will have to carry an unwanted pregnancy for a reduced period of time, potentially have a greater choice of type of procedure and also receive a less intensive procedure with a lower probability of adverse events. Therefore, the committee agreed that any intervention to reduce the time between initial presentation and procedure would result in an overall increase in quality of life.

Time horizon

The model only estimates a reduction in cost savings for the latest year, for which data was available. However, it is likely, especially in the case of structural changes to services or where there is a large initial investment in services, that any cost savings achieved would go beyond this time horizon potentially perpetually. The time horizon from this economic model may therefore not capture all benefits from some potential interventions.

Discounting

The economic model only had a time horizon of 1 year and therefore clinical outcomes and costs were not discounted at NICE's preferred 3.5% per annum. Potential cost savings beyond the time horizon of the model would need to take account of discounting.

Combined assumptions of the model

The alternative assumptions discussed above lead to 6 combined assumptions as listed below:

- **Assumption 1a:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) differs between the arms based on the proportions reported in the England and Wales Abortion Statistics 2017. Differences in adverse events are not included.
- **Assumption 2a:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) does not change from the base-case. Differences in adverse events are not included.
- **Assumption 1b:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) differs between the arms based on the proportions

reported in the England and Wales Abortion Statistics 2017. Differences in adverse events are included at the lower estimate of costs.

- **Assumption 2b:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) does not change from the base-case. The total proportion of each abortion method will not change. Differences in adverse events are included at the lower estimate of costs.
- **Assumption 1c:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) differs between the arms based on the proportions reported in the England and Wales Abortion Statistics 2017. Differences in adverse events are included at the higher estimate of costs.
- **Assumption 2c:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) does not change from the base-case. The total proportion of each abortion method will not change. Differences in adverse events are included at the higher estimate of costs.

A further sensitivity analysis was performed that assumed all medical abortions performed before 9^{+0} weeks' gestational age would incur the NHS reference cost for 'Medical Abortion, less than 14 weeks' gestation in an outpatient setting' as discussed above. This sensitivity analysis was performed only for assumption 1a and assumption 2a:

- **Sensitivity analysis assumption 1a:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) differs between the arms based on the proportions reported in the England and Wales Abortion Statistics 2017. All medical abortions performed before 9 weeks' gestational age will be on an outpatient basis. Differences in adverse events are not included.
- **Sensitivity analysis assumption 2a:** The gestational age at the time of abortion reduces by the assumed number of days in the comparator arm compared to the base-case. The method of abortion (surgical or medical) does not change from the base-case. All medical abortions performed before 9 weeks' gestational age will be on an outpatient basis. The total proportion of each abortion method will not change. Differences in adverse events not included.

Results

Total costs and potential cost savings from reducing the time between initial presentation and procedure

Table 27 presents: the total costs of providing all abortions per annum based on England and Wales Abortion Statistics 2017, potential total cost savings from reducing the time between initial presentation and procedure, and potential cost savings per woman from reducing the time between initial presentation and procedure. The total cost of performing all abortions was estimated at just under £156 million per year under all 3 assumptions. Under all assumptions, reducing the time between initial presentation and procedure by 7 days or more produced cost savings per annum greater than £1 million pound, which is the value that NICE consider a significant resource impact. Under assumption 1, where both the method and timing of the abortion changed with reduction in days, this figure was reached with a reduction of 1 day.

The number of additional medical abortions by reduction in days of pregnancy under assumption 1 are shown in Table 29. Given the assumptions of the model the number and proportion of medical abortions did not alter under assumption 2 from the base-case (Figure

6). With a 1 day given reduction over 1% of all abortions would change from a surgical to medical abortion. For a 21 day reduction just under 1 in 5 abortions would change from a surgical to medical abortion. Cost savings under assumption 1 were approximately 8 times higher than for assumption 2, where just the timing of abortion changed. This suggests that the majority of the potential savings in the economic model are achieved through women switching from a surgical abortion to a medical abortion as the gestational age at the time of the procedure is reduced. Adverse events, even under the higher estimate of these costs, were equal to £176,630 of total costs accounting for just 0.1% of all costs and were unlikely to change significantly with alternative estimates around the cost of adverse events. This was the same across all assumptions.

Sensitivity analysis for outpatient assumption

Under the assumption where all abortions before 9^{+0} weeks' gestational age are performed on an outpatient basis, total costs decrease for all assumptions by over £40 million (Table 28) and overall cost savings from reducing time between initial presentation and procedure are almost double that of the base case estimates. Over 1% of abortions of pregnancy can change to an outpatient procedure with only a 1 day reduction. This increase to just under 1 in 4 abortions of pregnancy when a 21 day reduction is assumed. (Table 29)

Table 27: Total cost saving and cost savings per procedure

Assumption	1a		2a		1b		2b		1c		2c	
Annual total Cost	£155,804,935				£155,855,796				£155,981,566			
Reduction in days	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure
1	£1,645,273	£8.68	£202,426	£1.07	£1,646,347	£8.68	£196,930	£1.04	£1,648,929	£8.70	£199,815	£1.05
2	£3,290,546	£17.35	£399,382	£2.11	£3,292,694	£17.37	£393,860	£2.08	£3,297,858	£17.39	£399,630	£2.11
3	£4,935,819	£26.03	£595,699	£3.14	£4,939,040	£26.05	£590,790	£3.12	£4,946,786	£26.09	£599,445	£3.16
4	£6,581,092	£34.71	£791,812	£4.18	£6,585,387	£34.73	£787,720	£4.15	£6,595,715	£34.78	£799,260	£4.22
5	£8,226,364	£43.38	£987,836	£5.21	£8,231,734	£43.41	£984,650	£5.19	£8,244,644	£43.48	£999,075	£5.27
6	£9,871,637	£52.06	£1,183,812	£6.24	£9,878,081	£52.10	£1,181,580	£6.23	£9,893,573	£52.18	£1,198,890	£6.32
7	£11,516,910	£60.74	£1,379,760	£7.28	£11,524,427	£60.78	£1,378,510	£7.27	£11,542,502	£60.87	£1,398,705	£7.38
8	£12,817,526	£67.60	£1,577,641	£8.32	£12,825,881	£67.64	£1,566,092	£8.26	£12,846,047	£67.75	£1,588,653	£8.38
9	£14,118,142	£74.46	£1,771,207	£9.34	£14,127,335	£74.51	£1,753,674	£9.25	£14,149,592	£74.62	£1,778,601	£9.38
10	£15,418,758	£81.32	£1,962,555	£10.35	£15,428,788	£81.37	£1,941,256	£10.24	£15,453,137	£81.50	£1,968,548	£10.38
11	£16,719,373	£88.18	£2,152,613	£11.35	£16,730,242	£88.23	£2,128,839	£11.23	£16,756,682	£88.37	£2,158,496	£11.38
12	£18,019,989	£95.04	£2,341,855	£12.35	£18,031,696	£95.10	£2,316,421	£12.22	£18,060,227	£95.25	£2,348,444	£12.39
13	£19,320,605	£101.89	£2,530,548	£13.35	£19,333,149	£101.96	£2,504,003	£13.21	£19,363,772	£102.12	£2,538,391	£13.39
14	£20,621,221	£108.75	£2,718,853	£14.34	£20,634,603	£108.82	£2,691,585	£14.20	£20,667,317	£109.00	£2,728,339	£14.39
15	£21,612,198	£113.98	£2,890,637	£15.24	£21,626,380	£114.05	£2,858,723	£15.08	£21,661,269	£114.24	£2,897,297	£15.28
16	£22,603,174	£119.21	£3,061,649	£16.15	£22,618,157	£119.29	£3,025,860	£15.96	£22,655,221	£119.48	£3,066,255	£16.17
17	£23,594,151	£124.43	£3,232,046	£17.05	£23,609,934	£124.52	£3,192,998	£16.84	£23,649,172	£124.72	£3,235,214	£17.06

Assumption	1a		2a		1b		2b		1c		2c	
18	£24,585,128	£129.66	£3,401,946	£17.94	£24,601,710	£129.75	£3,360,135	£17.72	£24,643,124	£129.96	£3,404,172	£17.95
19	£25,576,105	£134.89	£3,571,438	£18.84	£25,593,487	£134.98	£3,527,273	£18.60	£25,637,076	£135.21	£3,573,130	£18.84
20	£26,567,081	£140.11	£3,740,591	£19.73	£26,585,264	£140.21	£3,694,410	£19.48	£26,631,027	£140.45	£3,742,088	£19.74
21	£27,558,058	£145.34	£3,909,459	£20.62	£27,577,041	£145.44	£3,861,548	£20.37	£27,624,979	£145.69	£3,911,047	£20.63

Assumption 1a: Method changes, no adverse event costs, 2a: Method remains the same, no adverse event costs, 1b: Method changes, lower adverse event cost, 2b: Method remains same, lower adverse event cost, 1c: Method changes, higher adverse event cost, 2c Method remains the same, higher adverse event cost

Table 28: Total costs savings under outpatient assumption

Assumption	1a		2a		1b		2b		1c		2c	
Annual total cost	£112,435,282				£112,486,145				£112,611,914			
Reduction in days	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure	Total cost saving	Cost saving per procedure
1	£2,818,165	£14.86	£700,382	£3.69	£2,819,239	£14.87	£689,442	£3.64	£2,821,821	£14.88	£692,325	£3.65
2	£5,636,330	£29.73	£1,391,991	£7.34	£5,638,478	£29.74	£1,380,125	£7.28	£5,643,642	£29.76	£1,385,893	£7.31
3	£8,454,495	£44.59	£2,082,576	£10.98	£8,457,716	£44.60	£2,070,952	£10.92	£8,465,463	£44.65	£2,079,605	£10.97
4	£11,272,660	£59.45	£2,772,836	£14.62	£11,276,955	£59.47	£2,761,826	£14.57	£11,287,284	£59.53	£2,773,364	£14.63
5	£14,090,825	£74.31	£3,462,951	£18.26	£14,096,194	£74.34	£3,452,720	£18.21	£14,109,104	£74.41	£3,467,143	£18.29
6	£16,908,990	£89.18	£4,152,989	£21.90	£16,915,433	£89.21	£4,143,625	£21.85	£16,930,925	£89.29	£4,160,933	£21.94
7	£19,727,155	£104.04	£4,842,982	£25.54	£19,734,672	£104.08	£4,834,536	£25.50	£19,752,746	£104.17	£4,854,729	£25.60
8	£21,830,080	£115.13	£5,139,417	£27.10	£21,838,435	£115.17	£5,111,406	£26.96	£21,858,601	£115.28	£5,133,961	£27.08
9	£23,933,005	£126.22	£5,428,932	£28.63	£23,942,198	£126.27	£5,389,254	£28.42	£23,964,455	£126.39	£5,414,173	£28.55
10	£26,035,930	£137.31	£5,714,892	£30.14	£26,045,961	£137.36	£5,667,605	£29.89	£26,070,309	£137.49	£5,694,888	£30.03
11	£28,138,855	£148.40	£5,998,782	£31.64	£28,149,724	£148.46	£5,946,249	£31.36	£28,176,164	£148.60	£5,975,896	£31.52

Assumption	1a		2a		1b		2b		1c		2c	
12	£30,241,780	£159.49	£6,281,363	£33.13	£30,253,487	£159.55	£6,225,078	£32.83	£30,282,018	£159.70	£6,257,090	£33.00
13	£32,344,705	£170.58	£6,563,063	£34.61	£32,357,250	£170.65	£6,504,032	£34.30	£32,387,872	£170.81	£6,538,409	£34.48
14	£34,447,630	£181.67	£6,844,142	£36.10	£34,461,013	£181.74	£6,783,073	£35.77	£34,493,727	£181.92	£6,819,815	£35.97
15	£36,056,148	£190.16	£7,072,461	£37.30	£36,070,330	£190.23	£7,002,350	£36.93	£36,105,219	£190.41	£7,040,911	£37.13
16	£37,664,665	£198.64	£7,299,542	£38.50	£37,679,648	£198.72	£7,221,802	£38.09	£37,716,712	£198.91	£7,262,182	£38.30
17	£39,273,183	£207.12	£7,525,638	£39.69	£39,288,965	£207.20	£7,441,393	£39.24	£39,328,204	£207.41	£7,483,593	£39.47
18	£40,881,700	£215.60	£7,750,936	£40.88	£40,898,283	£215.69	£7,661,097	£40.40	£40,939,696	£215.91	£7,705,117	£40.64
19	£42,490,218	£224.09	£7,975,579	£42.06	£42,507,600	£224.18	£7,880,894	£41.56	£42,551,189	£224.41	£7,926,733	£41.80
20	£44,098,735	£232.57	£8,199,680	£43.24	£44,116,918	£232.67	£8,100,767	£42.72	£44,162,681	£232.91	£8,148,427	£42.97
21	£45,707,253	£241.05	£8,423,324	£44.42	£45,726,235	£241.15	£8,320,705	£43.88	£45,774,174	£241.41	£8,370,185	£44.14

Assumption 1a: Method Changes, no adverse event costs, 2a: Method remains the same, no adverse event costs, 1b: Method changes, lower adverse event cost, 2b: Method remains same, lower adverse event cost, 1c: Method changes, higher adverse event cost, 2c Method remains the same, higher adverse event cost

Table 29: Increase in medical abortions of pregnancy as a result of a reduction in days

Assumption 1a,b,c. Sensitivity Analysis 1a,b,c				
Reduction in days	Increase in number of medical abortions of pregnancy	Percentage of all abortions	Increase in number of outpatient procedures	Percentage of all abortions
1	2,188	1.2%	2,909	1.5%
2	4,376	2.3%	5,818	3.1%
3	6,565	3.5%	8,727	4.6%
4	8,753	4.6%	11,635	6.1%
5	10,941	5.8%	14,544	7.7%
6	13,129	6.9%	17,453	9.2%
7	15,317	8.1%	20,362	10.7%

Assumption 1a,b,c. Sensitivity Analysis 1a,b,c				
8	16,996	9.0%	22,352	11.8%
9	18,676	9.8%	24,341	12.8%
10	20,355	10.7%	26,331	13.9%
11	22,034	11.6%	28,321	14.9%
12	23,713	12.5%	30,311	16.0%
13	25,392	13.4%	32,300	17.0%
14	27,072	14.3%	34,290	18.1%
15	28,289	14.9%	35,822	18.9%
16	29,505	15.6%	37,353	19.7%
17	30,722	16.2%	38,885	20.5%
18	31,939	16.8%	40,416	21.3%
19	33,156	17.5%	41,948	22.1%
20	34,373	18.1%	43,479	22.9%
21	35,590	18.8%	45,011	23.7%

Discussion

The economic model estimates cost savings from a reduction in time between initial presentation and procedure. Under all assumptions, cost savings could reach millions of pounds with only modest reductions in the number of days. Under some assumptions, millions of pounds could be saved per annum with each additional day's reduction. The model identified 4 ways in which costs savings can be achieved:

- A reduction in adverse events
- Women transiting between the '14 to 20 weeks' gestation' tariffs and the 'less than 14 weeks' gestation' tariffs
- Women switching from surgical abortions to medical abortions (assumption 1 only)
- More women receiving the procedure on an outpatient rather than inpatient basis (sensitivity analysis only)

The large differences in cost savings between assumption 1 and assumption 2, and between the outpatient sensitivity analysis, strongly suggest that the majority of potential cost savings will come from women increasingly choosing medical abortion at earlier gestational ages and being able to receive this medical abortion on an outpatient rather than inpatient basis. Cost savings are also realised through reduction in adverse events and transitioning between the 2 NHS reference costs. Both of these only make up a small proportion of the total cost savings. It was also considered by the guideline committee that the distinction between the NHS reference costs is likely arbitrary and that there is no large clinical or resource use distinction between abortions carried out at 13 weeks' gestation and 14 weeks' gestation. Cost savings attributed to this are, therefore, likely to be artificial as a result of this cut off and these savings may not be realised in practice through less resource intensive interventions.

The model uses data, including type of procedure, gestational age and adverse events, on all abortions performed in England and Wales for 2017. All procedures and adverse events are costed from recent UK publically available sources. The model also looks at 8 alternative assumptions to account for uncertainty around estimates in the model in order to explore the robustness of results and through which processes savings are being achieved. Although estimated cost savings vary widely across different assumptions, reducing the time between initial presentation and procedure by only a few days produces significant potential savings, even under cautious assumptions.

The economic model only looks at potential cost savings and does not consider the cost of interventions which may bring about this change. No clinical evidence was identified which investigated an intervention primarily aimed at achieving a reduction in the time between initial presentation and procedure. Interventions such as increasing capacity, employing more staff or running clinics more frequently below capacity (reducing savings from economies of scale) will all have large resource implications associated with them, especially if implemented nationwide. Although cost savings can be large for very modest reductions in days, these could be partially or completely offset by the cost of the interventions needed to achieve them. The model also does not use costing data from independent abortion providers. It is not believed that conclusions would changes if this data was used in the model, with large cost differences between surgical and medical abortions and inpatient and outpatient procedures certain in all settings. It is likely, however, that the overall cost of providing all abortions would be millions of pounds cheaper under such cost data.

