Examensarbete

HÖGSKOLAN I SKÖVDE

Delivery of Abortion Services in the United Kingdom and Republic of Ireland, in Relation to the World Health Organization's Framework for Best Practices: A Literature Review.

Abortvård i Storbritannien och Irland i förhållande till Världshälsoorganisationens riktlinjer för högkvalitativ vård: en litteraturstudie.

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SAMMANFATTNING

Titel: Abortvård i Storbritannien och Irland i förhållande till Världshälsoorganisationens riktlinjer för högkvalitativ vård: en litteraturstudie.

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Sammanfattning

Introduktion: Säker och tillgänglig abortvård klassas som en grundläggande mänsklig rättighet och en viktig tillgång för att främja jämställdhet mellan könen. I mars 2022 publicerade Världshälsoorganisationen en uppdaterad version av sina rekommendationer för högkvalitativ abortvård bestående av komponenterna abortlagstiftning, vård före abort, abortvård, eftervård och tjänsteleveransalternativ och självförvaltningsmetoder. England, Skottland och Wales; Republiken Irland och Nordirland utgör tre olika regioner som verkar under separata abortlagar såväl historiskt som nu. **Syfte:** Att beskriva de tre regionernas leverans av abortvård med världshälsoorganisationens riktlinjer som utgångspunkt. **Metod:** En litteraturstudie i vilken 20 artiklar om abortvård i de olika regionerna har analyserats genom en tematisk analys med deduktiv ansats. **Resultat:** Abortvård bedöms säker i samtliga av de tre regionerna. Icke-rättsliga faktorer, såsom bristande kunskap bland vårdpersonal och samvetsvägran, skapar emellertid hinder för effektiv tillgänglighet av vård, särskilt i Irland och Nordirland. Vidare minskar tillgången till abortvård med stigande gestationsålder och kvinnor från alla regioner vittnar om att abort framställs som något skamligt både i media och inom vården. Telemedicinsk abortvård, som varit tillgängligt under COVID-19 pandemin, har bedömts som säker, effektiv och accepterad bland vårdtagare. **Slutsats:** Fler faktorer än rättsliga påverkar ett lands tillgång till abortvård och dessa måste tas till hänsyn vid utvecklandet av abortvård. Världshälsoorganisationens riktlinjer utgör ett användbart verktyg för att utvärdera och föreslå förbättringsmöjligheter inom abortvård.

ABSTRACT

Title: Delivery of Abortion Services in the United Kingdom and Republic of Ireland, in Relation to the World Health Organization's Framework for Best Practices: A Literature Review.

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Abstract

Introduction: Accessible abortion services is a fundamental human right and in March 2022, the World Health Organization (WHO) updated their recommendations for best abortion services practice covering the components Abortion regulation, Services across the continuum of care, Pre abortion care, Abortion care, Post abortion care and Service-delivery options and Self-management approaches. England, Scotland and Wales, the Republic of Ireland, and Northern Ireland have different abortion laws, both currently and historically, but they have strong historical ties to each other, offering a good comparison on how regional difference can impact abortion services. **Aim:** The aim of this literature review is to investigate the three regions' abortion service provision using the WHO guidelines as a framework. **Methods:** A literature review in which 20 articles describing abortion services in the three regions were thematically analyzed using a deductive approach. **Results:** Access to abortion in all regions is currently safe. However, non-legal barriers, such as lack of trained medical practitioners and conscientious objection, hinder accessibility of care, especially in the Irish regions. Moreover, the accessibility of abortions decreases with higher gestational ages in all regions and women describe a narrative of shame maintained by media and medical staff. The telemedical models introduced during the COVID-19 pandemic has been evaluated as safe, effective and accepted among care recipients **Conclusion:** Other factors than legal barriers impact the provision of abortion services. These barriers need to be considered when developing abortion service systems. The WHO guidelines serve as a useful tool to evaluate and improve abortion services.

Table of Contents

ABBREVATIONS

BPAS	British Pregnancy Advisory Service
CASP	Critical appraisal skills programme
D&E	Dilatation and Evacuation
DHSC	Department of Health and Social Care
GRAMMS	Good Reporting of a Mixed Methods Study
HSE	Health Service Executive
IPPF	International Planned Parenthood Federation
LARC	Long-acting reversible contraception
NAF	National Abortion Federation
NHS	National Health Service
NGO	Non-Governmental Organization
QOC	Quality of care
SRH	Sexual and reproductive health
STROBE	Strengthening the Reporting of Observational Studies in Epidemiology
WHO	World Health Organisation

1 INTRODUCTION

Safe abortion services are proclaimed as a foundational human right, as well as a state's obligation to provide in order to reduce discrimination against girls and women[1], however, approximately 40% of women of childbearing age (15-49 years) live in countries where abortion is either illegal and/or unavailable/inaccessible (Erdman & Cook, 2020; World Health Organization [WHO], 2012).

Induced abortion (hereafter referred to as *abortions)* is defined as a procedure to terminate a pregnancy. Failure to provide quality abortion service pose a serious threat to women's physical and mental well-being and abuses a spectra of human rights, including the right to life; the right to the highest attainable standard of physical and mental health; the right to benefit from scientific progress and its realization; the right to decide freely and responsibly on the number, spacing and timing of children; and the right to be free from torture and cruel, inhumane and degrading treatment and punishment (WHO, 2021). Improved global access to comprehensive abortion service within health systems has also been declared as fundamental to achieve the Sustainable Development Goals, designed to guide states, businesses and Non-Governmental Organizations (NGOs) to achieve a better and more sustainable future for all (WHO, 2022). This is especially noted in target 3.7: "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes" and 5.6 : "Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences" (United Nations, n.d.).

Globally, 121 million unintended pregnancies were estimated to occur yearly between the years of 2014 and 2019. In relative terms this equals 64 unintended pregnancies per 1000 women in reproductive age (15-49 years). 61 % of these were terminated with an abortion, which equates to 30% of all pregnancies ending with a termination (Bearak et al., 2020). Abortion is a common procedure that is considered safe if the methods recommended by the WHO are used, the environment is hygienical and the procedure is performed by a person with the necessary skills and knowledge. However, lack of safe, timely, affordable, geographically reachable, respectful and non-discriminatory abortion services, forces women to undergo less safe procedures and, globally, 45% of induced abortions are considered unsafe (WHO, 2022). Unsafe abortions are estimated to contribute to 4,7 - 13,2 % of the maternal mortality which yearly equals 13 865 to 38 940 lives that, according to WHO (n.d.), could have been spared. Data comparing the occurrence of abortion in different countries show that the relative number of induced abortions are similar in countries with or without liberal abortion regulations (40 and 36 per 1000 women, respectively). Thus, more restrictive regulations

[1] To ensure readability and consistency throughout the following text, the term "woman" will be utilized. It shall, however, be clarified that representatives for the study's target group may have a different gender identity than ciswoman. The needs of abortion care must be considered for all gender diverse individuals.

effect the safety of the abortions, rather than the total number of abortions performed in the country (WHO, n.d.) Other studies show that unsafe abortions are particularly common in families with fewer economic assets because more financially privileged groups to a greater extent have the ability to pay for advice from competent medical staff, either unlawfully in their own country or abroad, regardless of restrictive abortion regulations. Pregnant women with a lower socioeconomic status (SES), globally, tend to turn to providers of alternative medicine, medical providers with lacking skills or to perform the abortion on themselves (Singh et al., 2009).

1.1 World Health Organization's guidelines

Since 2020, WHO has included comprehensive abortion services in the list of essential health care services (WHO, 2021). In accordance with WHO's function of providing technical assistance in the field of health, the organization released an updated version of their best practice recommendations for safe abortion services in March 2022. The 50 recommendations cover the areas *Law and policy*, *Clinical services* and *Service delivery*. The quality of the guidelines is secured through extensive quality assurance processes with the aim of achieving the best possible individual and/or collective health outcome (WHO, 2022). Hereby follows a summary of the guidelines that are considered relevant for this study as they will serve as this study's theoretical framework. Medical recommendations regarding specific treatment protocols, for example pain medications or Rh-immunization have not been included.

1.1.1 Abortion Regulations

WHO (2022) recommends full decriminalization of abortion and states that abortion should be universally available upon request of the pregnant woman. If abortion is only legal on broad social grounds it is fundamental that these are aligned with human right policies. Moreover, WHO recommends against laws that prohibit abortion based on gestational age limits as there are safe abortion methods available regardless of gestational age (WHO, 2022).

1.1.2 Services across the continuum of care

Information and counselling on abortion services for pregnant women is recommended to be provided by community health workers, health workers, pharmacists, traditional and complementary medicine professionals, auxiliary nurses, nurses, midwives, associate clinicians, GPs and specialist medical practitioners (WHO, 2022).

1.1.3 Pre abortion care

WHO (2022) recommends against waiting periods for abortions, as well as third-party authorizations, even in cases where the pregnant person is under-aged. WHO also recommends against the use of ultrasound scanning as a prerequisite for providing abortion services as such legal regulation might limit the availability of care. They also highlight that many countries place legal restrictions on who is legally allowed to perform an abortion, which further limits availability. WHO thus recommends that a wide range of health professionals should be adequately trained to be able to carry out the procedure. Conscientious objection is a phenomenon described by Shanawani (2016) as the refusal to perform a legal responsibility

because of personal beliefs and WHO (2022) states that unregulated conscientious objections can harm the accessibility of an abortion service. States allowing providers to abstain from providing abortion services due to conscientious objection must ensure that the health system is organized in a way that prevents this from hindering abortion accessibility.

1.1.4 Abortion care

For medical abortions, WHO (2022) recommends using the medicine Misoprostol, either by itself or combined with Mifepristone. In the first 12 weeks of pregnancy, a medical abortion can either be self-administrated or provided by a community health worker, pharmacy worker, pharmacist, traditional or complementary medicine professional, auxiliary nurse, nurse, midwife, associate/advanced associate clinician, generalist medical practitioner or specialist medical practitioner. After the 12th week, the medical management is recommended to be carried out by a general medical practitioner or a specialist medical practitioner.

For surgical abortions in the first 14 weeks or pregnancy, vacuum aspirations are recommended to be performed by traditional or complementary medicine professionals, nurses, midwives, associate/advanced associate clinicians, generalist medical practitioners or specialist medical practitioners. After 14 weeks, the method of dilatation and evacuation (D&E) is recommended and should be performed by generalist medical practitioners or specialist medical practitioners.

1.1.5 Post abortion care

For uncomplicated abortions, WHO (2022) states that there is no medical need for follow-up visits. However, information on available follow-up services should always be provided in case they are desired. The woman must also be informed about symptoms of complications and failure of the abortion. WHO further states that the health system must be designed to recognize and handle complications of unsuccessful abortions. Contraception methods should be offered as a part of the abortion service, if the patient wishes to not get pregnant again.

1.1.6 Service-delivery options and self-management approaches

The option of home-administrating as an alternative to in-person service in order to carry through, or part of, the medical abortion should be provided. The parts that could be performed by the pregnant person herself, in the first 12 weeks, include self-assessment of eligibility, self-administration of abortion and self-assessment of the success of the abortion (WHO, 2022).

1.1.7 Values to drive safe abortion services

Abortion service providers must demonstrate key *values*, according to the framework. These values include dignity, autonomy, equality, confidentiality, communication, social support, supportive care and trust (WHO, 2022).

1.2 The cases: England, Scotland and Wales; the Republic of Ireland and Northern Ireland

Using the framework provided by WHO, this literature review will compare abortion services provided in the United Kingdom and the Republic of Ireland (hereinafter referred to as *Ireland*). These countries are similar regarding location and social and medical development, but different regarding their history of abortion policies and availability. England, Scotland and Wales will be treated as one region as these, despite slightly different interpretations, all are governed under the same legal act and have offered their citizens abortion on broad social grounds for many decades. Ireland serves as a separate case having had restrictive abortion regulations until 2019, now having managed to establish a good practice of abortion provision. In comparison Northern Ireland, which is a part of the United Kingdom, also changed their abortion policies in 2019 but have not yet managed to provide an equally accessible abortion service to its residents. Hence, Northern Ireland will in this text be treated as a separate region.