The economic model also assumes a uniform shift to a lower gestational age for all women. In practice, any intervention is likely to impact upon women differently with some women benefiting more than others. There is also likely to be some women who will have greater personal, societal or socioeconomic barriers to overcome compared with other women. These women may see little or no benefit from some potential interventions or will need more intensive and more costly interventions to achieve the same benefit. Delays may also happen between initial presentation and procedure which are outside of the control of health authorities, for example when women are considering their options. It would not be appropriate or possible for doctors and other health professionals to try and intervene in such circumstances even if it could lead to substantial cost savings. However, cost savings on a per abortion basis still remain large and even a 7 day reduction in waiting times achieved by 10% of women would result in a greater than £1 million cost saving. There is also great variation in this time between initial presentation and procedure throughout the UK with some primary care trusts being within the RCOG guidelines suggested 10 days and others having waits of up to 25 days (Grazia Daily 2017). Reduction in days may be more difficult and require greater resources dependent on the current number of days. Without clinical evidence to inform this, it is impossible to conclude.

The economic model also did not consider quality of life due to an absence of identified evidence in the area. It is certain that any reduction in time between initial presentation and procedure will lead to increases in quality of life through women having a reduced period of time with an unwanted pregnancy, receiving a less intensive procedure with lower adverse events and potentially having a greater choice of method and setting. Unless women are inappropriately rushed into receiving a procedure, which should never occur, there were no scenarios in which a reduction in this time would lead to a reduction in overall quality of life. Even if quality of life evidence was available to quantify this in terms of quality adjusted life years (QALYs), or was estimated through committee assumptions, it would still not be possible to estimate a meaningful incremental cost per QALY because, as discussed above, the cost of any potential intervention is not estimated by the model. As the incremental cost per QALY is used as a common metric to aid in the allocation of resources across different areas of healthcare, presenting it without the intervention costs included, as is almost universally the case in these estimates, and in line the NHS reference case (NICE 2016), would not be helpful in making decisions.

The guideline committee considered that even small reductions in time between initial presentation and procedure would likely lead to large cost savings even if it only impacted upon a proportion of women. The committee appreciated that there would be costs associated with decreasing these times but these could range from quite small, for example altering booking procedures, to quite large, in the cases where extra clinics and staff were needed. The large cost savings by the model, whilst not being able to suggest any particular intervention, gave weight to the benefits of introducing such interventions to reduce these times even when large costs were incurred. Appreciating that the time between initial presentation and procedure varied widely across England, a metric of reduction in days may not be the most appropriate way to make recommendations. From the guideline committee's clinical experience it was believed that the savings estimated in the model could most likely and practically be achieved through recommending an 'ideal' maximum time of 14 days (7 days between requesting an abortion and assessment and 7 days between assessment and procedure).

Appendix K – Excluded studies

Excluded studies for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

Clinical studies

Study	Reason for Exclusion
Committee opinion no. 613: increasing access to abortion, Obstetrics & GynecologyObstet Gynecol, 124, 1060-1065, 2014	Narrative review
Making safe abortion accessible: A practical guide for advocates, Reproductive Health Matters, 11, 209-210, 2003	Overview of guidance
Advocating for abortion access: Eleven country studies, Reproductive Health Matters, 10, 213-213, 2002	Overview of book
Aiken, A. R. A., Gomperts, R., Trussell, J., Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis, BJOG: An International Journal of Obstetrics and Gynaecology, 124, 1208-1215, 2017	Not relevant to the UK setting - women accessing abortion through telemedicine as abortion illegal in Ireland (at time of study)
Aiken, A. R. A., Johnson, D. M., Broussard, K., Padron, E., Experiences of women in Ireland who accessed abortion by travelling abroad or by using abortion medication at home: A qualitative study, BMJ Sexual and Reproductive Health, 44, 181-186, 2018	Not relevant to the UK setting - women accessing abortion through telemedicine or by travelling abroad as abortion illegal in Ireland (at time of study)
Aiken, A. R. A., Padron, E., Broussard, K., Johnson, D., The impact of Northern Ireland's abortion laws on women's abortion decision-making and experiences, BMJ Sexual and Reproductive Health., 2018	Not relevant to the UK setting - women accessing abortion through telemedicine or by travelling abroad as abortion illegal in Ireland (at time of study)
Aiken, A., Broussard, K., Johnson, D., Padron, E., The impacts of Irish abortion law on women's experiences accessing abortion care, European Journal of Contraception and Reproductive Health Care, 23 (Supplement 1), 55, 2018	Conference abstract - insufficient information presented
Aksel, S., Fein, L., Ketterer, E., Young, E., Backus, L., Unintended consequences: abortion training in the years after Roe v Wade, American Journal of Public Health, 103, 404-407, 2013	Editorial
Altshuler, A. L., Whaley, N. S., The patient perspective: perceptions of the quality of the abortion experience, Current Opinion in Obstetrics & Gynecology, 30, 407-413, 2018	Narrative review
Altshuler, Anna L., Ojanen-Goldsmith, Alison, Blumenthal, Paul D., Freedman, Lori R., A good	Experience of abortion - no themes about access

Study	Reason for Exclusion
abortion experience: A qualitative exploration of women's needs and preferences in clinical care, Social Science & Medicine, 191, 109-116, 2017	
Andersson, I. M., Christensson, K., Gemzell-Danielsson, K., Experiences, feelings and thoughts of women undergoing second trimester medical termination of pregnancy, PLoS ONE, 9 (12) (no pagination), 2014	Experience of abortion - no themes about access
Anonymous,, Medical abortion: Expanding access to safe abortion and saving women's lives, Reproductive Health Matters, 13, 11-12, 2005	Consensus statement
Anonymous,, Increasing access to abortion, Obstetrics and Gynecology, 124, 1060-1065, 2014	Narrative review
Anonymous,, Abortion training and education, Obstetrics and Gynecology, 124, 1055-1059, 2014	Narrative review
Anonymous,, Service delivery, Reproductive Health Matters, 13, 190-195, 2005	Summary of papers on service delivery
Astbury-Ward, E., Parry, O., Carnwell, R., Stigma, Abortion, and Disclosure-Findings from a Qualitative Study, Journal of Sexual Medicine, 9, 3137-3147, 2012	Experience of stigma experienced - no themes about access
Battistelli, M. F., Magnusson, S., Biggs, M. A., Freedman, L., Expanding the Abortion Provider Workforce: A Qualitative Study of Organizations Implementing a New California Policy, Perspectives on Sexual & Reproductive Health, 50, 33-39, 2018	No themes about access that are relevant to the UK setting
Baum, S. E., White, K., Hopkins, K., Potter, J. E., Grossman, D., Women's Experience Obtaining Abortion Care in Texas after Implementation of Restrictive Abortion Laws: A Qualitative Study, PloS one, 11, 2016	Experience of a restrictive law change - not relevant to the UK setting
Baum, S. E., White, K., Hopkins, K., Potter, J. E., Grossman, D., Impact of admitting privilege requirement on abortion providers in Texas, Contraception, 94 (4), 390, 2016	Abstract only - insufficient information
Becker, D., Diaz-Olavarrieta, C., Juarez, C., Garcia, S. G., Sanhueza Smith, P., Harper, C. C., Sociodemographic factors associated with obstacles to abortion care: findings from a survey of abortion patients in Mexico City, Women's health issues : official publication of the Jacobs Institute of Women's Health, 21, S16-20, 2011	Quantitative study
Beckman, L. J., Harvey, S. M., Satre, S. J., The delivery of medical abortion services: The views	Experience of providing abortion - no themes about access

Study	Reason for Exclusion
of experienced providers, Womens Health Issues, 12, 103-112, 2002	
Bell, Melissa M., Barriers in the provision of family planning information from social workers to their clients, Dissertation Abstracts International Section A: Humanities and Social Sciences, 69, 751, 2008	Abstract only - insufficient information
Bennett, I., Aguirre, A. C., Burg, J., Finkel, M. L., Wolff, E., Bowman, K., Fleischman, J., Initiating abortion training in residency programs: Issues and obstacles, Family Medicine, 38, 330-335, 2006	Experience of training - no themes about access to abortion
Bessett, D., Gorski, K., Jinadasa, D., Ostrow, M., Peterson, M. J., Out of time and out of pocket: experiences of women seeking state-subsidized insurance for abortion care in Massachusetts, Women's health issues : official publication of the Jacobs Institute of Women's Health, 21, S21-25, 2011	Not applicable to UK practice because it addresses securing insurance or Medicaid funding for abortion
Bessett, D., Gorski, K., Ostrow, M., Jinadasa, D., Peterson, M. J., Consequences of delays for women seeking state-subsidized insurance for abortion care in the commonwealth of Massachusetts, Contraception, 84, 316, 2011	Abstract only - insufficient information
Bessett, D., LaRoche, K., Foster, A. M., Barriers to abortion access and social stress; women's perspectives, Contraception, 98, 345-345, 2018	Conference abstract - insufficient information reported
Beynon-Jones, S. M., Timing is everything: The demarcation of 'later' abortions in Scotland, Social Studies of Science, 42, 53-74, 2012	Focus on gestational limits for abortion not access to abortion
Black, T., Harvey, P., Purdy, C., Slaughtering sacred cows: Six institutional obstacles to advances in family planning, European Journal of Contraception and Reproductive Health Care, 19, 317-320, 2014	Personal opinion
Block, A., Dehlendorf, C., Biggs, M. A., McNeil, S., Goodman, S., Postgraduate Experiences With an Advanced Reproductive Health and Abortion Training and Leadership Program, Family Medicine, 49, 706-713, 2017	Non-qualitative study
Bloomer, F., O'Dowd, K., Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform, Culture, Health & Sexuality, 16, 366-380, 2014	Narrative review
Brahmi, D., Dehlendorf, C., Engel, D., Grumbach, K., Joffe, C., Gold, M., A descriptive analysis of abortion training in family medicine residency programs, Family Medicine, 39, 399-403, 2007	Experience of training - no themes about access

Study	Reason for Exclusion
Bridges, K. M., ABORTION ACCESS IN AN ERA OF CONSTITUTIONAL INFIDELITY, Boston University Law Review, 93, 1297-1308, 2013	Essay
Buckingham, J. E., Access to abortion, Canadian Medical Association Journal, 176, 492-494, 2007	Letter
Calonge, B. N., Gayle, H. D., The safety and quality of abortion services in the United States: What does the evidence indicate?, Annals of Internal Medicine, 168, 878-880, 2018	Personal opinion
Cassidy, A. M., Herceg-Baron, R., Hock-Long, L., Whittaker, P. G., Access to adolescent reproductive health services: Financial and structural barriers to care, Perspectives on Sexual and Reproductive Health, 35, 144-147, 2003	Personal opinion
Chahal, H., Mumtaz, Z., Ideology Trumps: Health Care Providers a Barrier to Abortion Services, International Journal of Qualitative Methods, 15, 2016	Non-OECD country
Chang, S., Ball, R., Braun, M. M., Elective termination of pregnancy after vaccination reported to the Vaccine Adverse Event Reporting System (VAERS): 1990-2006, Vaccine, 26, 2428-2432, 2008	Non-qualitative study
Ciszewski, W., Zuradzki, T., Conscientious Refusal of Abortion in Emergency Life-Threatening Circumstances and Contested Judgments of Conscience, American Journal of Bioethics, 18, 62-64, 2018	Commentary
Cleaver, G., Access to abortion in the USA-the legal battle, Lancet (London, England), 389, 2361-2362, 2017	Commentary
Clyde, J., Bain, J., Castagnaro, K., Rueda, M., Tatum, C., Watson, K., Evolving capacity and decision-making in practice: Adolescents' access to legal abortion services in Mexico City, Reproductive Health Matters, 21, 167-175, 2013	Non-qualitative study
Cochrane, R. A., Cameron, S. T., Attitudes of Scottish abortion care providers towards provision of abortion after 16 weeks gestation within Scotland, European Journal of Contraception and Reproductive Health Care, 18, 215-220, 2013	Non-qualitative study
Cochrane, R., Milne, D., Cameron, S., Termination of pregnancy in Lothian: A health needs assessment, BJOG: An International Journal of Obstetrics and Gynaecology, 2), 17, 2012	Abstract only - insufficient information

Study	Reason for Exclusion
Cockrill, K., Weitz, T. A., Abortion Patients' Perceptions of Abortion Regulation, Women's Health Issues, 20, 12-19, 2010	Perception of abortion policies - no themes about access
Coleman-Minahan, K., Stevenson, A. J., Obront, L. M. S. W. E., Hays, J. D. S., Young Women's Experiences Obtaining Judicial Bypass for Abortion in Texas, Journal of Adolescent Health, 06, 06, 2018	Experience of judicial bypass of parental consent - not relevant to the UK setting
Collado, M. E., Legal abortion providers' experiences with abortion stigma in Mexico City's health facilities, International Journal of Gynecology and Obstetrics, 143 (Supplement 3), 527, 2018	Conference abstract - insufficient information reported
Committee on Health Care for Underserved, Women, ACOG Committee Opinion No. 613: Increasing access to abortion, Obstetrics & GynecologyObstet Gynecol, 124, 1060-5, 2014	Narrative review
Connolly, C., Access to abortion pared at state level, Washington post (Washington, D.C, : 1974)., A1, A4, 2005	Newspaper article
Contreras,X., van Dijk,M.G., Sanchez,T., Smith,P.S., Experiences and opinions of health-care professionals regarding legal abortion in Mexico City: a qualitative study, Studies in Family Planning, 42, 183-190, 2011	Experience of setting up abortion services in Mexico city where abortion was previously illegal - not relevant to the UK setting
Cooney, C., Hercher, L., Bajaj, K., Genetic Counselors' Perception of the Effect on Practice of Laws Restricting Abortion, Journal of Genetic Counseling, 26, 1059-1069, 2017	Experience of a restrictive law change - not relevant to the UK setting
Crowe, L., Graham, R. H., Robson, S. C., Rankin, J., Negotiating acceptable termination of pregnancy for non-lethal fetal anomaly: a qualitative study of professional perspectives, BMJ Open, 8, 7, 2018	Focus on decision making and justification for abortion due to fetal anomaly, not access to abortion
Culwell, K. R., Hurwitz, M., Addressing barriers to safe abortion, International Journal of Gynecology and Obstetrics, 121, S16-S19, 2013	Narrative review
Dãaz-Olavarrieta, Claudia, Cravioto, Vanessa M., Villalobos, Aremis, Deeb-Sossa, Natalia, Garcãa, Laura, Garcãa, Sandra G., Mexico City Legal Abortion Program: health workers experiences, Revista Panamericana de Salud Publica, 32, 399-404, 2012	Non-English language article
Dawson, A., Bateson, D., Estoesta, J., Sullivan, E., Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia, BMC Health Services Research, 16, 612, 2016	Includes quantitative studies that are not included for the protocol for this question

Study	Reason for Exclusion
de Bruyn, M., HIV, unwanted pregnancy and abortion - where is the human rights approach?, Reproductive Health Matters, 20, 70-79, 2012	Narrative review
de Moel-Mandel, C., Shelley, J. M., The legal and non-legal barriers to abortion access in Australia: a review of the evidence, European Journal of Contraception & Reproductive Health CareEur J Contracept Reprod Health Care, 22, 114-122, 2017	Includes non-qualitative studies which are not included in the protocol for this question
Dennis, A., Blanchard, K., Abortion providers' experiences with Medicaid abortion coverage policies: A qualitative multistate study, Health Services Research, 48, 236-252, 2013	Not applicable to UK practice because it addresses securing insurance or Medicaid funding for abortion
Dennis, A., Manski, R., Blanchard, K., Does medicaid coverage matter?: A qualitative multi-state study of abortion affordability for low-income women, Journal of health care for the poor and underserved, 25, 1571-1585, 2014	Not applicable to UK practice because it addresses securing insurance or Medicaid funding for abortion
Doran, F., Hornibrook, J., Rural New South Wales women's access to abortion services: highlights from an exploratory qualitative study, The Australian journal of rural health, 22, 121-126, 2014	Highlights of themes from Doran 2016 - no additional themes reported
Doran, F., Nancarrow, S., Barriers and facilitators of access to first-trimester abortion services for women in the developed world: A systematic review, Journal of Family Planning and Reproductive Health Care, 41, 170-180, 2015	Includes non-qualitative studies which are not included in the protocol for this question
Downie, J., Nassar, C., Barriers to access to abortion through a legal lens, Health law journal, 15, 143-173, 2007	Narrative review
Dragoman, M., Davis, A., Abortion care for adolescents, Clinical Obstetrics & Gynecology, 51, 281-9, 2008	Narrative review
Espey, E., ACOG committee opinion No. 424: Abortion access and training, Obstetrics and Gynecology, 113, 247-250, 2009	Article withdrawn from publication
Espey, E., Leeman, L., Ogburn, T., Skipper, B., Eyman, C., North, M., Has mifepristone medical abortion expanded abortion access in New Mexico? A survey of OB-GYN and Family Medicine physicians, Contraception, 84, 178-183, 2011	Non -qualitative study
Fiala, C., Kernreiter, J., Lusztig, D., Restrictions in access to abortion-the pregnant women's perspective, European Journal of Contraception and Reproductive Health Care, 23 (Supplement 1), 59, 2018	Conference abstract - insufficient information presented