In Table 1, available statistics from 2020 regarding number of registered abortions and abortions rates are presented for each region.

Table 1. Registered abortions carried out in the United Kingdom and Ireland, 2020.

	England, Scotland and Wales[2]	The Republic of Ireland[3]	Northern Ireland[4]
Number of abortions	223 732	6577	63 in the country, 365 registered residents who travelled to England or Wales for abortion
Age standardised abortion rate	18.2 per 1000 women in England and Wales 13.4 per 1000 women in Scotland	data missing	data missing
Medical abortions	86%	data missing	100%

[2] Department of Health and Social care [DHSC] (2022) & Public Health Scotland (2021)
[3] An Roinn Sláinte Department of Health (2021)
[4] Hillen et al. (2022)

1.3 National policies

This section of the literature review will compare differences in national and regional policies and laws regulating safe abortion services.

1.3.1 England, Scotland and Wales

In line with the Abortion Act (1967), abortions are available in approved premises in England, Scotland and Wales for pregnant individuals up to the 28th week of pregnancy. However, the Abortion Act of 1967 was revised in 1990 and the Human Fertilisation and Embryology Act (1990), which substituted the policy from 28 to 24 weeks, based on the belief that this is the cut off point for the foetus' viability. Furthermore, with the Offences against the Person Act (1861) still being in place, unlawful abortions can be subjects of criminal offences and therefore lead to legal charges for any person who intends to terminate a pregnancy. The Abortion Act (1967) does not include the region of Northern Ireland and therefore, the accessibility of legal abortions differ within the United Kingdom. In cases where two registered medical providers are of the opinion that the pregnancy has not exceeded the 24th week, and that the continuance of the pregnancy would put the woman, her family, or the foetus in greater risk of physical or emotional harm than an induced abortion, a termination is legally granted. The procedure must, according to the Abortion Act (1967), take place in a hospital environment and must be carried out by a registered medical professional. However, in 2018, English and Welsh women, aligned with regulations in Scotland, were given the option to take the second abortifacient agent, Misoprostol, at home, rather than at a hospital. This policy was, as a direct consequence of the COVID-19 pandemic, extended in March 2020 to include both Mifepristone and Misoprostol for women in England and Wales (DHSC, 2020). Conscientious objection can be relied on only in cases where an objection does not cause harm to the care recipient (Abortion Act, 1967).

1.3.2 The Republic of Ireland

The Health (Regulation of Termination of Pregnancy) Act (2018) came in force by January 1st, 2019, and thus, repealing the Eighth Amendment of the Constitution Act (1983), permitting the right to abortions under medical supervision until the 12th week of pregnancy after a mandatory three-day waiting period, free of charge for Irish residents. Terminations after the 12th week are allowed, but in these cases, it is required that two medical professionals, including at least one obstetrician, are of the opinion that the life or wellbeing of the woman is under risk of harm and that the foetus has not yet reached viability. An abortion may also be induced, should the medical opinion be of that the child would not survive the neonatal period (the first 28 days after birth). Conscientious objection can be relied on, should an objection not cause harm to the care recipient. Offences listed in the act include those of a person who intentionally terminates a pregnancy otherwise than in accordance with the Health (Regulation of Termination of Pregnancy) Act 2018, and thus including prescriptions, administrations or suppletion of abortifacient agents, knowing the intention of terminating a pregnancy. However, offenses listed in the act do not apply to the pregnant individual in respect of their own pregnancy. A person found guilty shall be liable on conviction to a fine and/or imprisonment no longer than 14 years (Health (Regulation of Termination of Pregnancy) Act, 2018).

1.3.3 Northern Ireland

The Abortion (Northern Ireland) Regulations (2020) came into force in March, 2020, following the repeal of sections related to terminations of pregnancies from the Offences against the Person Act (1861). The decision of repealing the 158-year-old act was made in 2019, and enacted in the Northern Ireland (Executive Formation etc) Act (2019).

The current regulations authorize abortions by registered medical providers per the pregnant individuals request until the 12th week of pregnancy. Medical abortions are allowed until the 10th week of pregnancy, and recommended abortifacient agents are Mifepristone or Misoprostol. Has the pregnancy exceeded the 12th week, but not the 24th, an abortion may be induced by a registered medical provider, should the continuance of the pregnancy put the pregnant individual in greater risk of suffering than in the case of a termination. An abortion is authorized with no gestational limits if the continuance of the pregnancy would put the pregnant woman, or the foetus, in a greater risk of suffering or death than if the pregnancy was to be terminated. In all cases exceeded the 12th week, two medical professionals are required to be of the opinion that the rules of terminating the pregnancy are being followed. Medical providers are not required to perform the abortion and conscientious objection can be relied on, however, this rule does not apply to situations where the care recipient's life or health is in danger, as presented in the Abortion (Northern Ireland) Regulations (2020).

A summary of mentioned acts, categorized after the seven indicators mentioned by the WHO, can be seen in Table 2.

Table 2. Summary of national abortion related policies.

	England, Scotland, Wales	Republic of Ireland	Northern Ireland
Abortion regulation	The gestational limit for abortions, approved based on broad social grounds, is 24 weeks.	Per the pregnant individual's request until the 12th week of gestation. Should two medical practitioners be of the opinion that continuing the pregnancy after 12 weeks would put the woman at risk, an abortion may be induced. This also applied for cases where a condition affecting the foetus which might lead to death either before, or within 28 days of, birth.	Per the pregnant individual's request until the 12th week of gestation. Should two registered medical professionals be of the opinion that continuing a pregnancy would involve risk of injury of the pregnant individual, an abortion may be induced up to the 24th week of gestation. Should the woman's, or the foetus', life be in danger, there is no gestational limit for induced abortions.
Services across the continuum of care	The procedure must be carried out by a registered medical practitioner.	The procedure must be carried out by an obstetrician.	The procedure must be carried out by a registered medical practitioner.
Pre abortion care	Two medical practitioners must approve the termination before inducing the abortion. No mandatory waiting times.	In all cases over 12 weeks pregnancy, two medical practitioners must approve the termination. One of the two medical practitioners must be an obstetrician. A mandatory three	In all cases over 12 weeks pregnancy, two medical practitioners must approve the termination. Conscientious objection can be relied on in cases where the objection does