Study	Reason for Exclusion
Finer, L. B., Frohwirth, L. F., Dauphinee, L. A., Singh, S., Moore, A. M., Timing of steps and reasons for delays in obtaining abortions in the United States, Contraception, 74, 334-344, 2006	Not applicable to UK practice because it addresses securing insurance or Medicaid funding for abortion
Finnie, S., Foy, R., Mather, J., The pathway to induced abortion: Women's experiences and general practitioner attitudes, Journal of Family Planning and Reproductive Health Care, 32, 15-18, 2006	Non-qualitative study
Foster, A., Exploring Polish women's experiences using a medication abortion telemedicine service: A qualitative study, European Journal of Contraception and Reproductive Health Care, 23 (Supplement 1), 59-60, 2018	Conference abstract - insufficient information presented
Foster, A. M., LaRoche, K. J., El-Haddad, J., DeGroot, L., El-Mowafi, I. M., "If I ever did have a daughter, I wouldn't raise her in New Brunswick:" exploring women's experiences obtaining abortion care before and after policy reform, Contraception., 05, 2017	Experience of law change - not relevant to the UK setting
Foster, D. G., Kimport, K., Who seeks abortions at or after 20 weeks?, Perspectives on sexual and reproductive health, 45, 210-218, 2013	Non-qualitative study
Foy, R., Walker, A., Ramsay, C., Penney, G., Grimshaw, J., Francis, J., Theory-based identification of barriers to quality improvement: Induced abortion care, International Journal for Quality in Health Care, 17, 147-155, 2005	Insufficient information about qualitative methods and results from qualitative component of study
Fuentes, L., Gerdts, C., Baum, S. E., Keefe-Oates, B., Potter, J., White, K., Hopkins, K., Grossman, D., Texas women's experiences accessing abortion services after a restrictive abortion law, Contraception, 93, 470-470, 2016	Abstract only - insufficient information
Fuentes, L., Lebenkoff, S., White, K., Gerdts, C., Hopkins, K., Potter, J. E., Grossman, D., Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas, Contraception, 93, 292-297, 2016	Experience of a restrictive law change - not relevant to the UK setting
Ganatra, B., Guest, P., Berer, M., Expanding access to medical abortion: Challenges and opportunities, Reproductive Health Matters, Part S1. 22, 1-3, 2015	Personal opinion
Ganatra, B., Johnson, B. R., Jr., Evidence-based practices can improve safety and timeliness of care for women needing safe termination of pregnancy, BJOG: An International Journal of Obstetrics & GynaecologyBjog, 123, 1692, 2016	Commentary

Study	Reason for Exclusion
Goldbeck-Wood, S., Aiken, A., Horwell, D., Heikinheimo, O., Acharya, G., Editorial Board, B. M. J. Sexual Reprodu, Criminalised abortion in UK obstructs reflective choice and best care, Bmj-British Medical JournalBMJ-British Medical Journal, 362, 2, 2018	Editorial
Goodman, S., Shih, G., Hawkins, M., Feierabend, S., Lossy, P., Waxman, N. J., Gold, M., Dehlendorf, C., A long-term evaluation of a required reproductive health training rotation with opt-out provisions for family medicine residents, Family medicine, 45, 180-6, 2013	Non-qualitative study
Greenberg, M., Herbitter, C., Gawinski, B. A., Fletcher, J., Gold, M., Barriers and enablers to becoming abortion providers: the reproductive health program, Family Medicine, 44, 493-500, 2012	Barriers and enablers to abortion training - no themes about access to abortion itself
Greenberg, S., Nothnagle, M., An "Invaluable Skill": Reflections on Abortion Training and Postresidency Practice, Family medicine, 50, 691-693, 2018	Population not in PICO: only 8/20 graduates intended to provide abortion post-residency and themes not presented separately for those who did want to provide abortion services
Grindlay, K., Seymour, J. W., Fix, L., Reiger, S., Keefe-Oates, B., Grossman, D., Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study, Perspectives on Sexual & Reproductive Health, 49, 245-252, 2017	No themes about access applicable to the UK setting
Grindlay, K., Yanow, S., Jelinska, K., Gomperts, R., Grossman, D., Abortion Restrictions in the U.S. Military: Voices from Women Deployed Overseas, Women's Health Issues, 21, 259-264, 2011	No themes about access applicable to the UK setting
Grossman, D., Garcia, S. G., Kingston, J., Schweikert, S., Mexican Women Seeking Safe Abortion Services in San Diego, California, Health Care for Women International, 33, 1060-1069, 2012	Not applicable as it involves travel from countries where abortion is illegal
Guiahi, M., Westover, C., Lim, S., Westhoff, C. L., The New York City mayoral abortion training initiative at public hospitals, Contraception, 86, 577-82, 2012	Experience of training initiative - no themes about access
Haldane, J., Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services, Bjog-an International Journal of Obstetrics and Gynaecology, 115, 1587-1588, 2008	Letter
Handa, Manavi, Rosenberg, Simone, Ontario Midwives' Attitudes About Abortion and Abortion Provision, Canadian Journal of Midwifery Research & Practice, 15, 8-35, 2016	Qualitative studies about attitudes to, rather than access to, abortion

Study	Reason for Exclusion
Harris, L. H., Grossman, D., Confronting the challenge of unsafe second-trimester abortion, International Journal of Gynecology and Obstetrics, 115, 77-79, 2011	Narrative review
Herbitter,C., Kumar,V., Karasz,A., Gold,M., Abortion training at multiple sites: an unexpected curriculum for teaching systems-based practice, Teaching and Learning in Medicine, 22, 102-106, 2010	Experience of training - no themes about access that are relevant to the UK setting
Holmquist, S., "idon'T Recommendit for the weak of heart": Resilience among providers initiating second-trimester inpatient abortion services, Contraception, 94 (4), 398, 2016	Abstract only - insufficient information
Homaifar, N., Freedman, L., French, V., "She's on her own": a thematic analysis of clinicians' comments on abortion referral, Contraception, 95, 470-476, 2017	Focus on physicians referral behaviour - no themes about access
Hughes, R., MacGille Eathain, R., Sykes, J., Improving sex and relationships education in remote and rural Scotland: Collecting the views and experiences of young people in the Highlands, HIV Medicine, 19 (Supplement 2), S91, 2018	Conference abstract - insufficient information presented
Janiak, E., Kawachi, I., Goldberg, A., Gottlieb, B., Abortion barriers and perceptions of gestational age among women seeking abortion care in the latter half of the second trimester, Contraception, 89, 322-327, 2014	Non-qualitative study
Johnson, A., Access to elective abortions for female prisoners under the Eighth and Fourteenth Amendments, American Journal of Law & MedicineAm J Law Med, 37, 652-683, 2011	Narrative review
Jolley, S., Promoting teenage sexual health: an investigation into the knowledge, activities and perceptions of gynaecology nurses, Journal of advanced nursing, 36, 246-255, 2001	Qualitative study about experience of providing sexual health service to teenagers - no themes specific to abortion access
Jones,R.K., Henshaw,S.K., Mifepristone for early medical abortion: experiences in France, Great Britain and Sweden, Perspectives on Sexual and Reproductive Health, 34, 154-161, 2002	Narrative review
Kacanek, D., Dennis, A., Miller, K., Blanchard, K., Medicaid Funding for Abortion: Providers' Experiences with Cases Involving Rape, Incest and Life Endangerment, Perspectives on Sexual and Reproductive Health, 42, 79-86, 2010	Not applicable to UK practice because it addresses securing insurance or Medicaid funding for abortion
Karasek, D., Roberts, S. C. M., Weitz, T. A., Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence before	Non-qualitative study

Study	Reason for Exclusion
Arizona's Two-visit 24-hour Mandatory Waiting Period Law, Women's Health Issues, 26, 60-66, 2016	
Keogh, L. A., Newton, D., Bayly, C., McNamee, K., Hardiman, A., Webster, A., Bismark, M., Intended and unintended consequences of abortion law reform: perspectives of abortion experts in Victoria, Australia, Journal of Family Planning & Reproductive Health Care, 43, 18-24, 2017	Experience of legalising abortion in Victoria, Australia - no themes about access relevant to the UK setting
Kimport, K., Weitz, T. A., Freedman, L., The Stratified Legitimacy of Abortions, Journal of Health and Social Behavior, 57, 503-516, 2016	Focus on physician decision making - no themes about access
Lawrence, Gina, Leyser-Whalen, Ophra, Trapped Without Choice: An Exploration of Abortion Access in the Southern U.S, Women's Reproductive Health, 4, 141-143, 2017	Film review
Lee, E., Ingham, R., Why do women present late for induced abortion?, Best Practice and Research: Clinical Obstetrics and Gynaecology, 24, 479-489, 2010	Narrative review
Leroy, H., Creutz-Leroy, M., Boivin, J. M., General medical practice and medicinal voluntary termination of pregnancy in Grand Est, France, Revue d'Epidemiologie et de Sante Publique., 2018	Non-English language article
Lotto, R., Armstrong, N., Smith, L. K., Care provision during termination of pregnancy following diagnosis of a severe congenital anomaly - A qualitative study of what is important to parents, Midwifery, 43, 14-20, 2016	Experience of abortion - no themes about access
MacFarlane, K. A., O'Neil, M. L., Tekdemir, D., Cetin, E., Bilgen, B., Foster, A. M., Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey, Reproductive Health Matters, 24, 62-70, 2016	Not applicable to UK practice because it addresses difficulties in services securing funding
Mark, A., Zulu, N., Ujah, O., High-quality abortion care for young women: Evidence, partnerships and preparing the next generation, International Journal of Gynecology and Obstetrics, 5), E33, 2015	Conference abstract - insufficient information
Mauri, P. A., Squillace, F., The experience of Italian nurses and midwives in the termination of pregnancy: a qualitative study, European Journal of Contraception and Reproductive Health Care, 22, 227-232, 2017	Experience of providing abortions - no themes about access
Mayers, P. M., Parkes, B., Green, B., Turner, J., Experiences of registered midwives assisting with termination of pregnancies at a tertiary level	Experience of providing abortions - no themes about access

Study	Reason for Exclusion
hospital, Health SA Gesondheid, 10, 15-25, 2005	
McLemore, M. R., Desai, S., Freedman, L., James, E. A., Taylor, D., Women Know Best-Findings from a Thematic Analysis of 5,214 Surveys of Abortion Care Experience, Women's Health Issues, 24, 594-599, 2014	Experience of abortion - no themes about access
Mercier, R. J., Buchbinder, M., Bryant, A., Britton, L., The experiences and adaptations of abortion providers practicing under a new TRAP law: A qualitative study, Contraception, 91, 507-512, 2015	Experience of a restrictive law change - not relevant to the UK setting
Moayedi, G., Davis, C., Insights in Public Health: Equitable Access to Abortion Care in Hawai'i: Identifying Gaps and Solutions, Hawai'i Journal of Medicine & Public Health : A Journal of Asia Pacific Medicine & Public HealthHawaii J Med Public Health, 77, 169-172, 2018	Commentary
Nicholson, Jackie, Slade, Pauline, Fletcher, Joanne, Termination of pregnancy services: Experiences of gynaecological nurses, Journal of Advanced Nursing, 66, 2245-2256, 2010	Experience of providing abortions - no themes about access
Norman, W. V., Dickens, B. M., Abortion by telemedicine: an equitable option for Irish women, Bmj-British Medical Journal, 357, 2017	Editorial
Norman, W. V., Munro, S., Devane, C., Dunn, S., Guilbert, E., Wagner, M. S., Soon, J., Renner, R., Brooks, M., Costescu, D., Waddington, A., Kaczorowski, J., Davies, C., Kendall, T., Research integrated with policy makers: Real-time health policy and service improvements during 'CART-mifepristone implementation research', Canada, European Journal of Contraception and Reproductive Health Care, 23 (Supplement 1), 40-41, 2018	Conference abstract - insufficient information reported
Norman, W. V., Soon, J. A., Maughn, N., Dressler, J., Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS), PLoS ONE, 8 (6) (no pagination), 2013	Non-qualitative study
Olavarrieta, C. D., Garcia, S. G., Arangure, A., Cravioto, V., Villalobos, A., AbiSamra, R., Rochat, R., Becker, D., Women's experiences of and perspectives on abortion at public facilities in Mexico City three years following decriminalization, International Journal of Gynaecology & ObstetricsInt J Gynaecol Obstet, 118 Suppl 1, S15-20, 2012	Experience of abortion - no themes about access
Otero-Garcia, L., Goicolea, I., Gea-Sanchez, M., Sanz-Barbero, B., Access to and use of sexual and reproductive health services provided by	Experience of providing sexual and reproductive health services to immigrant women - no themes about access to abortions

Study	Reason for Exclusion
midwives among rural immigrant women in Spain: midwives' perspectives, Global health action, 6, 22645, 2013	
Parry, S., Bravo, E., Use of misoprostol in the management of second-semester inevitable abortion, Rev. Chil. Obstet. Ginecol, 66, 472â479, 2001	Non-English language article
Patev, A. J., Hood, K. B., PREDICTING WOMEN'S REPRODUCTIVE CARE ACCESS UNDER THE CURRENT POLITICAL ADMINISTRATION: THE ROLE OF ABORTION MISINFORMATION, Annals of Behavioral Medicine, 52, S516-S516, 2018	Conference abstract - insufficient information reported
Perrin, E., Berthoud, M., Pott, M., Vera, A. G. T., Bianchi-Demicheli, F., Views of healthcare professionals dealing with legal termination of pregnancy up to 12 WA in French-speaking Switzerland, Swiss Medical Weekly, 142, 2012	Experience of providing abortions - no themes about access
Poddar,A., Tyagi,J., Hawkins,E., Opemuyi,I., Standards of care provided by Early Pregnancy Assessment Units (EPAU): A UK-wide survey, Journal of Obstetrics & Gynaecology,J Obstet Gynaecol, 31, 640-644, 2011	Non-qualitative study
Prine, L., Lesnewski, R., Bregman, R., Integrating medical abortion into a residency practice, Family Medicine, 35, 469-471, 2003	Non-qualitative study
Purcell, C., Cameron, S., Lawton, J., Glasier, A., Harden, J., Self-management of first trimester medical termination of pregnancy: a qualitative study of women's experiences, BJOG: An International Journal of Obstetrics and Gynaecology, 124, 2001-2008, 2017	Experience of abortion - no themes about access
Purcell, C., Cameron, S., Lawton, J., Glasier, A., Harden, J., The changing body work of abortion: a qualitative study of the experiences of health professionals, Sociology of health & illness, 39, 78-94, 2017	Experience of providing abortions - no themes about access
Raymond, E. G., Chong, E., Hyland, P., Increasing Access to Abortion With Telemedicine, JAMA Internal MedicineJAMA Intern Med, 176, 585-6, 2016	Personal opinion
Rowlands, S., Lopez-Arregui, E., Expert Grp, Abortion, European Soc Contraception, Reprod, How health services can improve access to abortion, European Journal of Contraception and Reproductive Health Care, 21, 1-3, 2016	Editorial
Senderowicz, L., Sanhueza, P., Langer, A., Socioeconomic status and abortion tourism in Mexico City: implications for equity, Contraception, 93, 472-472, 2016	Non-qualitative study

Study	Reason for Exclusion
Shah, I. H., Weinberger, M. B., Expanding access to medical abortion: Perspectives of women and providers in developing countries, International Journal of Gynecology and Obstetrics, 118, S1-S3, 2012	Editorial
Sheinfeld, L., Arnot, G., El-Haddad, J., Foster, A. M., Assessing abortion coverage in nurse practitioner programs in Canada: a national survey of program directors, Contraception, 94, 483-488, 2016	Assessing coverage of abortion in nurse education
Simmonds, Katherine Elisabeth, Nurse Practitioners' and Certified Nurse Midwives' Experiences Providing Comprehensive Early Abortion Care in New England, Nurse Practitioners' & Certified Nurse Midwives' Experiences Providing Comprehensive Early Abortion Care In New England, 1-1, 2018	Dissertation
Simmons, Megan K., Examining the impact of social ecological factors on women's pregnancy and parenting decision-making, Dissertation Abstracts International: Section B: The Sciences and Engineering, 79, No Pagination Specified, 2018	Abstract only - insufficient information reported
Thomas, A., Inmate access to elective abortion: social policy, medicine and the law, Health matrix (Cleveland, Ohio : 1991), 19, 539-569, 2009	Commentary
Turk, J. K., Steinauer, J. E., Landy, U., Kerns, J. L., Barriers to D&E practice among family planning subspecialists, Contraception, 88, 561-567, 2013	Non-qualitative study
Upadhyay, U. D., Weitz, T. A., Jones, R. K., Barar, R. E., Foster, D. G., Denial of abortion because of provider gestational age limits in the United States, American journal of public health, 104, 1687-1694, 2014	Non-qualitative study
van Dijk, M. G., Arellano Mendoza, L. J., Arangure Peraza, A. G., Toriz Prado, A. A., Krumholz, A., Yam, E. A., Women's experiences with legal abortion in Mexico City: a qualitative study, Studies in Family Planning, 42, 167-74, 2011	Experience of abortion - no themes about access
Waddington, A., Hahn, P. M., Reid, R., Determinants of Late Presentation for Induced Abortion Care, Journal of Obstetrics and Gynaecology Canada, 37, 40-45, 2015	Non-qualitative study
Wainwright, M., Colvin, C. J., Swartz, A., Leon, N., Self-management of medical abortion: a qualitative evidence synthesis, Reproductive Health MattersReprod Health Matters, 24, 155-67, 2016	Includes studies from non-OECD countries which are not included in the protocol for this review question.