	Conscientious objection can be relied on only if the objection does not lead to grave permanent injury of the abortion seeker.	days must elapse between the first examination and the termination. Conscientious objection can be relied on, however, the person who has a conscientious objection is required to make arrangements for the transfer of care to enable the pregnant individual's abortion.	not physically or mentally harm the abortion seeker.
Abortion care	Not mentioned, however, both medical and surgical abortions can be carried out up to 24 weeks gestation, with vacuum aspiration being available up to 14 weeks, and D&E after 14 weeks (National Health Service [NHS], 2020)	Not mentioned, however, surgical abortions are rarely offered in cases earlier than 9 weeks gestation (Health Service Executive [HSE], 2018)	Medical abortions are allowed until the 10th week of gestation.
Post abortion care	Not mentioned	Not mentioned	Not mentioned
Service-delivery options and self-management approaches	During the COVID-19 pandemic, temporary regulations allowed telemedicine to be used for both abortifacient agents (DHSC, 2020). The Abortion Act (1967) states that the abortion must be carried out in a hospital or in a place approved by the Secretary of State.	During the COVID-19 pandemic, temporary regulations allowed telemedicine to be used (Moreau et al., 2021); the implementation of telemedicine is not mentioned in the Health (Regulation of Termination of Pregnancy) Act (2018).	The first step of a medical termination must take place in a Department approved environment. The second medication, Misoprostol, may be taken in the home of the pregnant individual.
Values	Not mentioned	Consent to medical treatment is required.	Consent to medical treatment is required.

1.4 Public health relevance

WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2020). The lack of available and accessible abortion due to policy regulations or other factors, hinder girls' and women's physical and mental wellbeing, thus violating fundamental human rights. Bodily autonomy and the ability to freely choose to seek abortion services is therefore considered being part of the human rights spectra. Failure to provide such services does not reduce the number of abortions performed, but rather the safety of the procedures, and restrictive abortion regulations therefore pose a serious threat to the health of women and girls.

There are numerous national and international abortion service guidelines available that describe safe abortion services, including International Planned Parenthood Federation [IPPF] (2014) and National Abortion Federation [NAF] (2020), however, in a bid to protect vital health services internationally, WHO released an updated version of abortion care guidelines in March 2022. WHO's functions include establishing, observing and

implementing international standards in health and health care, thus playing an essential role in the governance of global health. A framework is defined as a basic conceptional structure and utilized guidelines serve as a framework in which to study and compare safe abortion services ("Framework", n.d.). For this study, the terms *WHO guidelines* and *WHO framework* are thus interchangeable.

England, Scotland and Wales, Northern Ireland and Ireland constitute three geographically and demographically similar regions. Their different histories of, and current, abortion regulations provide cases which are relevant to compare in relation to understanding what effect they have on the actual accessibility and availability of high-quality abortion services.

1.5 Problem formulation

Safe and accessible abortion services are a human right that influences the health and wellbeing of women, and the absence of safe abortion services is estimated to cause up to 14,2% of maternal deaths yearly. These services have been stated as an important priority to achieve Agenda 2030. In March 2022, WHO's guidelines on best practice abortion care were updated to guide countries and communities in their implementation and evaluation of abortion services. The regions of England, Scotland and Wales; Ireland and Northern Ireland serve as three cases with different abortion regulations and service provision, both currently and historically. Research could inform us about the relation between services provided and regulations regarding abortion, but there is a gap in knowledge due to the non-existing collected review of current research into services provided. To assess these regulations' influence on the actual outcome of abortion services in each of the three regions, the WHO framework can be used. The evaluation can be used to formulate suggestions on how legislation enable or hinder abortion services.

2 STUDY AIM

This study aims to investigate earlier research into the provision of abortion services within the policy regions of a) England, Scotland and Wales; b) Republic of Ireland and c) Northern Ireland, to tell us about how well regulation is implemented, and, by extension, investigate what research into abortion service provision can tell us about the relation between regional legislation and WHO recommendations.

3 METHOD

Due to WHO's role in governing global health, the newly updated version of the abortion care guidelines was considered the best framework to use in evaluating safe abortion services. The guidelines (WHO, 2022) were here utilized as a framework for classifying, evaluating and comparing both national policies and the actual service provision in three studied regions.

3.1 Data collection

To fulfil the study aim, a literature review was conducted. The purpose of a literature review is to identify and synthesize current evidence on a predefined subject, hence suitable for this study's objective. This review specifically aimed to investigate earlier research into the provision of abortion services within the policy regions of a) England, Scotland and Wales; b) Republic of Ireland and c) Northern Ireland, to tell us about how well regulation is implemented, and, by extension, investigate what research into abortion service provision can tell us about the relation between regional legislation and WHO recommendations.

Initially, to conduct the literature review, the databases PubMed and CINAHL were used, to identify relevant studies from each region. These databases cover a wide range of peer-reviewed articles in the subject of medicine, nursing and health. The aim was to include 20-30 original articles from any of the regions that seemed to enlighten any of the factors identified by WHO as crucial to abortion service provision. The search terms used were based on the WHO guidelines and have been listed in Table 3. The initial searches were made in May 2022 and all listed searches were utilized in both databases. However, as PubMed was utilized first, and most articles were recurring in CINAHL, only one additional article was found through the second database. A list of potential eligible articles was generated based on titles and abstracts. Articles included have been summarized in Appendix A. The aim was to include as recent articles as possible, however, different criteria were used for the different regions as their legal histories differ.

Moreover, quality assessments were conducted for each of the included articles, using checklists such as CASP, GRAMMS and STROBE. These assessments were summarized and have been included in Appendix B. The choice of checklists was based on the design of each study.

Table 3. Utilized search terms.

Search terms	Publication date	Results	Articles viewed	Articles from this search that were included in this literature review
Abortion AND United Kingdom	2017-2022	648	100	*Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain* (Aiken et al., 2018)
				It's a small bit of advice, but actually on the day, made such a difference…: perception of quality in abortion care in England and Wales (Whitehouse et al., 2021)

Abortion AND United Kingdom AND telemedicine	2017-2022	20	20	*Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study* (Aiken et al., 2021a)
Abortion AND United Kingdom AND access	2017-2022	83	83	*A formative evaluation of online information to support abortion access in England, Northern Ireland and the republic of Ireland* (Duffy et al., 2018)
Abortion AND United Kingdom AND patient satisfaction	2017-2022	17	17	
Abortion AND United Kingdom AND patient satisfaction	2012-2022	26	26	*Shifting abortion care from a hospital to a community sexual and reproductive health care setting* (Cameron et al., 2016)
Abortion AND United Kingdom AND inequal*	2017-2022	3	3	
Abortion AND United Kingdom AND inequal*	2012-2022	7	7	*Initiative to close the gap in equalities in abortion provision in a remote and rural UK setting* (Caird et al., 2016)
Post-abortion AND United Kingdom	2017-2022	21	21	*Specialist follow-up contraceptive support after abortion - Impact on effective contraceptive use at six months and subsequent abortions: A randomized controlled trial* (Kumar et al., 2019)
Abortion AND United Kingdom AND Conscientious objection	2017-2022	12	12	
Abortion AND Northen Ireland	2012-2022	84	50	*Abortion provision in Northern Ireland: the views of health professionals working in obstetrics and gynaecology units* (Bloomer et al., 2022)
				Introduction of the national health service early medical abortion service in Northern Ireland - an emergency response to the COVID-19 pandemic (Kirk et al., 2021)
Abortion AND Ireland	2018	159	50	*Termination of pregnancy: staff knowledge and training* (O'Shaughnessy et al., 2021)
				Analysing MyOption: experiences of Ireland's abortion information and support service (Grimes et al., 2022)
				Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 pandemic: a regression discontinuity analysis (Aiken et al., 2021b)
				The changing landscape of abortion care: Embodied experiences of structural stigma in the Republic of Ireland and Northern Ireland (Broussard, 2020)

Post abortion AND Ireland	2018-2022	10	10	*Termination of pregnancy services in Irish general practice from January 2019 to June 2019* (Horgan et al., 2021)
Republic of Ireland AND Abortion	2018 -2022	159	20	*Legal and non-legal barriers to abortion in Ireland and the United Kingdom* (Calkin & Berny, 2021)
Termination of pregnancy AND Ireland	2018-2022	82	40	*Attitudes and experiences with termination of pregnancy among Irish obstetrics & gynaecology trainees in the context of recent legal change: A survey study* (Stifani et al. 2021)
Abortion act AND United Kingdom [5]	2012-2022	13	2	*The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revisited* (Lee et al., 2018)

As a sufficient number of relevant articles could not be identified during the initial search, additional articles were found by looking into the references of already included articles. These have been listed in Table 4.

Table 4. Additional articles included in the study.

Article
'Repeat abortion', a phrase to be avoided? Qualitative insights into labelling and stigma (Hoggart et al., 2017)
Self-management of first trimester medical termination of pregnancy: a qualitative study of women's experiences (Purcell et al., 2017)
Telemedicine medical abortion under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic (Reynolds-Wright et al., 2021)

3.2 Criteria for inclusion and exclusion

Articles were included if they were peer-reviewed, original articles written in English, published after the different regions most recent policy changes regarding abortions, covering subjects regarding revived care or perceptions from health care practitioners or patients. Both qualitative and quantitative studies were included.

The exclusion criteria were certain publication types (reviews, meta analyses), study subjects that did not relate to any of the WHO indicators regarding recommended abortion services and non-human studies. Articles written from other perspectives than care recipients and/or providers were also excluded, e.g., economic evaluations. Of the 464 articles reviewed, 444 were excluded due to the criteria described here.

[5] Retrieved from CINAHL.

3.3 Analysis

A thematic analysis with a deductive approach was used and the seven indicators of the WHO framework for abortion services served as themes. During a thematic analysis, Braun and Clarke (2006) describe that the researcher shall search across collected data to identify, analyze and describe recurring themes and patterns. The process also includes the researcher's interpretation of data in order to process and select codes to establish themes. However, as a deductive approach was utilized, the themes were pre-determined based on said guidelines. This approach is described by e.g., Bryman (2001). First, the 20 included articles were printed, read thoroughly and coded to the appropriate WHO framework criteria using coloured highlighters. For each article the region(s) of focus was noted and an appropriate checklist for quality assurance was filled out (see Appendix B). Secondly, an article summary was made in excel, summarizing the findings for each report in relation to the seven themes, as described in Appendix A. Thirdly, the findings from each region were summarized in relation to each of the seven themes. This summary serves as the main result of this literature study and is available in section 4.1. During the process, the findings and interpretations were discussed between the two authors to minimize the risk of researcher bias. This approach is recommended by, among others, Bowling (2014).

3.4 Ethical considerations

Neither ethical approval nor informed consent was required for the literature study itself, as it did not include collection of primary data. The ethics of studies in the included articles have been assessed using the checklists summarized in Appendix B. Moreover, all included articles were peer reviewed and given oversight by ethical committees.

Ethical issues that arise with literature reviews include potential conflicts of interest and issues of representation (Suri, 2020). These risks have been acknowledged and the aim was to include articles representing different perspectives on the topic. However, no systematic measures have been taken to eliminate the potential issue of lacking representation.

4 RESULTS

Results of this study will present findings from a literature review of 20 scientific original articles, with the aim of investigating earlier research into the provision of abortion services within the policy regions of a) England, Scotland and Wales; b) Republic of Ireland and c) Northern Ireland, to tell us about how well regulation is implemented, and, by extension, investigate what research into abortion service provision can tell us about the relation between regional legislation and WHO recommendations. As results vary by regions, summaries will be presented in Table 5-11 on how each region performs for the given criteria, followed by a short summary of similarities and differences between the regions' ability to meet the given indicators of quality care.

4.1.1 Abortion regulations

Table 5. Study findings, abortion regulations.