Study	Reason for Exclusion
Wear, D., From pragmatism to politics: A qualitative study of abortion providers, Women and Health, 36, 103-113, 2002	Experience of providing abortions - no themes about access
Weitz, T. A., Fogel, S. B., The Denial of Abortion Care Information, Referrals, and Services Undermines Quality Care for U.S. Women, Women's Health Issues, 20, 7-11, 2010	Commentary
Welsh, P., McCarthy, M., Cromer, B., Abortion in adolescence: A four-country comparison, Women's Health Issues, 11, 73-79, 2001	None of the identified themes were relevant to the UK setting
Zurek, M., O'Donnell, J., Hart, R., Rogow, D., Referral-making in the current landscape of abortion access, Contraception, 91, 1-5, 2015	Commentary

OECD: Organisation for Economic Co-operation and Development; PICO: population intervention comparison and outcomes

Economic studies

No economic evidence was identified for this review. See supplementary material 2 for further information.

Excluded studies for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

Clinical studies

Study	Reason for Exclusion
Afable-Munsuz, A., Gould, H., Stewart, F., Phillips, K. A., Van Bebber, S. L., Moore, C., Provider practice models for and costs of delivering medication abortion - evidence from 11 US abortion care settings, Contraception, 75, 45-51, 2007	Insufficient presentation of results
Ahmed, W., Public health implications of #ShoutYourAbortion, Public HealthPublic Health, 163, 35-41, 2018	Outcomes not in PICO: expression of abortion views on social media
Ali Jawaid, S., Proceedings of an advance course in obstetrics and gynaecology, Pakistan Journal of Medical Sciences, 17, 177-188, 2001	Overview of an obstetrics and gynaecology course
Alvey, J., Bryant, A. G., Curtis, S., Speizer, I. S., Morgan, S. P., Tippett, R., Hodgkinson, J. C., Perreira, K., Trends in Abortion Incidence and Availability in North Carolina, 1980-2013, Southern Medical Journal, 110, 714-721, 2017	Non-comparative study: trends in abortion rates over time
Anonymous,, The independence of private versus public abortion providers: Implications for abortion stigma, Journal of Family Planning and Reproductive Health Care, 38, 262-263, 2012	Personal opinion piece
Argent, V., Pavey, L., Can nurses legally perform surgical induced abortion?, Journal of Family Planning & Reproductive Health CareJ Fam Plann Reprod Health Care, 33, 79-82, 2007	Review of abortion laws
Astbury-Ward, E., Abortion 'on the NHS': The National Health Service and abortion stigma, Journal of Family Planning and Reproductive Health Care, 41, 168-169, 2015	Personal opinion piece

Study	Reason for Exclusion
Barnard, S., Kim, C., Park, M. H., Ngo, T. D., Doctors or mid-level providers for abortion, Cochrane Database of Systematic Reviews, 2015	Outcomes not in PICO: complication rates
Baum, S., White, K., Hopkins, K., Potter, J., Grossman, D., Rapid response to evaluate policy: Assessing changes in medical abortion using real-time data-collection from Texas abortion providers, Contraception, 98, 339-340, 2018	Conference abstract - insufficient information reported
Bennett, I., Johnson, M., Wu, J. P., Kalkstein, K., Wolff, E., Bellamy, S., Fleischman, J., A family medicine training collaborative in early abortion, Family medicine, 39, 164-6, 2007	Outcomes not in PICO: knowledge of and attitudes to abortion
Berer,M., Provision of abortion by mid-level providers: international policy, practice and perspectives, Bulletin of the World Health Organization, 87, 58-63, 2009	Narrative review
Billings, D. L., Moreno, C., Ramos, C., Gonzalez de Leon, D., Ramirez, R., Villasenor Martinez, L., Rivera Diaz, M., Constructing access to legal abortion services in Mexico City, Reproductive Health Matters, 10, 86-94, 2002	Setting not in PICO: Mexico city prior to legalisation of elective abortion
Bloomer, F. K., O'Dowd, K., Macleod, C., Breaking the silence on abortion: the role of adult community abortion education in fostering resistance to norms, Culture, Health & Sexuality, 19, 709-722, 2017	Qualitative study
Boetzkes, E., Robert, D., Swanson, C., Secrecy, integrity, agency: nurses and genetic terminations, The Journal of clinical ethics, 13, 124-130, 2002	Commentary
Caird, L., Cameron, S. T., Hough, T., Mackay, L., Glasier, A., Initiatives to close the gap in inequalities in abortion provision in a remote and rural UK setting, Journal of Family Planning and Reproductive Health Care, 42, 68-70, 2016	Non-comparative study: outcomes following changes made to 1 service
Carvajal, D. N., Khanna, N., Williams, M., Gold, M., Systems Change Enhances Access to Family Planning Training and Care Delivery, Family Medicine, 48, 642-644, 2016	Before and after study with less than 40 women
Chamberlain-Webber, J., Tackling the sexual health crisis head on, Professional nurse (London, England), 20, 10-15, 2005	News article
Chong, Y. S., Mattar, C. N., Mid-level providers: a safe solution for unsafe abortion, Lancet, 368, 1939-1940, 2006	Commentary
Clark, W. H., Gold, M., Grossman, D., Winikoff, B., Can mifepristone medical abortion be simplified? A review of the evidence and questions for future research, Contraception, 75, 245-250, 2007	Narrative review
Coeytaux, F., Moore, K., Gelberg, L., Convincing new providers to offer medical abortion: What will it take?, Perspectives on Sexual and Reproductive Health, 35, 44-47, 2003	Qualitative study
Colman, S., Joyce, T., Regulating Abortion: Impact on Patients and Providers in Texas, Journal of Policy Analysis and Management, 30, 775-797, 2011	Intervention and outcomes not in PICO: trends in abortion rates following implementation of Woman's Right to Know Act in Texas
Dalton, V. K., Xu, X., Mullan, P., Danso, K. A., Kwawukume, Y., Gyan, K., Johnson, T. R. B., International family planning	Setting not in PICO: Non-OECD country

Study	Reason for Exclusion
fellowship program: Advanced training in family planning to reduce unsafe abortion, International Perspectives on Sexual and Reproductive Health, 39, 42-46, 2013	
Dawson, A., Bateson, D., Estoesta, J., Sullivan, E., Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia, BMC Health Services Research, 16, 612, 2016	Includes non-comparative studies, qualitative studies and comparisons not in PICO
De Costa, C. M., We "never" train women in Sydney, Medical Journal of Australia, 193, 674-678, 2010	Autobiographical account
Eastwood, K. L., Kacmar, J. E., Steinauer, J., Weitzen, S., Boardman, L. A., Abortion training in United States obstetrics and gynecology residency programs, Obstetrics and Gynecology, 108, 303-308, 2006	Outcomes not in PICO: description of training programs and number of abortions completed as part of training
Edwards, T. M., How med students put abortion back in the classroom, Time, 157, 59-60, 2001	Magazine article
Elliott, L., Henderson, M., Nixon, C., Wight, D., Has untargeted sexual health promotion for young people reached its limit? A quasi-experimental study, Journal of Epidemiology and Community Health, 67, 398-404, 2013	Outcomes not in PICO: sexual health knowledge, attitudes and behaviour
Fey, C. M., Evans, C. M., Raising interest in Contraception and Sexual Health: Special Study Modules for medical students, Journal of Family Planning and Reproductive Health Care, 34, 64-65, 2008	Personal account of special study module in contraception and sexual health
Fischer, R. L., Schaeffer, K., Hunter, R. L., Attitudes of obstetrics and gynecology residents toward abortion participation: A Philadelphia area survey, Contraception, 72, 200-205, 2005	Results not presented separately for different training models
Foster, A. M., Van Dis, J., Steinauer, J., Educational and Legislative Initiatives Affecting Residency Training in Abortion, Journal of the American Medical Association, 290, 1777-1778, 2003	Narrative review
Frank, J. E., Conscientious refusal in family medicine residency training, Family medicine, 43, 330-333, 2011	Non-comparative study: survey of conscientious objection among family medicine residents
Ganatra, B., Health worker roles in safe abortion care and post-abortion contraception, The Lancet Global HealthLancet Glob Health, 3, e512-3, 2015	Commentary
Gleeson, R., Forde, E., Bates, E., Powell, S., Eadon-Jones, E., Draper, H., Medical students' attitudes towards abortion: A UK study, Journal of Medical Ethics, 34, 783-787, 2008	Non-comparative study: survey of attitudes toward abortion among medical students from one medical school
Goldman,M.B., Occhiuto,J.S., Peterson,L.E., Zapka,J.G., Palmer,R.H., Physician assistants as providers of surgically induced abortion services, American Journal of Public Health, 94, 1352-1357, 2004	Outcomes not in PICO: complication rates
Goodman, S., Shih, G., Hawkins, M., Feierabend, S., Lossy, P., Waxman, N. J., Gold, M., Dehlendorf, C., A long-term evaluation of a required reproductive health training rotation with opt-out	Comparison not in PICO: full training participants versus opt-out participants

Study	Reason for Exclusion
provisions for family medicine residents, Family medicine, 45, 180-6, 2013	
Grossman, D. A., Grindlay, K., Buchacker, T., Potter, J. E., Schmertmann, C. P., Changes in service delivery patterns after introduction of telemedicine provision of medical abortion in Iowa, American Journal of Public Health, 103, 73-78, 2013	Outcomes not in PICO: abortion trends and distance travelled
Grossman, D., Grindlay, K., Safety of Medical Abortion Provided Through Telemedicine Compared With In Person, Obstetrics & GynecologyObstet Gynecol, 130, 778-782, 2017	Outcomes not in PICO: complication rates
Jackson, C. B., Expanding the pool of abortion providers: nurse-midwives, nurse practitioners, and physician assistants, Women's health issues : official publication of the Jacobs Institute of Women's Health, 21, S42-43, 2011	Commentary
Jackson, C. B., Foster, A. M., Ob/Gyn training in abortion care: Results from a national survey, Contraception, 86, 407-412, 2012	Outcomes not in PICO: description of training received
Janiak, E., Freeman, S., Maurer, R., Berkman, L. F., Goldberg, A. B., Bartz, D., Relationship of job role and clinic type to perceived stigma and occupational stress among abortion workers, Contraception, 24, 24, 2018	Insufficient presentation of results
Kaller, S., Raifman, S., Grossman, D., Women's experiences with telemedicine for preabortion informed consent visits in Utah, Contraception, 98, 339-339, 2018	Conference abstract - insufficient information reported
Kavanagh, A., Aiken, A. R. A., The language of abortion: time to terminate TOP FOR: Mandating TOP reduces research visibility and engenders stigma, 125, 1065-1065, 2018	Published debate
Koyama, A., Williams, R., Abortion in medical school curricula, McGill Journal of Medicine, 8, 157-160, 2005	Commentary
Kramlich, M., Coercing conscience: the effort to mandate abortion as a standard of care, The national Catholic bioethics quarterly, 4, 29-40, 2004	Commentary
Krishnan, S., Dalvie, S., From unwanted pregnancy to safe abortion: Sharing information about abortion in Asia through animation, Reproductive Health Matters, 23, 126-135, 2015	Non-comparative study: development and dissemination of animated film about abortion
Lathrop, E., Rochat, R., The GEMMA Seminar: a graduate public health course on global elimination of maternal mortality from abortion, Contraception, 87, 6-10, 2013	Commentary
Latkovic, M. S., Pro-life nurses and cooperation in abortion: ordinary care or extraordinary intervention?, The national Catholic bioethics quarterly, 4, 89-102, 2004	Commentary
Lee, D. J., Family planning training for the primary care team: Reversing the trends of 'sexual-ill health', British Journal of General Practice, 54, 152-153, 2004	Commentary
Lee, E., Ingham, R., Why do women present late for induced abortion?, Best Practice and Research: Clinical Obstetrics and Gynaecology, 24, 479-489, 2010	Narrative review
Levi, A., Goodman, S., Weitz, T., AbiSamra, R., Nobel, K., Desai, S., Battistelli, M., Taylor, D., Training in aspiration abortion care: An observational cohort study of achieving procedural	Outcomes not in PICO: complication rates and learning process

Study	Reason for Exclusion
competence, International Journal of Nursing StudiesInt J Nurs Stud, 88, 53-59, 2018	
Liauw, J., Dineley, B., Gerster, K., Hill, N., Costescu, D., Abortion training in Canadian obstetrics and gynecology residency programs, Contraception, 94, 478-482, 2016	Outcomes not in PICO: description of training received
Logsdon, M. B., Handler, A., Godfrey, E. M., Women's preferences for the location of abortion services: a pilot study in two Chicago clinics, Maternal and Child Health Journal, 16, 212-216, 2012	Comparison not in PICO: primary care services versus specialist abortion clinic
Lydon-Rochelle, M. T., Minimal intervention - Nurse-midwives in the United States, New England Journal of Medicine, 351, 1929-1931, 2004	Personal perspective: no mention of abortion
Macisaac, L., Vickery, Z., Routine training is not enough: structured training in family planning and abortion improves residents' competency scores and intentions to provide abortion after graduation more than ad hoc training, Contraception, 85, 294-8, 2012	Comparison not in PICO: structured routine training versus ad hoc routine training
Mahood, S., Liskowich, S., Clark, M., Abortion training at the University of Saskatchewan highly sought after, Canadian Family Physician, 64, 713-713, 2018	Letter
Martin, L. A., Debbink, M., Hassinger, J., Youatt, E., Harris, L. H., Abortion providers, stigma and professional quality of life, Contraception, 90, 581-587, 2014	Insufficient presentation of results
Martin, L. A., Hassinger, J. A., Seewald, M., Harris, L. H., Evaluation of Abortion Stigma in the Workforce: Development of the Revised Abortion Providers Stigma Scale, Women's Health Issues, 28, 59-67, 2018	Outcomes not in PICO: scale development
Mizuno, M., Kinefuchi, E., Kimura, R., Tsuda, A., Professional quality of life of Japanese nurses/midwives providing abortion/childbirth care, Nursing EthicsNurs Ethics, 20, 539-550, 2013	Non-comparative study: cross sectional survey of professional quality of life
Moreau, C., Bajos, N., Bouyer, J., Cocon, Group, Access to health care for induced abortions: analysis by means of a French national survey, European Journal of Public Health, 14, 369-74, 2004	Comparison not in PICO: first health provider contacted (self-referral not included)
Myran, D. T., Bardsley, J., El Hindi, T., Whitehead, K., Abortion education in Canadian family medicine residency programs, BMC Medical EducationBMC Med Educ, 18, 121, 2018	Comparisons not in PICO: formal versus informal education and exposure to abortions
Myran, D. T., Carew, C. L., Tang, J., Whyte, H., Fisher, W. A., Medical Students' Intentions to Seek Abortion Training and to Provide Abortion Services in Future Practice, Journal of Obstetrics and Gynaecology Canada, 37, 236-244, 2015	Non-comparative study: survey of medical students intentions to train in and provide abortion services
Myran, D., Bardsley, J., Abortion remains absent from family medicine training in Canada, Canadian Family Physician, 64, 618-619, 2018	Commentary
Nieminen, P., Lappalainen, S., Ristimaki, P., Myllykangas, M., Mustonen, A. M., Opinions on conscientious objection to induced	Outcomes not in PICO: views on conscientious objection

Study	Reason for Exclusion
abortion among Finnish medical and nursing students and professionals, BMC medical ethics, 16, 17, 2015	
Norman, W. V., Hestrin, B., Dueck, R., Access to Complex Abortion Care Service and Planning Improved through a Toll-Free Telephone Resource Line, Obstetrics & Gynecology InternationalObstet Gynecol Int, 2014, 913241, 2014	Non-comparative study: development and implementation of centralised referral system (no data presented from before system was introduced)
Norman, W. V., Soon, J. A., Maughn, N., Dressler, J., Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS), PLoS ONE, 8 (6) (no pagination), 2013	Outcomes not in PICO: description of available services and barriers to delivering services
Nothnagle, M., Benefits of a learner-centred abortion curriculum for family medicine residents, Journal of Family Planning and Reproductive Health Care, 34, 107-110, 2008	Outcomes not in PICO: knowledge and skills pre- and post-participation in abortion curriculum
O'Donnell, J., Holt, K., Nobel, K., Zurek, M., Evaluation of a Training for Health and Social Service Providers on Abortion Referral-Making, Maternal & Child Health JournalMatern Child Health J, 06, 06, 2018	Comparison not in PICO: before and after study of training program on referral for abortion
Pace, L., Sandahl, Y., Backus, L., Silveira, M., Steinauer, J., Medical Students for Choice's Reproductive Health Externships: impact on medical students' knowledge, attitudes and intention to provide abortions, Contraception, 78, 31-35, 2008	Comparison not in PICO: before and after study of participation in a reproductive health externship
Patil, E., Darney, B., Orme-Evans, K., Beckley, E. H., Bergander, L., Nichols, M., Bednarek, P. H., Aspiration Abortion With Immediate Intrauterine Device Insertion: Comparing Outcomes of Advanced Practice Clinicians and Physicians, Journal of Midwifery & Women's HealthJ Midwifery Womens Health, 61, 325-30, 2016	Outcomes not in PICO: complication rates and IUD continuation
Paul, M., Nobel, K., Goodman, S., Lossy, P., Moschella, J. E., Hammer, H., Abortion training in three family medicine programs: resident and patient outcomes, Family medicine, 39, 184-9, 2007	Insufficient presentation of results: no comparison of intention to provide abortion services before and after integration of routine abortion training. (No other outcomes of interest reported)
Perrot, Chantal, Continued lack of abortion training is disheartening, Canadian Family Physician, 64, 792-793, 2018	Letter
Petersen, L. R., Religion, plausibility structures, and education's effect on attitudes toward elective abortion, Journal for the Scientific Study of ReligionJ. Sci. Stud. Relig., 40, 187-203, 2001	Non-comparative study among general population: survey investigate effect of religion and education level on attitudes towards elective abortion
Phillips, S., Swift, S., Therapeutic abortion counseling and provision: Are Canadian family physicians opting out?, Canadian Family Physician, 62, 297-8, e169-70, 2016	Commentary
Prine, L., Lesnewski, R., Bregman, R., Integrating medical abortion into a residency practice, Family Medicine, 35, 469-471, 2003	Outcomes not in PICO: description of workshop

Study	Reason for Exclusion
	participation and barriers to delivering abortion services
Ramashwar, S., Digests. Nurses in Mexico Provide Safe, Successful Medication Abortions, International Perspectives on Sexual & Reproductive Health, 41, 112-112, 2015	Summary of Olavarrieta 2015
Raymond, E. G., Chong, E., Hyland, P., Increasing Access to Abortion With Telemedicine, JAMA Internal MedicineJAMA Intern Med, 176, 585-6, 2016	Personal opinion piece
Raymond, E., Kaczorowski, J., Smith, P., Sellors, J., Walsh, A., Medical abortion and family physicians. Survey of residents and practitioners in two Ontario settings, Canadian Family Physician, 48, 538-544, 2002	Comparison not in PICO: urban versus rural setting
Reisman, A. B., Outing the hidden curriculum [10], Hastings Center Report, 36, 9, 2006	Commentary
Renner, R. M., Brahmi, D., Kapp, N., Who can provide effective and safe termination of pregnancy care? A systematic review *, BJOG: An International Journal of Obstetrics and Gynaecology, 120, 23-31, 2013	Outcomes not in PICO: complication rates
Rodriguez-Calvo, M. S., Martinez-Silva, I. M., Soto, J. L., Concheiro, L., Munoz-Barus, J. I., University students' attitudes towards Voluntary Interruption of Pregnancy, Legal Medicine, 14, 209-213, 2012	Non-comparative study: survey of university students attitudes towards voluntary abortion
Romero, D., Maldonado, L., Fuentes, L., Prine, L., Association of reproductive health training on intention to provide services after residency: the family physician resident survey, Family medicine, 47, 22-30, 2015	Non-comparative study: survey of training received and intention to provide abortion services among people who received routine training or opted-in to elective training
Rosenstein, M. G., Turk, J. K., Caughey, A. B., Steinauer, J. E., Kerns, J. L., Dilation and evacuation training in maternal-fetal medicine fellowships, American Journal of Obstetrics and Gynecology, 210, 569.e1-569.e5, 2014	Non-comparative study: survey of training received, how training should be delivered and intention to provide abortion services among maternal-fetal medicine fellows and program directors
Rowlands, S., The development of a nationwide central booking service for abortion, European Journal of Contraception and Reproductive Health Care, 11, 210-214, 2006	Non-comparative study: development and implementation of centralised referral system (no comparison of before and after implementation)
Roy, G., Parvataneni, R., Friedman, B., Eastwood, K., Darney, P. D., Steinauer, J., Abortion training in Canadian obstetrics and gynecology residency programs, Obstetrics and Gynecology, 108, 309-314, 2006	Insufficient presentation of results
Sabourin, J. N., Burnett, M., A review of therapeutic abortions and related areas of concern in Canada, Journal of Obstetrics & Gynaecology Canada: JOGC, 34, 532-42, 2012	Narrative review
Savage, Nola, Gibbons, Helen, THE NURSE ROLE IN MEDICATION ABORTION PROVISION, A SOUTH	Commentary

Study	Reason for Exclusion
AUSTRALIAN EXPERIENCE, Australian Nursing & Midwifery Journal, 25, 33-33, 2017	
Schwarz, E. B., Luetkemeyer, A., Greene, D., Weitz, T., Stewart, F., Lindes, D., Willing and able? Provision of early medical abortion by primary care physicians, Journal of General Internal MedicineJ. Gen. Intern. Med., 18, 305-305, 2003	Abstract: survey
Seelig, M. D., Gelberg, L., Tavrow, P., Lee, M., Rubenstein, L. V., Determinants of physician unwillingness to offer medical abortion using mifepristone, Womens Health Issues, 16, 14-21, 2006	Non-comparative study: survey of physicians not currently providing abortion services but not personally opposed to medical abortions
Seymour, J., Snow, J., Thompson, T. A., Garnsey, C., Kohn, J., Grossman, D., Patient-reported acceptability of receiving medication for abortion via telemedicine at Planned Parenthood health centers in seven states, Contraception, 98, 342-342, 2018	Conference abstract - insufficient information reported
Sharma,S., Guthrie,K., Nurse-led telephone consultation and outpatient local anaesthetic abortion: a pilot project, Journal of Family Planning and Reproductive Health Care, 32, 19-22, 2006	Outcomes not in PICO: description of use of services and staff satisfaction with services
Shotorbani, S., Zimmerman, F. J., Bell, J. F., Ward, D., Assefi, N., Attitudes and Intentions of Future Health Care Providers Toward Abortion Provision, Perspectives on Sexual and Reproductive Health, 36, 58-63, 2004	Non comparative study: survey of health sciences students attitudes to and intention to provide abortion services
Silva,M., McNeill,R., Ashton,T., Factors affecting delays in first trimester pregnancy termination services in New Zealand, Australian and New Zealand journal of public health, 35, 140-145, 2011	Non-comparative study: questionnaire of women attending abortion clinics examining factors affecting delays
Silwal, K., Shrestha, T., Dulal, R. K., Effects of educational intervention among reproductive age group women on safe abortion, Journal of the Nepal Medical Association, 52, 612-618, 2013	Setting not in PICO: Non-OECD country
Simmons, A., Taking the judgement out of abortion, Nursing New Zealand (Wellington, N.Z: 1995). 11, 26-27, 2005	Personal opinion piece
Sisson, G., Kimport, K., After After Tiller: the impact of a documentary film on understandings of third-trimester abortion, Culture, Health & Sexuality, 18, 695-709, 2016	Qualitative study
Sjostrom, S., Dragoman, M., Fonhus, M. S., Ganatra, B., Gemzell-Danielsson, K., Effectiveness, safety, and acceptability of first-trimester medical termination of pregnancy performed by non-doctor providers: a systematic review, BJOG: An International Journal of Obstetrics and Gynaecology, 124, 1928-1940, 2017	Includes non-OECD countries
Sorhaindo, A. M., Morris, J. L., Serah,, SERAH: Supporting Expanded Roles for safe Abortion care by Health workers-A working group to enable the implementation of the WHO guidelines for expanded roles of health workers in safe abortion and postabortion care, International Journal of Gynaecology & ObstetricsInt J Gynaecol Obstet, 134, 1-2, 2016	Commentary and development of a collaborative working group

Study	Reason for Exclusion
Stam, P., Stuart v. Camnitz: Setting the Standard of Care for Abortion Providers In North Carolina, Issues in law & medicine, 32, 133-138, 2017	Review of abortion laws and legal case
Steele, R., Medical students' attitudes to abortion: a comparison between Queen's University Belfast and the University of Oslo, Journal of Medical Ethics, 35, 390-394, 2009	Comparison not in PICO: comparisons of attitudes towards abortion services in Belfast and Oslo
Steinauer, J. E., Hawkins, M., Turk, J. K., Darney, P., Preskill, F., Landy, U., Opting out of abortion training: Benefits of partial participation in a dedicated family planning rotation for ob-gyn residents, Contraception, 87, 88-92, 2013	Comparison not in PICO: residents who fully participated in versus those that opted out of, opt-out abortion training
Steinauer, J. E., Landy, U., Jackson, R. A., Darney, P. D., The effect of training on the provision of elective abortion: A survey of five residency programs, American Journal of Obstetrics and Gynecology, 188, 1161-1163, 2003	Non-comparative study: survey examining correlation between abortion provision and training received (no comparison of opt-in versus opt-out, or routinely integrated versus not training models)
Steinauer, J. E., Turk, J. K., Fulton, M. C., Simonson, K. H., Landy, U., The benefits of family planning training: a 10-year review of the Ryan Residency Training Program, Contraception, 88, 275-80, 2013	Comparison not in PICO: before and after study of routine opt-out abortion training
Steinauer, J. E., Turk, J. K., Pomerantz, T., Simonson, K., Learman, L. A., Landy, U., Abortion training in US obstetrics and gynecology residency programs, American Journal of Obstetrics and Gynecology, 219, 86.e1-86.e6, 2018	Description of available obstetrics and gynaecology residency training programs
Steinauer, J., Darney, P., Auerbach, R. D., Controversies in OB/GYN. Should all residents be trained to do abortions?, Contemporary OB/GYN, 50, 56-60, 2005	Published debate
Steinauer, J., Drey, E. A., Lewis, R., Landy, U., Learman, L. A., Obstetrics and gynecology resident satisfaction with an integrated, comprehensive abortion rotation, Obstetrics and Gynecology, 105, 1335-1340, 2005	Non-comparative study: evaluation of an abortion rotation integrated in an obstetrics and gynaecology residency program
Steinauer, J., Silveira, M., Lewis, R., Preskill, F., Landy, U., Impact of formal family planning residency training on clinical competence in uterine evacuation techniques, Contraception, 76, 372-6, 2007	Comparison not in PICO: before and after study of clinical competence following participation in opt-out family planning training
Steinauer, J., Turk, J., Koenemann, K., Simonson, K., Landy, U., Benefits of required family planning training in the United States, International Journal of Gynecology and Obstetrics, 143 (Supplement 3), 468-469, 2018	Conference abstract - insufficient information reported
Stewart, F. H., Darney, P. D., Abortion: teaching why as well as how, Perspectives on Sexual & Reproductive HealthPerspect Sex Reprod Health, 35, 37-9, 2003	Commentary
Stulberg, D. B., Monast, K., Dahlquist, I. H., Palmer, K., Provision of abortion and other reproductive health services among former Midwest Access Project trainees, Contraception, 97, 341-345, 2018	Non-comparative study: survey of provision of abortion services among alumni from one training program

Study	Reason for Exclusion
Summit, A. K., Gold, M., The Effects of Abortion Training on Family Medicine Residents' Clinical Experience, Family medicine, 49, 22-27, 2017	Comparison not in PICO: before and after study of experience, attitudes and post-residency intentions to provide abortion services following opt-out training programs
Sundari Ravindran, T. K., Fonn, S., Are social franchises contributing to universal access to reproductive health services in low-income countries?, Reproductive Health Matters, 19, 85-101, 2011	Setting not in PICO: non-OECD countries
Taylor, D., Hwang, A. C., Mifepristone for medical abortion. Exploring a new option for nurse practitioners, AWHONN LifelinesAwhonn Lifelines, 7, 524-9, 2003	Commentary and narrative review
Tocce, K., Sheeder, J., Vontver, L., Failure to achieve the association of professors in gynecology and obstetrics objectives for abortion in third-year medical student curriculum, Journal of Reproductive Medicine for the Obstetrician and Gynecologist, 56, 474-478, 2011	Comparison not in PICO: before and after study of knowledge and experience following abortion training at 1 medical school
Turk, J. K., Preskill, F., Landy, U., Rocca, C. H., Steinauer, J. E., Availability and characteristics of abortion training in US ob-gyn residency programs: A national survey, Contraception, 89, 271-277, 2014	Outcomes not in PICO: description of training received
Turk, J., Simonson, K., Landy, U., Steinauer, J., Restrictions affecting abortion training in obstetrics and gynecology residency programs, Contraception, 98, 372-373, 2018	Conference abstract - insufficient information reported
Turner, K. L., Pearson, E., George, A., Andersen, K. L., Values clarification workshops to improve abortion knowledge, attitudes and intentions: A pre-post assessment in 12 countries, Reproductive Health, 15 (1) (no pagination), 2018	Setting not in PICO: non-OECD countries (results not reported separately for OECD countries if included)
Waterman, E., Bednarek, P., Baldwin, M., Provider assessment of complete surgical abortion at very early gestations, Contraception, 98, 339-339, 2018	Assessment of completeness of very early surgical abortion
Weitz, T. A., Taylor, D., Desai, S., Upadhyay, U. D., Waldman, J., Battistelli, M. F., Drey, E. A., Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver, American Journal of Public Health, 103, 454-461, 2013	Outcomes not in PICO: complication rates
Wiebe, E. R., Use of telemedicine for providing medical abortion, International Journal of Gynaecology & ObstetricsInt J Gynaecol Obstet, 124, 177-8, 2014	Non-comparative study: feasibility of telemedicine
Wilkinson, P., French, R., Kane, R., Lachowycz, K., Stephenson, J., Grundy, C., Jacklin, P., Kingori, P., Stevens, M., Wellings, K., Teenage conceptions, abortions, and births in England, 1994-2003, and the national teenage pregnancy strategy, Lancet, 368, 1879-86, 2006	Outcomes not in PICO: conception, abortion and birth trends
Williams, M. T., Bonner, L., Sex education attitudes and outcomes among North American women, Adolescence, 41, 1-14, 2006	Outcomes not in PICO: satisfaction with sexual education received, rates of unplanned pregnancy and abortions

Study	Reason for Exclusion
Williams, S. G., Roberts, S., Kerns, J. L., Effects of Legislation Regulating Abortion in Arizona, Womens Health Issues, 06, 06, 2018	Outcomes not in PICO: abortion trends
Wu,J.P., Bennett,I., Levine,J.P., Aguirre,A.C., Bellamy,S., Fleischman,J., The effect of a simple educational intervention on interest in early abortion training among family medicine residents, Contraception, 73, 613-617, 2006	Comparison not in PICO: before and after study of interest in and support for abortion training following an educational lecture
Yanikkerem, E., Ertem, G., Ustgorul, S., Karakus, A., Baydar, O., Esmeray, N., Turkish nursing students' attitudes towards voluntary induced abortion, Journal of the Pakistan Medical Association, 68, 410-416, 2018	Non-comparative study: survey of nursing students attitudes towards abortion
Zurek, M., O'Donnell, J., Hart, R., Rogow, D., Referral-making in the current landscape of abortion access, Contraception, 91, 1-5, 2015	Commentary

IUD: intrauterine device; OECD: Organisation for Economic Co-operation and Development; PICO: population, intervention, comparison, outcome

Economic studies

No economic evidence was identified for this review.

Appendix L – Research recommendations

Research recommendations for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

No research recommendations were made for this review.

Research recommendations for review question: What strategies improve the factors that help or hinder the accessibility and sustainability of a safe abortion service?

No research recommendations were made for this review.

Appendix M – Qualitative quotes

Qualitative quotes for review question: What factors help or hinder the accessibility and sustainability of a safe abortion service?