England, Scotland, Wales	The countries interpret the same act differently. A study by Calkin and Berny (2021) showed difficulties accessing abortion services in Scotland and Wales if the gestational age had exceeded 18 weeks. The study also highlighted that surgical abortions were rarely offered to women whose pregnancies had past 12 weeks (sometimes 16) in Wales. English abortion providers were stated to interpret the act least restrictively and many women in the UK still relied on English clinics to access abortion services. Lee et al. (2018) stated that medical professionals described the law as a hampering force to the exercise of clinical judgment. Another study by Aiken et al. (2018) highlighted illegal immigrants and certain visa holders in the UK not being able to access legal abortion services. During the pandemic, telemedical abortions became legal in all three countries (Aiken et al., 2021a; Reynold-Wright et al., 2021).
Ireland	Findings underlined the need of further abortion accessibility for women with a gestational age over 12 weeks (Horgan et al., 2021; Grimes et al., 2022; Calkin and Berny, 2021) Broussard (2020) also stated that greater access would allow women to terminate their pregnancies at earlier gestations. Results from O'Shaughnessy et al. (2021), Stifani et al. (2022) and Grimes et al. (2022) indicated that medical professionals want and need further abortion related training. Most medical professionals agreed with current regulations, about 20% believed abortion services should be available on request even after the 12 week limit and a further 20% were of favour of more restrictive laws (Stifani et al., 2022).
Northern Ireland	Broussard (2020) stated that medical staff expressed a fear of legal repercussions related to abortion services. She further believed that decriminalization of self-managed abortion would lead to a reduced stigma. In Northern Ireland, most of the Trusts only provided care until 10 weeks' gestation, despite the legal 12-week limit, which means many women still relied on England's clinics to access abortion services (Calkin & Berny, 2021). A study by Bloomer et al. (2021) showed a broad support for decriminalization of abortion up to 24 weeks gestation within the medical profession.

Considering the WHO guidelines on abortion regulations, it was more difficult to access services the higher the gestational age is in all three regions (see table 5). Despite new laws, many women in other regions relied on English abortion services as it is difficult to access abortion services after the gestational ages of 10 weeks in Northern Ireland; 12 weeks in Ireland and 18 weeks in Scotland and Wales (Calkin & Berny, 2021). However, even in England, there were groups such as illegal immigrants and certain visa holders that could not access abortion services either, which indicates that access to the English health system was

not fully universal (Aiken et al., 2018). Studies from Ireland and Northern Ireland indicated that a majority of medical professionals were in favour of the recent liberalization of abortion legalisations but that many still experienced a lack of training and/or fear of legal repercussions hindering the actual care provision (Broussard, 2020; Grimes et al., 2022; Stifani et al., 2022).

4.1.2 Services across the continuum of care

Table 6. Study findings, Services across the continuum of care.

England, Scotland, Wales	Abortion seekers in the United Kingdom valued accurate information as a substantial factor of quality of care (QOC) (Whitehouse et al., 2021). Abortion providers were assessed to manage well in information delivery and abortion service recipients declared feeling well informed when getting care at hospitals and sexual and reproductive health (SRH) settings (93% and 100%, respectively) (Cameron et al., 2016). A study by Purcell et al. (2017) indicated that women passing an abortion at home also felt like they received sufficient information. However, less than 1/3 of reviewed online sources on how to get an abortion were judged as good/excellent and almost 1/2 were inaccurate with current abortion regulations (Duffy et al., 2018). Results from Lee et al. (2018) indicated that abortion providers believed a larger array of medical professionals should be allowed to work with abortions.
Ireland	Almost half of available internet-based information was found to be inaccurate with policies currently in place (Duffy et al., 2018). Results from O'Shaughnessy et al. (2021), Grimes et al. (2022) and Broussard (2020) indicated an existing knowledge gap with medical professionals, and this was presented as a barrier to safe care. However, Stifani et al. (2022) presented that 70% of obstetrics and gynaecology trainees got a "perfect knowledge score" regarding abortion services, but a large number of respondents felt unable to provide abortions due to lack of previous exposure and education. Grimes et al. (2022) further argued for serious limitations regarding services from the country's abortion information and support service, MyOptions.
Northern Ireland	Close to half (48.4%) of available internet-based information provided was found to be inaccurate with current policies (Duffy et al., 2018). Broussard (2020) presented a need for more information regarding the abortion process, and a present problem with misinformation regarding the safety of self-management. The Northern Ireland Health Minister was yet to commission abortion services, and the services were not easily available to abortion seekers, according to Calkin and Berny (2021). Furthermore, results from Bloomer et al. (2021) indicated lower willingness to participate in both medical and surgical abortions amongst SRH clinicians, who are currently the providers of early medical abortion services in Northern Ireland. Many women had no access to local care following the geographical unevenness of abortion services. A referral pathway was established in partnership with the *charity Informing Choices NI* to facilitate self-referral, initial assessments and safeguarding (Kirk et al., 2021). During the COVID-19 pandemic, Northern Ireland recorded a significant increase in telemedicine requests from private telemedicine services (Women on Web), since in-clinic appointments were only available by travelling abroad - which during the pandemic was not possible (Aiken et al., 2021b).

As stated in table 6, the regions' available online-information were rated badly in regard to quality and conformity with country specific legislation (Duffy et al., 2018). However, care recipients in England, Scotland and Wales gave high ratings regarding the information delivery from abortion providers (Cameron et al., 2016; Purcell et al., 2017) while the lack of information was highlighted as a barrier to accessible abortion services in Ireland and Northern Ireland (Broussard, 2020; Grimes et al., 2022). Insufficient knowledge and experience among medical staff complicated access to safe care in Ireland (Broussard, 2020; Grimes et al., 2022; O'Shaughnessy et al., 2021) while the unavailability of clinics as well as

medical staff willing to participate in abortion procedures created barriers to care in Northern Ireland (Bloomer et al., 2021; Calkin & Berny, 2021).

4.1.3 Pre abortion care

Table 7. Study findings, pre abortion care.

England, Scotland, Wales	Women assessed short waiting times as being an important factor of QOC (Whitehouse et al., 2021) and a study by Aiken et al. from 2018 confirmed that long waiting times were a common contributor to women seeking abortion services outside the official healthcare sector. As presented by Cameron et al. (2016), the mean waiting time decreased from 7 to 5.9 days when abortion was provided by SRH clinics instead of hospitals. When the telemedical model was introduced in 2020, the mean waiting time decreased by 4.2 days (Aiken et al., 2021a). The "two doctor's approval" was presented as a barrier to care and the requirement caused delays for services (Lee et al., 2018). When the telemedical model was introduced all countries authorized abortions without the need for pre-ultrasound assessment (Aiken et al., 2021b). The model allowed women to have a consultation through telephone or video chat, and ultrasounds were only required if necessary, e.g., due to high or uncertain gestational age, if the woman was younger than 16 years old or if she experienced certain pregnancy symptoms (Aiken et al., 2021a; Reynold-Wright, 2021). In a study by Reynold-Wright et al. (2021), 21.3% of women who had telephone consultations were referred to an ultrasound.
Ireland	O'Shaughnessy et al. (2021) presented that medical staff lacked knowledge regarding pre abortion care. Calkin and Berny (2021) stated that the mandatory waiting time led to the denial of care for some abortion seekers and Horgan et al. (2021) underlined the need for further research regarding into whether the three-day wait enhances safety or acts as a barrier to care. Patient experiences would improve by reducing waiting periods, according to Broussard (2020). The country also had a problem with medical providers relying on conscientious objection, as this led to a geographical unevenness regarding the accessibility of abortion services (Calkin & Berny, 2021; Grimes et al, 2022). Grimes et al., (2022) further stated that it took a long time for abortion seekers to make appointments due to obstructive doctors.
Northern Ireland	Broussard (2020) stated that patient experiences would improve by reducing waiting periods. Out of 572 initial clients during the first three months since decriminalization, 1/3 were treated as very early medical abortions, which allowed treatment without ultrasound. This was made possible due to quick referrals and short waiting times (Kirk et al., 2021). Following the COVID-19 pandemic, the rapidly set up sexual and reproductive health clinics met a substantial proportion of abortion needs and provided short waiting times (Bloomer et al., 2021).

Contrary to WHO recommendations for timely access to care, findings from all three regions confirmed that long waiting times had a significant negative impact on women's experiences of abortion services (see table 7) (e.g., Aiken et al., 2018; Broussard, 2020; Horgan et al., 2021). Ireland has a mandatory waiting time of three days (Horgan et al., 2021) and conscientious objection among medical practitioners further increased waiting times, which, according to the WHO guidelines, should be avoided (Calkin & Berny, 2021; Grimes et al, 2022). Moreover, medical professionals in Ireland seemed to lack knowledge in regards of pre abortion care (O'Shaughnessy et al., 2021). In England, Scotland, Wales and Northern Ireland, the COVID-19 pandemic catalysed more effective pre abortion care, cut waiting times drastically and made it possible to have an early medical abortion without the need for ultrasounds. This development aligned with WHO's recommendation against ultrasound as a prerequisite for abortion (Aiken et al., 2021a; Bloomer et al., 2021; Kirk et al., 2021).

4.1.4 Abortion care

Table 8. Study findings, abortion care.

England, Scotland, Wales	Studies showed that abortions being implemented in a hospital setting, in a SRH setting or at home were safe and effective (Cameron et al., 2016; Reynold-Wright et al., 2021), and full or partial self-administrated abortions seemed accepted among most care recipients (Aiken et al., 2021a; Caird et al., 2015; Purcell et al, 2017). No-test medical abortions were however only permitted when the gestational age did not exceed 10 weeks in England and Wales (Aiken et al., 2021a) and 12 weeks in Scotland (Reynold-Wright, 2021). Two studies indicated that some women felt forced to terminate their pregnancy with a method that was not their preference (Purcell et al., 2017; Whitehouse et al., 2021). According to Caird et al. (2015), a medical abortion at home was only permitted if the woman lived within 30 minutes from the clinic. Before recent changes regarding telemedicine, women in Scotland had to go to a clinic to be administered medications but were thereafter allowed to leave to "pass" the abortion at home (Purcell et al., 2017). Purcell et al. (2017) described the transport as challenging for many women passing the abortion at home, especially in cases where they had to use public transport. A pilot study by Caird et al. (2015) argued that the use of local, rather than general, anaesthesia made it possible for women to have a surgical abortion assessment, procedure and dischargement the same day which benefitted women who lived far from the care setting.
Ireland	98% of abortions in 2019 took place before 12 weeks' gestation (Calkin & Berny, 2021). A majority of respondents in a study by O'Shaughnessy et al. (2021) had correct knowledge about the main abortion methods, and Horgan et al. (2021) stated that the abortion services follow national guidelines. However, results from Grimes et al. (2022) indicated that surgical abortions were rarely offered. Medical trainees were also less likely to be willing to provide surgical abortions rather than medical (Stifani et al., 2022).
Northern Ireland	Kirk et al. (2021) stated that there was no surgical option and no service for women at 10 weeks' gestation or more, which meant Northern Irish women still had to travel to access abortion services.

Results presented in table 8 stated that studies from Ireland and England, Wales and Scotland indicated that provided abortion care was safe and/or followed national guidelines. However, findings from all three regions indicated failure in providing women with their preferred abortion method.

4.1.5 Post abortion care

Table 9. Study findings, post abortion care.

England, Scotland, Wales	Both women who had an abortion in a clinical setting and women who had a full or partial self-managed abortion were provided with a low sensitivity pregnancy test to assess the successfulness of the abortion (Reynold-Wright et al., 2021; Purcell et al., 2017). Since telemedical abortions were introduced under NHS provision a 24/7 telephone post abortion support service were established (Aiken et al., 2021a). Even though the success rate and risk for complications showed no significant difference between hospital settings, SRH clinic settings and telemedical settings, studies indicated that more women made telephone contact about concerns when the abortion was not carried out in a hospital (Cameron et al., 2016; Reynols-Wright et al., 2021). 37% of all abortions in England and Wales are subsequential (Hoggart et al., 2017). Women in the UK are entitled to free contraception methods (Kumar et al., 2019). Women valued not feeling pressured to choose a certain contraception method as an important factor of QOC (Whitehouse et al., 2021). For women performing telemedical abortions, contraception methods were discussed during the initial consultation and women who wished