Table 13: Theme 1: Service-level barriers

Study	Evidence
Sub-theme 1.1: Long waiting times and delays	
Aiken 2018b	"..experiencing delays in accessing services, including waiting times of several weeks. Amelia, a 34-year-old woman living in England explained: 'I've been in touch with my doctor and have been referred but they can't see me for nearly three weeks. I cannot wait that long. I have nine children who need me and every day is feeling like torture at the minute. My marriage has ended and I cannot physically face another child on my own. I just want to get on with my life and raising the children I do have and who need me now.'" page 179
Cano 2016	"Another participant waited over a month to get her ultrasound after her family doctor appointment. She suspects that the ultrasound department intentionally delayed her procedure; she was nearing the 12-week gestational age limit by the time her family doctor received the ultrasound results and was immediately scheduled for the next procedure date in-territory." page 492
Doran 2016	"Women's experiences of the GP process varied from being easy and supported (one participant) to very challenging. Challenges related to delays in seeing a rural GP, lack of willingness of GPs to refer" page 4
Doran 2016	"delays caused by the need for blood tests or ultrasounds" page 4
Dressler 2013	"Several physicians indicated feeling overwhelmed by their inability to meet local requirements for abortion service in a timely manner due to facility restrictions. Some noted waiting lists in excess of five weeks from first contact until the procedure could be performed." page 3
Hulme-Chambers 2018	"Almost all women said they were able to obtain an appointment with the clinic within a week. No one felt this was too long to wait." page 25
Kruss 2014	"Financial and geographical barriers were frequently cited by participants... For rural women seeking a termination, costs can include the procedure itself, transportation and accommodation, calling metropolitan services for appointments, child care and loss of wages. Geographical barriers referred to limited rural services, waiting lists and less opportunity to see a female doctor, as well as the strain of leaving support systems behind when travelling to Melbourne." page 302
Kumar 2004	"Some women complained about the difficulty in getting urgent appointments with their GPs. 'The problem with the surgery is they no longer have a walk in, which I don't quite understand why that's happened because even though it's not a total emergency, it is. What do you take as an emergency?'" page 53
Margo 2016	"Some women noted that their appointments at two clinics were delayed because of unexpected scheduling challenges. For example, one clinic introduced an electronic medical record system and scheduled fewer patients during the transition period. One participant reported that her appointment was postponed as a result of physician scheduling problems. Such delays could be caused by situations that commonly occur in many medical settings, but they highlight the precarious nature of abortion access in states with few providers." page 203

Study	Evidence
Purcell 2014	"Once women requested an abortion and were referred to specialist services, delays were uncommon, and most participants were satisfied in this respect... Natalie—who was 22 and eventually had an abortion in England at 21 weeks—experienced both personal and service-related problems that caused her to pass the local gestational limit:'[The general practitioner] booked me in, and I went to a clinic, and then it just took so long. I found out when I was 13 weeks, and it took three weeks for me to get an appointment [for abortion]. So, that was making me 16 weeks, and then I missed the appointment and thought it was the following week.… I had to go back to the doctor [and wait to be referred] again. And now I'm just back from [England].'" page 105
Sub-theme 1.2: Difficulty navigating the healthcare system	
Cano 2016	"Most women were unaware of what obtaining an abortion would entail and those without a family physician had difficulty navigating where to go and who to contact. As Sofia, a 38-year-old woman who obtained her abortion in 2015, explained, 'So it took me a little bit of searching around, you know, I called different people, different places, and eventually I got in touch with the sexual clinic.' Even for participants that did have a family doctor, some reported difficulty getting an appointment in a timely manner or receiving inadequate information about the overarching process. Alyssa, a 26-year-old woman who obtained her abortion in 2012, described her uncertainty, 'Yeah they don't really lay it out clearly, like what's gonna happen, like you have no idea.'" page 491
Cano 2016	"'So if they could somehow even just bundle those appointments? Like so that they're all on the same day…and make them more like just convenient.' (Heather, 29) When asked how services could be improved, participants made suggestions to streamline the service and decrease the wait times." page 493
Doran 2016	"lack of information provided about the procedure or the clinic, lack of information about medical abortion and the required follow-up visit" page 4
Doran 2016	"Different models including more integrated women's health care were suggested. Moira's idea was a 'one-stop shop where women could go for help to get pregnant or if they want to end their pregnancy', which could also potentially increase privacy and deter protestors. Fern proposed that abortion services needed to be 'part of proper women's health care: it still needs to be dragged out of the back alley'". page 7
Jerman 2017	"Lack of information, resources or referrals, including lack of transparency" page 17
Jerman 2017	"Need to make multiple visits to the procedure clinic" page 17
Jerman 2017	"Encountering crisis pregnancy centers that delayed abortion care" page 17
Kumar 2004	"Further difficulties faced by women who had recently moved into the area included not being registered with a GP, difficulties finding a GP, and lack of awareness about alternative routes for referral. 'When I arrived here I went to the hospital emergency and he gave me a paper with a number. He said I need a doctor. When I called it was not possible in the area because all are full.'" page 53
Kung 2018	"Key informants largely echoed the view that poor dissemination of information is not a barrier to abortion access under the health exception in Britain. Only one respondent acknowledged minor difficulties in getting information to specific communities: "I think there is always going to be hard to reach communities and maybe the women in some ethnic communities, recent immigrants, women who don't have good English, there are probably problems of information"" page 8

Study	Evidence
Say 2005	"...directly linking family planning services to abortion clinics was considered to have improved access to appointments. Such developments were dependent upon an 'organisational commitment', in particular the prioritisation of dedicated resources by health boards" page 22
White 2016	"About one half turned to the Internet to find a clinic and others talked to women in their social networks who previously had abortions. Approximately one-half of those who used these strategies commented that finding a clinic was easy because 'the place just popped up' when they searched online or they were referred through an organizational website... Seven women found multiple clinics in their online searches, three of which did not identify the nearest facility. Additionally, six women stated that finding a clinic was difficult and confusing, and a 28-year-old woman who lived almost 80 miles away from the clinic where she obtained services said, 'the hardest thing was finding somewhere to go.'" page 300
Sub-theme 1.3: Insufficient resources and hours of operation	
Cano 2016	"Women who accessed care through the new Yukon Sexual Health Clinic identified the need for expanded clinic hours and more providers offering care. As Karen explained, 'So there's one nurse practitioner and [the physician], but that's not enough, like they need other people working and supporting women.'" page 493
Dressler 2013	"Several rural physicians faced logistical challenges when scheduling patients for counselling (occurring at their private practice offices), timely ultrasounds and for procedures... Typically, rural abortion providers are required to fit into their private practice office time the counseling and pre-operative assessment that would be performed by allied health professionals in the interdisciplinary urban abortion clinics. For example, one participant stated, ''You know, at a freestanding [urban] abortion clinic, they have counselors that do a lot of the counseling with the patients. So actually you [one physician] can provide a lot more care to a larger group of women.''" page 3
Hulme 2015	"Respondents advocated for broadening the scope of practice of nurse practitioners, registered nurses and pharmacists to help bypass access barriers to reproductive health services. 'There's no reason I see why nurse practitioners couldn't do medical abortions – we already do IUD insertions and we manage miscarriages within our scope of practice'"(Nurse Practitioner, British Columbia)." page 59
Jerman 2017	"Unavailable appointment times at other clinics (e.g., because of overbooking or excessive demand)" page 17
Kruss 2014	"Financial and geographical barriers were frequently cited by participants... For rural women seeking a termination, costs can include the procedure itself, transportation and accommodation, calling metropolitan services for appointments, child care and loss of wages. Geographical barriers referred to limited rural services, waiting lists and less opportunity to see a female doctor, as well as the strain of leaving support systems behind when travelling to Melbourne." page 302
Kruss 2014	"Participants were invited to consider what could be done to reduce the access barriers they identified. While expanding services was considered essential (e.g. using a visiting model, increasing incentives to train in TOP, reducing the cost of EC), participants acknowledged that this might not always be possible or sufficient and advocated strategies to increase access to metropolitan services (e.g. travel assistance)." page 304

Study	Evidence
Larsson 2016	"Even though all interviewees agreed that foreign-born patients often demand more time, there were no routines or guidelines in the clinics that allowed for extended appointments for this purpose. However, the health care providers had their own means to acquire the time needed through cooperation, by planning or by scheduling patients for return visits: 'I think we, as colleagues, cooperate very well; for example, I know in advance which patient is coming here tomorrow, and then we know, we plan really well. If I have a patient with a professional interpreter, then someone else takes care of all the other patients /…/ You manage by planning in advance, we usually do that.' (Midwife 9)" page 17
Margo 2016	"Participant experience varied regarding appointment scheduling and timing. In two clinics, abortions could be booked only on certain days because of the rotating schedules of doctors. Limited availability made scheduling more difficult and sometimes resulted in delays in care." page 203
White 2016	"Because Clinic A offered services only once a week, women obtaining care at that location also waited more than 48 hours to have their abortion" page 301

GP: general practitioner; IUD: intrauterine device

Table 30: Theme 2: Financial barriers

Study	Evidence
Sub-theme 2.1: Funding for people ineligible for free NHS services	
Aiken 2018b	"Women who are ineligible for free, non-emergency NHS services face particular barriers finding and paying for abortion care on their own. Most commonly, these women are either undocumented immigrants, or have been admitted under a visa program and are thus considered visitors to rather than naturalized ordinary residents of Great Britain. Leila, who is 22 years old and living in England explained 'I completely lack the money for services and I am not a resident of UK. I am completely alone and really need help.'" page 180
Sub-theme 2.2: Patient expenses	
Doran 2016	"Not all women mentioned problems with money but several did. Some women's partners paid the abortion fee, even if they were separated. Some women commented that the abortion cost, whilst expensive in the short term, was not as expensive as raising a child. Many women borrowed money to help with petrol, abortion fees or accommodation... Molly commented that the fee in itself 'wasn't that much but it's all the associated costs' of getting to the clinic." page 5
Hulme 2015	"The cost of travel and accommodation and the cost of therapeutic abortion itself in private abortion clinics were reported as major barriers for Canadian women living outside of urban areas." page 55
Jerman 2017	"Need to raise money for procedure and related costs e.g., travel, logistics" page 17
Kruss 2014	"Financial and geographical barriers were frequently cited by participants... For rural women seeking a termination, costs can include the procedure itself, transportation and accommodation, calling metropolitan services for appointments, child care and loss of wages. Geographical barriers referred to limited rural services, waiting lists and less opportunity to see a female doctor, as well as the strain of leaving support systems behind when travelling to Melbourne." page 302
Ostrach 2014	"…concerns about being able to pay for food and gas during her trip to the clinic and back complicated her travel arrangements." page 1010

Study	Evidence
Purcell 2014	"Women who did travel to England had to mobilize a range of resources, including financial, practical and emotional support, and access to these varied. Travel costs— train tickets or flights and 2–3 nights' accommodation, booked at short notice—were high. The women who travelled were in a range of socioeconomic positions, but none found it easy to obtain such funds, and none was clear on how to claim reimbursement from health services." Page 105
White 2016	"Compared with women obtaining first trimester procedures, the eight women who had second trimester abortions were more often delayed in scheduling the consultation visit because they did not initially recognize their pregnancy or needed additional time to save money or reach a decision about having an abortion... 'money had gotten messed up in between that week and so I had to wait a little bit longer,'" page 301-302
White 2016	"…women obtaining abortions at 15 or more weeks from LMP had extended time away from home to accommodate their need for cervical preparation before the abortion; they also reported extra out-of-pocket expenses, unrelated to the cost of the procedure. Two women having abortions at 16 or more weeks from LMP reported staying overnight in a hotel for their 2-day procedures. One of these women, a 23-year-old mother of three traveling more than 90 miles with her own mother, stated, 'I had to have someone to watch my kids, and I had to get in a hotel down there for a day, because I really could not leave [town]. I could not be too far.'" page 302
Sub-theme 2.3: Lack of financial input to services	
Dressler 2013	"In general, the urban abortion providers faced fewer or no barriers to provision... The challenges that did emerge for some of the urban providers included lack of operating room time for those providing hospital-based services, and increasing restrictions on the basic funding support for the urban purpose-specific clinics (''abortion clinics''). As one urban physician stated: '…not so much that the funding is going to be threatened to the service as a whole but it may be threatened to the organization where I work.'" page 2
Say 2005	"'Those who control spending on health do not see abortion care as a priority.' [I4]" page 22

Table 31: Theme 3: Logistical barriers

Study	Evidence
Sub-theme 3.1: Difficulty arranging time off work	
Aiken 2018b	"Another common barrier was logistical difficulties getting to a clinic due to inability to get time away from work or childcare to attend one or more appointments. Linda, a 31-year-old working mother living in Scotland echoed many others when she explained: 'I am only 2 weeks pregnant, I already have 3 kids and I am a single working mum. I am unable to go to the hospital as I do not have the funds to pay for childcare while I would be in there. I am unable to take time off work and I can't tell my family so there is no one I can ask to look after the kids. I really need to do this in my own home.'" page 180
Jerman 2017	"Making arrangements after appointment was scheduled (e.g., for transportation, accommodations, child care and work schedule changes " page 17
Margo 2016	"The greatest logistical barriers occurred as women prepared for their abortion appointments. They described the financial burden of paying for the abortion, arranging transportation and negotiating time off work for the appointment and aftercare. Though the interviewer asked participants about child-care

Study	Evidence
	arrangements, they did not consider this aspect of preparation to be a major challenge." page 203
Margo 2016	"Employed participants reported diverse experiences regarding taking time off for the appointment, the time needed for having a medication abortion at home and the suggested postabortion recovery period. Some participants managed their own schedules, and their concern was primarily over lost work time. Others needed supervisor approval for time off. Some had supervisors with whom they felt comfortable explaining why they needed the time, and so anticipated a compassionate response; however, many participants feared judgment if their supervisor knew of the abortion... Several participants reported that their work schedules prevented them from scheduling the abortion as they truly wished. One woman had an aspiration abortion rather than the desired medication abortion because of work-related scheduling delays; another woman experienced delays that led to her having the abortion at a clinic that was not her first choice." page 204
Ostrach 2014	"the logistical hassles of waiting for... a boss to approve a time-off" page 1010
Purcell 2014	"For women who were employed, another difficulty was taking time off work. Irregular work patterns and low autonomy positions left some women unsure of their rights to sick pay, and the need to explain their absence to managers or colleagues was magnified for those who had to travel, since they had to account for a potentially longer absence." page 105
White 2016	"Women also were unable to return within 48 hours because they had to make multiple arrangements to accommodate the extended time needed for travel. For example, a 30-year-old woman, who returned to the clinic 60 miles away 5 days after her consultation visit, said that in addition to taking off work, 'I had to find a ride and make sure my dad had to get my children for me.. [The clinic] isn't just a hop up the road.' page 301
Sub-theme 3.2: Difficulty arranging childcare	
Aiken 2018b	"Another common barrier was logistical difficulties getting to a clinic due to inability to get time away from work or childcare to attend one or more appointments. Linda, a 31-year-old working mother living in Scotland echoed many others when she explained: 'I am only 2 weeks pregnant, I already have 3 kids and I am a single working mum. I am unable to go to the hospital as I do not have the funds to pay for childcare while I would be in there. I am unable to take time off work and I can't tell my family so there is no one I can ask to look after the kids. I really need to do this in my own home.'" page 180
Doran 2016	"Support was discussed in relation to child care or a support person. Five women required early morning child care, which was provided by either a formal childcare provider or by friends or family. The clinic requirements were for someone to drive them home. Moira suggested this could have been particularly challenging for young women, for women who had no one to accompany them and for women without a licence. Skye also wondered how challenging this could be for women with few social or personal resources to negotiate loans and deal with the stigma and challenges." page 6
Jerman 2017	"Making arrangements after appointment was scheduled (e.g., for transportation, accommodations, child care and work schedule changes " page 17
Ostrach 2014	"finding someone... who could also watch her children, was a major obstacle" page 1010
White 2016	"Women also were unable to return within 48 hours because they had to make multiple arrangements to accommodate the extended time needed for travel. For

Study	Evidence
	example, a 30-year-old woman, who returned to the clinic 60 miles away 5 days after her consultation visit, said that in addition to taking off work, 'I had to find a ride and make sure my dad had to get my children for me.. [The clinic] isn't just a hop up the road.' page 301
White 2016	"…women obtaining abortions at 15 or more weeks from LMP had extended time away from home to accommodate their need for cervical preparation before the abortion; they also reported extra out-of-pocket expenses, unrelated to the cost of the procedure. Two women having abortions at 16 or more weeks from LMP reported staying overnight in a hotel for their 2-day procedures. One of these women, a 23-year-old mother of three traveling more than 90 miles with her own mother, stated, 'I had to have someone to watch my kids, and I had to get in a hotel down there for a day, because I really could not leave [town]. I could not be too far.'" page 302
Sub-theme 3.3: Additional expenses and delays caused by travel arrangements	
Aiken 2018b	"For other women, major barriers to clinic access were long travel distances or lack of transport. Rachel, a 30-year-old woman living in England explained: 'My nearest clinic is over 100 miles away and I have no idea how I would get there and back home after the abortion.'" page 180
Doran 2016	"Participants travelled 1–9 hours one way to reach a clinic and five women required overnight accommodation. All except one woman used private transport to travel to the clinic. Moira travelled on an overnight train to Brisbane. For Fern it was a 'harrowing day', requiring a 6-hour journey to the clinic and then the return journey home, all in one day. Clara, who had previously had an abortion in the city, compared the city/regional experience as 'chalk and cheese' and was 'gobsmacked' she had to travel 'all that way to another state' where she felt 'isolated and horrible driving over that border'." page 6
Hulme-Chambers 2018	"Service improvement suggestions included improving access to MToP and the availability of the medication in rural areas. Travel distances were often seen as resolvable through more rurally-based services being available" page 26
Jerman 2017	"Requiring multiple means of transport to get to appointment" page 17
Jerman 2017	"Limited or no options near home" page 17
Jerman 2017	"Clinic closure in home state" page 17
Kruss 2014	"Participants were invited to consider what could be done to reduce the access barriers they identified. While expanding services was considered essential (e.g. using a visiting model, increasing incentives to train in TOP, reducing the cost of EC), participants acknowledged that this might not always be possible or sufficient and advocated strategies to increase access to metropolitan services (e.g. travel assistance)." page 304
Margo 2016	"The greatest logistical barriers occurred as women prepared for their abortion appointments. They described the financial burden of paying for the abortion, arranging transportation and negotiating time off work for the appointment and aftercare. Though the interviewer asked participants about child-care arrangements, they did not consider this aspect of preparation to be a major challenge." page 203
Sub-theme 3.4: Arranging drive home can cause delays and necessitate unwanted disclosure	
Cano 2016	"Transportation challenges are further amplified for women living in remote communities, where there are few or no public transportation options available to travel to Whitehorse. Kristen, a 27-year-old woman, did not want anyone to know about her second abortion, 'Yeah, I drove myself actually because I didn't

Study	Evidence
	want to tell my mom…and they said I needed somebody to pick me up, but I said I had somebody to pick me up but I didn't, I just, I drove myself home afterwards'" page 493
Doran 2016	"Support was discussed in relation to child care or a support person. Five women required early morning child care, which was provided by either a formal childcare provider or by friends or family. The clinic requirements were for someone to drive them home. Moira suggested this could have been particularly challenging for young women, for women who had no one to accompany them and for women without a licence. Skye also wondered how challenging this could be for women with few social or personal resources to negotiate loans and deal with the stigma and challenges." page 6
Margo 2016	"Because of the scarcity of clinics, transportation was another obstacle. At all three clinics, oral or intravenous sedation is recommended as standard care for women receiving aspiration abortions, and many women agreed to this. These women required a ride home following their procedures. For some, securing a ride from their partner, friends or family was simple, but for others, this requirement presented a major challenge and may have necessitated unwanted disclosure." page 204
Ostrach 2014	"…finding someone who could miss work to give her a ride to the clinic.. was a major obstacle" page 1010
White 2016	"Women also were unable to return within 48 hours because they had to make multiple arrangements to accommodate the extended time needed for travel. For example, a 30-year-old woman, who returned to the clinic 60 miles away 5 days after her consultation visit, said that in addition to taking off work, 'I had to find a ride and make sure my dad had to get my children for me.. [The clinic] isn't just a hop up the road.' page 301
White 2016	"Women having first trimester aspiration abortions noted that clinic policy required them to have someone who could drive them home after their appointment. A 34-year-old woman explained that she would have been unable to get an abortion if her boyfriend had not already been off from work and could drive her more than 150 miles one way on the day of her procedure, 'If I didn't find anybody to go with me that means.I may have to keep the pregnancy.. I don't have any family here. So I [was] kind of like 'Lord, come on,' but I made it.'" page 301
Sub-theme 3.5: Teenagers more affected by logistical barriers than other women	
Kruss 2014	"Rural teenage women in the Grampians were noted as being particularly disadvantaged, with participants noting that teenagers are constrained more than other women regarding transportation to a service, confronting moralistic service providers wanting consent from parents, denial about a pregnancy and restrictions placed on services that can be provided by school nurses." page 303
Sub-theme 3.6: More appointments needed for medical abortion is a barrier to choosing medical abortion	
Doran 2016	"All women commented that medical abortion was not a feasible option because of logistical factors that prevented them from returning for the required follow-up appointment. Some women did see their GP for recommended follow-up care whilst some did not see the need for it." page 6

GP: general practitioner; NHS: National Health Service

Table 32: Theme 4: Personal barriers

Study	Evidence
Sub-theme 4.1: Prior negative experiences	
Aiken 2018b	"Finally, some women reported prior negative experiences with clinical services or experienced judgmental attitudes from healthcare providers, and were afraid of encountering the same situation a second time. Jessica, who is 27 years old and living in England explained: 'I know what is available to me. I've had bad experiences in the past. I do not want to talk to anyone or go anywhere. I won't have a hospital abortion again. I find it ironic that it would be easier for me to get what I need in a country where abortion is illegal!'" page 180
Purcell 2014	"Orla, who was 20 and had an abortion locally at 17 weeks, explained that she had “compartmentalized” her thinking, in part from fear of the procedure, which she had been through before: 'I think that was where the emotional block was, actually going and admitting it, and going through the procedure, because last time was fairly traumatic, and it was uncomfortable and painful, and I was upset and alone.... Having to go and do it again was hard, so putting it off was easier.'" page 104
Sub-theme 4.2: Perceived stigma	
Aiken 2018b	"Many women wished to keep their abortion secret because of either perceived or experienced stigma around abortion. As Meera, who is 29 years old and lives in England explained: 'I'm ashamed and embarrassed to return to clinic as I've been for an abortion before and know I will be judged for having another one. The stigma of having to walk into any face-to-face setting is too much.'" page 180
Doran 2016	"An emergent theme was of women’s experiences of stigma, shame and secrecy. All women commented on the stigma they experienced surrounding abortion, which for some was particularly apparent in small rural towns. External stigma was exacerbated by protestors, and internalised stigma was linked to feelings of shame and secrecy. Some women discussed the consequences of stigma and the lack of respect for women to make reproductive decisions concerning their own bodies." page 4
Doran 2016	"Women commented on social barriers linked to women’s rights and overly complicated systems that if addressed could improve access to abortion services for all women" page 7
Kruss 2014	"One reported issue was a feeling of being ‘judged’ by health professionals, with some doctors refusing to make referrals" page 303
MacFarlane 2017	"'There is no law that states that women can't be in a sexual relationship before marriage, but the moral, unwritten laws [make] it difficult to seek and receive reproductive health care. These already existed, but they have gotten worse with this current government.' (Melek, age 24) Notably, some of the unmarried women in our study discussed how their marital status influenced their decision to have an abortion. In addition, Yasemin felt that she was charged a higher price and received a lower quality of care because she was unmarried. Even though abortion care in the private sector was generally described as nonjudgmental, some unmarried women anticipated that they would be judged by providers, especially because of the recent negative publicity surrounding abortion in the media, and were surprised when they received nonjudgmental care." page 157
MacFarlane 2017	"Melek felt that the government's rhetoric has created an antiabortion and anti-reproductive-health climate that impacts access to services. '[The political situation affects] my access to the pill, or just simply going to the Ob/Gyn. I get

Study	Evidence
	scared to go to the doctor. It takes away my right to access medical care…'" page 158
O'Donnell 2018	"'"All I could do was look online, because I don't know anyone in my area that has had this done. Or anyone that would really admit to it." – Kentucky, early twenties, recruited at abortion facility" page 11
Ostrach 2014	"She described worrying about having to ask for help with travel arrangements and costs, fearing family members would be judgmental or reluctant to help" page 1010
Ostrach 2014	"she described harassment by anti-abortion protesters routinely found at the clinic entrance as a major barrier" page 1010
Purcell 2014	"The delay in asserting candidacy for services was also linked to fear of others' reactions. This fear was a factor in the delay that 17-year-old Melissa—who had an abortion locally—experienced between discovering her pregnancy at around four weeks and terminating at 18: 'I really didn't know how to handle it, I was just so confused, like, 'What do I do?' … I was just so scared,… I just didn't want [my mother] to be disappointed.'" page 103
Sub-theme 4.3: Comorbid medical conditions	
Aiken 2018b	"For other women, issues such as severe anxiety made it hard for them to leave the house, leading to a strong preference or necessity for both consultations and procedures to take place in private at home. Tina, who is 35 years old and lives in England explained: 'I am on medication for the depression and anxiety and I struggle to leave the house. I do all my shopping online, my child is picked up and dropped off for school in a taxi. Simple things like leaving the house to take the bins out are an impossible task for me... I know I couldn't cope with this pregnancy and I certainly wouldn't be able to cope with a baby but I know I can't go outside to the doctors and I certainly wouldn't cope with a hospital visit.'" page 180
Sub-theme 4.4: Threat of violence	
Aiken 2018b	"Just over 1 in 6 reasons (18%) involved a situation where women did not feel able to seek abortion services at a clinic or hospital because of the fear or threat of partner violence or a situation involving a controlling family. These circumstances ranged from fear of strong disapproval on religious grounds—leading to shunning or, in extreme circumstances, fear of honor killing—to inability to leave the house without permission from a partner and fear of physical violence from a partner disapproving of abortion... Susan, who is 30 years old and lives in England, described her situation living with domestic violence and unable to seek care at a clinic or hospital for fear of partner intervention or retaliation: 'I'm in a controlling relationship, he watches my every move, I'm so scared he will find out, I believe he's trying to trap me and will hurt me. I can't breathe. If he finds out, he wouldn't let me go ahead, then I will be trapped forever. I cannot live my life like this.'" page 181
Larsson 2016	"One challenging experience, as brought up by several of the interviewees, was the encounters with abortion care-seeking women and girls/women with backgrounds in countries that accepted honour-based violence. These patients were either foreign-born or born in Sweden to immigrant parents. The main concern for these women and girls was, according to health care providers, the fear of their families finding out about them being pregnant or having boyfriends: 'There was this young woman who lived with protected ID, and she actually said that "If my family gets to know about this, then I'll be dead tomorrow." And she was going to have an abortion. (…) The last thing she said when she walked from here was "If you read about a woman who's been killed in the newspapers

Study	Evidence
	tomorrow, you know it's me." She was so afraid. She was wearing clothes to cover herself up when she (left)… She was afraid to even be seen in this building.' (Midwife 6)" page 16
Ostrach 2014	"Multiple women and clinic staff discussed intimate partner violence as both a safety concern and a psychosocial obstacle... Clinic staff frequently mentioned intimate partner violence as a major barrier to access, or as a factor that compounded the impact of other obstacles." page 1011
Theme 4.5: Negative physician attitudes and conflicts with personal beliefs can impact provision of services and obtaining referrals	
Black 2015	"...the decisions of ethics committees were viewed to some extent as representing personal beliefs and not necessarily based on the law or ethical implications: 'Because I think they tend to feel they can choose which women they can offer termination to or not, [based] on their own value judgment. . .,' (Interview 6, p7)" page 146
Dawson 2017	"One interviewee reported that she delayed referring women so that they could have more thinking time: 'Letting them know that they've actually got time in many situations to make a decision. It's not a decision that needs to be made straight away. I think that to me is so important. Any decision that is made at that point has the potential of affecting them forever… it's just whether they do go ahead with the termination or they don't go ahead with the termination, there are consequences either way. That to me in that first consultation is so important. We'll walk through this together making sure that they're safe at that moment in time for them to go away and digest everything that was said and then coming back for review and follow up.' [GP non-provider, metropolitan]" page 6
Doran 2016	"Women's experiences of the GP process varied from being easy and supported (one participant) to very challenging. Challenges related to delays in seeing a rural GP, lack of willingness of GPs to refer" page 4
Dressler 2013	"Conversely, rural participants faced many challenges to provide abortion service in their communities... The barriers associated with this setting included lack of operating room time for abortions, a tendency to defer an abortion case for an ''urgent'' non-abortion case, and difficulties in logistically scheduling operating room staff (e.g., nurses and anesthesiologists) to accommodate staff who did not wish to participate in abortion care." page 3
Freedman 2010	"Dr. S had been directly threatened by an out going senior partner while interviewing for a position in an obstetrics and gynecology private practice in a large midwestern city. Dr. S remembered, 'He leaned across the desk and said, If I ever find out you did elective abortion any time in your professional life, you'll never practice medicine in [this state] again. Do you understand that?' In contrast, some groups communicated their abortion prohibitions in a more collegial way. For example, Dr. D, practicing in a small southern town, recalled the interview with his private group practice, in which they discussed his having participated in abortion training during residency. A senior member of the group with strong antiabortion views pressed him to explain why he had participated. The partners told him during the interview, 'We're not going to be doing that.' And Dr. M, practicing in the Northeast, recounted: 'When I finished my residency, I went to [a northeastern state], and I was working in a small hospital. ... No one at the hospital would ever perform an abortion. ... It wasn't a religious hospital, but it was a very conservative town, and they just felt like they didn't want to be associated with doing terminations. And they told me that at the interview'" page 148

Study	Evidence
Freedman 2010	"The committee, which includes physicians with different areas of specialization (e.g., family practice and pediatrics) and a chaplain, dis cusses every case under consideration. However, Dr. G said, 'the policy that we have is basically no elective abortions"; the committee approves abortions only for women whose fetus has a fatal anomaly or for whom the pregnancy may cause serious health risks, and refers other women elsewhere.' page 148
Freedman 2010	"A few physicians attempted to moonlight while working in private practices where abortion provision was prohibited, and they were surprised to find out that their groups prohibited it outside the practice as well. Dr. K, from the Midwest said, 'I brought it back to the group, and they nixed it and said absolutely not, just because they didn't want my name associated with the [abortion] clinic.'" page 148
Freedman 2010	"In other instances, despite the absence of overt restrictions, participants found that the culture of their group practice or institution was to discourage abortion provision and refer women elsewhere for abortion services. For example, Dr. F, from a large southern city, said abortions are never done in her practice. She learned this shortly after being hired, when she noticed that abortion providers were listed in the referral book in the office. She casually asked a colleague about whether practice members do abortions, and the colleague explained that because of one senior partner's opposition, patients were always referred elsewhere for abortions." page 148
Freedman 2010	"Another physician, Dr. R, working in a suburb of a large western city, explained that she does not perform abortions because some staff at the public hospital where she performs surgery are opposed to abortion and refuse to assist in procedures. In Dr. R's view, the policies of her group practice are not prohibitive, but the culture of the practice makes it so: 'It's a big deal. I don't know if the nurses don't want to be part of it or they all just like to band together ... because if you're the one that says you don't mind doing it, everyone else is going to look at you. So if there's an abortion procedure that needs to be done, I send [the woman] to Planned Parenthood. It's not worth my time and effort to jump through the hoops of the hospital to make that happen. ... Actually, in my first couple months in practice, the people that are in my office here told me, 'Don't even bother.'" page 148
Hulme 2015	"In Prince Edward Island, New Brunswick and the Yukon, where women require referrals for abortion services, as well as rural and Northern communities, informants described difficulty in finding a physician who will refer, with resulting delays in abortion care. 'She went to the walk-in clinic and the doctor there said – he said, 'Oh, well, you might as well keep the baby. Do you know how hard it is to get pregnant?' and she was crushed, terrified, upset, didn't know what to do. Because she went for help and this man told her that – 'You're lucky to be pregnant. Why would you want to get rid of it?'" (Family Physician, New Brunswick)" page 56-57
Hulme-Chambers 2018	"A small number of women reported feeling that their GP was obstructionist about MToP referral. Women described GPs staring blankly at them or giving them odd facial expressions, referring them to health professionals not directly associated with MToP, or being told they had find an abortion service themselves. 'She [GP] didn't really offer any sort of emotion at all…I couldn't really tell where she was standing on it [abortion] and she didn't – there was no offer of any information about anything, any options, when I went to her. As I had already made up my mind it would have been nice for her to talk to me about options and how those options would work. (Participant #10, age 26)'" page 25
Jerman 2017	"Hoop-jumping (logistics involved in securing an appointment" page 17

Study	Evidence
Kruss 2014	“Some local doctors were suspected of deliberately delaying women’s access to TOP, ‘doing harm by withholding [information] . . .’, forcing women to find their way to services by accident: 'We have become suspicious that GPs are actually delaying them accessing a service because of their own views on abortion so they are sending them off to get multiple ultrasounds . . .'" page 303
Kumar 2004	"Many women were keen to have the procedure done quickly and some commented on unnecessary delays during the referral process... Some women were asked by their GP to think about their decision and return another day, and some health professionals avoided discussing the options available following a positive pregnancy test... For women who had found the decision-making process difficult, such delays acted as a deterrent, making them think again about their decision and so causing further mental anguish. 'It was actually one of the most frustrating things, especially if you’re dealing with, trying to make a difficult decision. I think that might actually deter other people and make them sort of say, ‘Forget this, I’ve tried once, I’ve tried twice, I’m not gonna try this again’.'" page 53
Margo 2016	"There was variation in whether health professionals discussed comprehensive pregnancy options with participants, whether they gave an abortion referral and how participants felt about their encounters. Of the 20 women who reported contact with a medical professional or crisis pregnancy center staff, seven were given a referral for abortion services. Of those who did not receive a referral, only four explicitly wished one had been offered, including one woman whose overtly antiabortion doctor recommended a crisis pregnancy center for “unbiased” counselling." page 202
Margo 2016	"Of the seven participants who were given referrals for abortion services, four reported feeling they were well treated and received nonjudgmental, thorough information. These women were seen in a family planning clinic, in an urgent care clinic, and by their usual gynecologist or primary care doctor. The interactions were characterized by direct communication and lack of judgment. One participant described her experience this way: 'We discussed all of the options, and he told me, ‘If you choose not to go forward with the pregnancy, you can go here,’ and explained what would be done [and] how the procedure would take place…. I’ve been with him for nine years, so the conversation was very easy'. The three women who described a negative or neutral referral experience received the requested information, but felt judged or were treated indifferently. An 18-yearold black woman who lived in an urban area told how an urgent care clinic doctor provided the requested abortion referral handwritten on a diabetes pamphlet, after which his demeanor changed from friendly to curt: 'After I said, ‘Well, maybe I don’t want to keep it,’ he was like, ‘Wait,’ and walked out of the room. And then he gave me a brochure that somebody had written on ‘Planned Parenthood,’ and then he just left. I thought it was rude. You’re a doctor, you’re a professional.'" page 202
O’Donnell 2018	""[My doctor] is just the doctor my sister uses. It’s really the only doctor [where I live]…He’s nice. He’s sweet. He’s kind of more of a traditional person as well. My sister actually just had an abortion, and she had some complications. She couldn’t even tell her doctor about it because he would have dropped her as a patient, because he’s dropped a couple of his other patients for the same reason…[when she was pregnant with her first child], he was asking her if she was gonna keep the baby at first, and she said yes, and he said, ‘Okay, good. I let go of a couple of patients because they decided otherwise.’ – Tennessee, early twenties, recruited at abortion facility" page 11

Study	Evidence
Purcell 2014	"Some women expected that staff might be unreceptive to their request to have an abortion and therefore delayed their assertion of candidacy. However, only one participant met with any clear objection: A general practitioner advised Yvonne that at 17 weeks, she was 'too late" for a termination, as the fetus was "a baby now.'" page 105
Purcell 2014	"In addition, women who traveled to England for an abortion were aware that services were less available in Scotland, and felt there was judgment implicit in this disparity. Vivienne was aware of and perplexed by the fact that if a fetal anomaly had been detected, she could have been treated within five miles of home, rather than several hundred miles away." page 105
Say 2005	"Negative attitudes of gynaecologists towards abortion care had significantly restrained service development in some hospitals. Such attitudes were rooted in different perceptions. Most gynaecologists did not prioritise abortion care; it was not 'real gynaecology'... 'They look at [abortion care] as a nuisance. Sometimes this is quite obstructive and acts as a barrier, not consciously, but by really being unhelpful.'" page 21
Say 2005	"Abortion also created perceived ethical conflicts (e.g. between preserving and ending life) and justification for religious and moral objections. Some gynaecologists believed the problem was rooted in women's own faults, and were intolerant and judgmental towards women requesting abortion." page 21
Say 2005	"Negative attitudes to abortion also existed amongst general practitioners (GPs), which hindered the speed or quality of referrals." page 21
White 2016	"One woman stated that the clinic staff simply made her an appointment for prenatal care noting that 'they do not really talk about that [abortion] there,' and another, age 28 and who suffered from several chronic health conditions, said her regular doctor 'was totally against the idea..He didn't want me to have any other options besides having [the baby],' and dismissed her request for information." page 300
Sub-theme 4.6: Social support	
O'Donnell 2018	""I talked to my sister I live with. Actually, she's the only one I told about me coming here today. She was very supportive. No matter what I do, she supports me and she'll be there. She just looked at me and she's like, 'Are you okay?' I'm like, 'Yeah, I'm fine.' She's like, 'I noticed you just looked really off lately.' I'm like, 'No, I'm good.' She ooked at me and she's like, 'What's wrong?' I just kind of looked up at her and I told her, 'I'm pregnant,' and we just cried. She was my age when she was pregnant with her child. But she ended up having the baby. I already knew that she had been here for an abortion, because she told me, obviously." – Tennessee, early twenties, recruited at abortion facility" page 11
O'Donnell 2018	""My friend had actually been [to the clinic] before. She had gotten pregnant by a guy that was abusing her, and she went – instead of telling him, she went and had it done. And me and her had been friends since high school. So I already knew that she had it done, and when I needed it, I called her and I said, 'Do you care to drive me? Since you already know where it's at, and it'll save me some stress that morning.'" – Kentucky, mid-twenties, recruited at centre of commerce" page 11
O'Donnell 2018	""It was really scary, and just felt like, 'How did this happen to me?' I couldn't talk to my mom. It was really hard. He lives with his parents, and they didn't know. You couldn't really talk about it on the phone or anything. It just felt like I was having to keep such a huge secret, such a burden. It still is, even after all this is done." – Kentucky, late teens, recruited at abortion facility" page 11

Study	Evidence
Ostrach 2014	"..lack of support made it difficult for them to overcome obstacles." page 1010; "Conversely, when women had a strong support network in place they tended to describe feeling “capable of managing other barriers” such as, for example, those associated with finding the needed financial resources and arranging time off from work." page 1011

GP: general practitioner; mToP: medical termination of pregnancy; Ob/Gyn: obstetrics/gynaecology; ToP: termination of pregnancy

Table 33: Theme 5: Legal and policy barriers

Study	Evidence
Aiken 2018b	“For others, a change in law to decriminalize self-sourced and self-managed abortion was the clear solution." page 181
Black 2015	"Eighteen doctors alluded to the difficulty they had in accessing private and public hospital termination services for women with a fetal abnormality post 20 weeks gestation. Twenty one of the 22 practitioners or their colleagues had to refer women interstate to have an abortion because the ethics committee would take too long to convene: 'Well that’s not the way it’s supposed to be but in practice it seems extremely difficult to arrange. . .Apparently the X hospital should do this but they seem to have to constitute ethics committees at a drop of a hat to look at some of these issues, and by then, of course its 20, 21, 22 23, 24 weeks, no guarantee, incredibly stressful for the woman, So we try to arrange it privately or interstate. It’s much less stressful for everyone.' (Interview 7, p5–6)" page 146
Freedman 2010	"Physicians working for large HMOs or health networks, both religiously affiliated and nonsectarian, can find themselves without the autonomy to decide whether to provide abortions. Catholic health networks, which account for one-sixth of hospital beds and yearly hospital admissions in the United States, pose extensive restrictions on reproductive health care services provided within their properties and by their employees. One physician, who was on the faculty in her residency program at the time of the interview, remarked: "The majority of our residents stay in town, and we have a very strong [Catholic] health care system that has a lot of tentacles through the community. ... Even though you have an independent practice, they own the building, and they refuse to allow you to do abortions?even if it's in your own [private] practice. ... There're several private groups associated with that facility, and so it makes it really tough." page 149
Jerman 2017	"Waiting periods (state-imposed)" page 17
Jerman 2017	"Gestational limits (state- or clinic-imposed)" page 17
Say 2005	“There were arbitrary upper gestational age limits to perform abortions; some gynaecologists were performing abortions for gestations no later than 15–16 weeks, or even 12 weeks. Individual preferences, ‘without logic’, caused variable access to care." page 21

HMOs: health maintenance organisations

Table 34: Theme 6: Privacy and confidentiality concerns

Study	Evidence
Aiken 2018b	"Others feared breach of confidentiality if they accessed in-clinic services, sometimes due to working within the hospital or clinic themselves, or having friends or family working there." page 180
Hulme 2015	"Rural, Northern and Aboriginal communities face a unique set of challenges related to provider attitudes. These patients have very limited choice in

Study	Evidence
	healthcare providers and are not assured confidentiality in settings where they may know everyone working at the clinic." page 57
Jerman 2017	"Involving unwanted persons in the abortion decision or travel arrangements" page 17
Kruss 2014	"Confidentiality and privacy were raised as access barriers to both EC and TOP and were often used interchangeably. It was reported that rural women have little choice but to see someone they might know socially, unless they travel some distance to access a service. They come from a rural town. . .they can't tell anyone what is happening . . . they are so nervous about somebody in the town finding out . . ." page 303
Purcell 2014	"For women who were employed, another difficulty was taking time off work. Irregular work patterns and low autonomy positions left some women unsure of their rights to sick pay, and the need to explain their absence to managers or colleagues was magnified for those who had to travel, since they had to account for a potentially longer absence." page 105
White 2016	"Almost all women were able to make the necessary arrangements by relying on those who already knew about their decision to have an abortion. However, because they had recently taken time off for the consultation visit, two participants having first trimester abortions (as well as two having second trimester procedures) reported they reluctantly had to disclose to others why they needed additional coverage at work or for childcare." page 301

EC: emergency contraction; ToP: termination of pregnancy

Table 35: Theme 7: Training and education

Study	Evidence
Dawson 2017	"Some GPs expressed confusion over appropriate places to refer their patients: 'I'm starting to question myself about whether I know all the possible referral avenues with regards to abortion. It's something I need to just go over, it might just be today. I think just having that information and having the right information and the appropriate information that we can pass on to our clients.' [GP non-provider, metropolitan]" page 7
Dressler 2013	"Two physicians described pressure to always be available as the sole abortion provider in their community. One participant discontinued his/her surgical abortion practice because s/he was unable to find another physician to assist in providing 24 hour availability for emergency care in case of a complication. Another participant discussed his/her frustration with the isolation as follows: 'Biggest barriers I see, and things that might see me stopping, is the sheer volume. And if it's only me trying to see everyone, with no breaks and, you know, to feel like you can't even take a week away because, either it'd pile up or people aren't going to be able to be seen…The biggest barrier is just…keeping myself from getting burnt out, providing the services and feeling like I can't do as much as I want to.'" page 3
Dressler 2013	"Additionally, physicians providing abortion service in rural communities lack professional support in the form of easily accessible continuing professional education events and camaraderie." page 3
Dressler 2013	"Many urban abortion providers described no concerns with the availability of other physicians to replace their services. One participant stated, 'I think in [urban facility], [my services] could easily be replaced, there are many physicians who would like to work at [urban facility] but there just is not the space at the time. So, in the [city name] area I don't think it would be much of an

Study	Evidence
	issue.' This perceived availability of replacements was less pronounced in the smaller urban centers and among the urban providers who performed second trimester abortions. With respect to training new physician replacements, many urban providers described an established training program through the local university-based medical school, or having participated in the provision of abortion training for family practice or obstetrician-gynecology residents and rural physicians." page 3-4
Dressler 2013	"Rural physicians perceived a lack of available replacements. One physician stated, 'Nobody would ever [provide abortion] here. I'm the only one. We approached other people, like the other physicians, and there's nobody interested in doing it.' Rural physicians were less likely to train other physicians in skills for provision of abortion, in their communities. One participant described a feeling of insecurity in training another physician, particularly in light of the lack of specialist back up in the event of a complication. As well, two physicians described a lack of volume of abortion cases as a deterrent to the local training of new abortion providers. 'I was hoping to get this [physician] trained but I think [the physician] is going to have to go to a[n urban] clinic where there are several cases a day, so [the physician] can get [many] cases in … if it's going to have any chance of being successful.'" page 4
Hulme 2015	"Respondents called for expanded undergraduate and continuing education family planning training programs for physicians, nurses and midwives, including updated information on abortion." page 60
Kruss 2014	"Myths about abortion leaving women infertile were still being spread, despite evidence to the contrary. While misinformation also occurs in metropolitan areas, the effects in a rural environment might be more significant because the limited pool of people a woman knows mean myths travel faster and 'stick' more in the absence of disconfirming information/ conversations." page 303
Kung 2018	"Respondents in Britain discussed [NHS] hospital-based providers losing their clinical skills in abortion due to abortion services occurring overwhelmingly in independent sector clinics." page 6
Purcell 2014	"It was more common for general practitioners to appear "confused" or "unclear" regarding the gestational limit of their NHS board, and to initially tell women that the limit was lower than the actual case, before having to seek clarification from their local abortion service." page 105
Say 2005	"Lack of knowledge and skills among gynaecologists were barriers to performing certain procedures. For example, the near-universal use of general anaesthesia for surgical abortions partly reflected clinicians' unfamiliarity with local anaesthesia. The introduction of local anaesthesia was further constrained by uncertainties over its benefits and acceptability to women... '[Gynaecologists] do not see developing the necessary skills for abortion as a priority.'" page 21
Say 2005	"The enhanced role of nurses could help expand services, but both the lack of self confidence among nurses and the lack of doctors' confidence in nurses limited action on this opportunity." page 22; "..the expanded role of nursing staff in medical abortion was hindered by shortfalls in NHS training budgets to ensure education in the legal, technical and emotional aspects of abortion." page 22

GP: general practitioner; NHS: National Health Service

Table 36: Theme 8: Community prescribing and telemedicine

Study	Evidence
Dawson 2017	"One GP provider spoke about the importance of MTOP for Aboriginal women: 'I think it's certainly a more accessible option for them because it doesn't have a financial barrier or a distance barrier...'." page 5
Doran 2016	"Some thought access to medical abortion was a way to reduce a complicated process: 'If RU486 was prescribed by my doctor, I wouldn't have had to go through all that', commented June" page 7
Grindlay 2013	"Clinic staff cited numerous benefits to introducing telemedicine into their clinic system. This included the greater reach of the physicians, who could now be "in three places at once," greater efficiency of resources with women and providers no longer having to travel such long distances, and fewer cancelations and delays related to travel in inclement weather. As one staff member reflected, 'To give choice to a lot more people is exciting, very fulfilling to me personally and professionally. The helplessness you feel about not being able to help people because they can't get here - they don't have a ride, they don't have the money, they don't have whatever, you know - a lot of those problems have gone away so that I'm feeling very pleased.'" page e120-e121
Grindlay 2013	"Another benefit that staff saw was the reduced number of visits that women had to make to outlying clinics. Before telemedicine, women typically had to come to the clinic over the course of 2 days because the doctor had a limited window in which to see patients at the outlying clinics, women would typically do their "pre-op" activities on one day, and then come back a second day to consult with the doctor. With telemedicine, patients at outlying clinics could typically complete their visit in 1 day." page e121
Grindlay 2013	"The greater flexibility of telemedicine also enabled clinics to offer services more frequently and with a wider range of times available to women. Whereas before patients at outlying clinics could only be seen on a particular day of the week or month that the doctor visited the clinic, telemedicine allowed them to potentially schedule any day of the week if needed. Staff found this to be of particular benefit to women who could only take a specific day off from work or school. It also made it possible for clinics to see patients earlier in pregnancy, and to ensure they had access to medical abortion by better accommodating women with a limited timeframe for eligibility. Before telemedicine, a patient might have had to wait up to 2 weeks for an appointment, which could put them out of the window of eligibility" page e121
Grindlay 2017	"Respondents overwhelmingly reported the greatest impacts of telemedicine introduction in their clinics were for the patients, and that it facilitated a more patient centred approach to care where women were able to be seen sooner, with greater choice in abortion procedure type, and closer to their home." page 681
Grindlay 2017	"Participants (n=8) uniformly noted the most significant gain from telemedicine was that clinics could schedule appointments on additional days and times that better meet patients' needs and in turn allow women to be seen at earlier gestational ages. Before telemedicine, a physician would come to some facilities one or two times per month. This wait time could put women outside of the gestational age eligibility window for a medical abortion... 'We can see them much earlier than waiting for our next scheduled [in-person physician] day, which can be, you know, three and a half weeks in time. [For] women in that kind of situation, three weeks is a lot of time, you know—it can make a pretty big difference.' (Medical assistant/ patient care coordinator" page 682

Study	Evidence
Grindlay 2017	"Participants (n=7) widely agreed that women were given greater choice in whether to have a medical or surgical abortion as a result of decreased wait times and the resulting lower gestational ages at which women could be seen, as well as the increased availability of the service. They felt that prior to telemedicine, women did not always have a 'real' choice because of the time-sensitive nature of medical abortion. As a physician reported, 'I've had some patients that wanted the medication abortion, didn't want a surgical abortion, and by the time they could have gotten to us in another part of the state . . . or for me to come to them . . . they wouldn't have been eligible anymore.'" page 682
Grindlay 2017	"Several providers (n=3) also noted that the expanded availability of medical abortion had rippling impacts on surgical abortion access. Because medical abortion could be shifted to a wider range of days, women could be more easily scheduled for surgical abortions on the few days a physician was in the outlying clinic." page 682
Grindlay 2017	"Participants (n=5) also described the impacts on women in terms of reduced travel. Prior to telemedicine, women either had to wait for the provider to come to their closest clinic, or they could drive or fly to another part of the state or for out-of-state care. Respondents noted that this disproportionately affected poor women and those living in rural areas who were not readily able to travel. As one participant said, 'I feel like it's vastly increased our access to the women that are most vulnerable. You know, our wealthier patients will get whatever they need, regardless of telemedicine, but in rural areas it's a lot more difficult'" page 682
Grindlay 2017	"... telemedicine enabled clinics to schedule physicians on an as-needed basis, rather than dedicate an entire day to clinical work. One physician stated, 'It gives us huge flexibility because . . . instead of having a doctor scheduled and having to fill an entire day to make it feasible for the doctor to come in, you know, I can be doing an administrative day and take an hour out of an administrative day and see three medication abortion patients.'" page 683
Hulme 2015	"A few respondents also suggested piloting Skype and telephone consultations to expand access to medical abortion care." page 60

GP: general practitioner; MTOP: medical termination of pregnancy