	to have pills or condoms sent together with the medication could. Women who wished to book in to have a LARC method could do so. However, the rate of women who chose a LARC contraception method was substantially lower for women having a telemedical abortion (ca 1/10 in contrast to 1/3) (Reynold-Wright et al., 2021). Specialist contraception support was trialled by Kumar et al. (2019) but did not improve the use of contraception methods or decreased the need for subsequential abortions. A study by Hoggart et al. (2017) investigated women having more than one abortion during their reproductive lifetime, showing no clear pattern in the use of contraception methods. In general, women wished not to get pregnant again and made sure to use contraception methods. However, several women reported having to quit as the side effects were unmanageable, and others reported getting pregnant again despite the use of contraception (emergency contraception included).
Ireland	Results from O'Shaughnessy et al. (2021) indicated that medical staff wanted more training regarding post abortion care, and Stifani et al. (2022) stated that medical trainees were concerned about complications following surgical abortions. Previous abortion seekers that preferred to proceed with an abortion in a clinic listed fears of complications as one of the reasons behind not wanting to self-manage the termination (Broussard, 2020). Out of 420 cases included in a study by Horgan et al. (2021), it was revealed that 6 women got a mild infection following their abortion and 33 were referred to hospital. They also stated that use of contraception methods in the study's post abortion group rose from 34% to 69%.
Northern Ireland	Kirk et al. (2021) stated that during the first three months after the decriminalization, no serious complications were reported, and contraception methods were offered at all clinics. Furthermore, the rapidly set up SRH clinics (following the COVID-19 pandemic) met a substantial proportion of abortion needs, providing post abortion contraception (Bloomer et al., 2021). Aiken et al. (2021b) stated that follow up care was recommended to be provided in person. In the study by Broussard et al. (2020), results indicated that previous abortion seekers that preferred to proceed with their abortions in-clinic listed fears of complications as one of the reasons behind not wanting to self-manage the termination.

As presented in table 9, fear of complications was a common factor to prefer in-clinic care (Broussard et al., 2020), however, studies from England, Scotland and Wales showed that self-administrated abortions were as safe as those performed in-clinic (Cameron et al., 2016; Reynols-Wright et al., 2021) and the overall rate of abortion complications were low in all regions (Horgan et al., 2021; Kirk et al., 2021). Against the recommendations of WHO, Northern Irelanders were recommended to in-person follow up care. On the contrary, England, Scotland and Wales set up telephone service lines for this purpose. In line with WHO recommendations, contraception consultations were reported to be an integrated part of abortion services in all regions (Bloomer et al., 2021; Horgan et al., 2021; Kumar et al., 2019). England, Wales and Scotland and Northern Ireland were stated to have found ways to provide contraception services during the pandemic (Bloomer et al., 2021; Reynold-Wright et al., 2021). However, a study by Hoggart et al. (2017) suggested that contraception methods lack effectiveness and acceptability among users.

4.1.6 Service-delivery options and self-management approaches

Table 10. Study findings, service-delivery options and self-management approaches.

England, Scotland and Wales	Results from Lee et al. (2018) indicated that medical providers found that the 50 year old Act has been interpreted to state that both abortifacient agents must be taken on licensed premises. An overall support of self-managing abortions was recorded as they have been proven to be safe and effective in other countries (Lee et al., 2018). Before the telemedical model was established, there were women who had to travel more than 100 miles to have an abortion (Caird et al., 2015). Women have had telemedical abortions provided by voluntary organizations before it was legalized in 2020, and Aiken et al. (2018) examined the reasons behind requesting care from the organization Women on Web and highlighted logistic reasons (travel distance/child and work commitments), partner and family control, mental health problems and personal preferences as reasons behind seeking informal care. Whitehouse et al. (2021) also highlighted long travel distances, difficulties with childcare and travel expenses as factors contributing to negative in-clinic abortion experiences. The telemedical model has shown very high effectiveness and treatment success, and the risk for complications is not higher than for in-clinic abortions (Aiken et al., 2021a; Reynold-Wright, 2021). Assessments by women having had a telemedical abortion confirm high acceptability (96% and 95% respectively) and most women would opt for it again if they had to have another abortion (80% and 89% respectively) (Aiken et al., 2021a; Reynold-Wright, 2021). A telemedical abortion was performed by telephone-based consultation, the gestational age was determined based on the date of the last menstrual period and drugs were delivered home or available for pick up at a clinic. In England and Wales, the gestational limit was set to 12 weeks and in Scotland to 10 weeks (Aiken et al., 2021a; Reynolds-Wright, 2021).
Ireland	Before recent policy changes, Irish residents could only access telemedicine services provided by voluntary organizations from the Netherlands (Duffy et al. 2018). During the COVID-19 pandemic, the geographical unevenness of abortion services was temporarily improved by the introduction of legal telemedicine services. This further led to abortions taking place at earlier gestations, which demonstrated that the previous legal requirement of taking the first pill in a clinic acted as a barrier to abortion care. Inadequate services will continuously lead to a higher demand for self- managed abortions, according to Calkin and Berny (2021). Self-managing also allows for further empowerment regarding how the patient wants the procedure to be carried out (Broussard, 2020).
Northern Ireland	Before recent policy changes, Northern Irish residents could only access telemedicine services provided by voluntary organizations from the Netherlands (Duffy et al. 2018). During the COVID-19 pandemic, the second pill (Misoprostol) could be taken at home, however, unlike in the rest of the UK, the home use of both pills was not authorized (Kirk et al., 2021). During this time, Northern Ireland showed a 28% increase in requests from the private telemedicine service Women on Web. Observed increases in these requests may represent a shift in demands from in-clinic to self-managed abortions, as suggested by Aiken et al. (2021b). They further stated that a “pills by post” service was introduced in Northern Ireland by British Pregnancy Advisory Service (BPAS), and that the implementation of telemedicine, in line with WHO recommendations, would help to meet the demand for truly patient-centred care. Self-managing also allowed for further empowerment regarding how the patient wanted the procedure to be carried out, and many respondents included in the study by Broussard (2020) requested telemedicine as their geographical position didn't allow for in- clinic abortions.

The (legal or illegal) provision of telemedicine has had positive effects on the accessibility of abortion services in all regions (see table 10). This method has been reported as useful in

situations where the abortion applicant has relied on telemedicine because of logistic reasons, partner or family control and for mental health reasons, and as stated by Calkin and Berny (2021), inadequate care will continuously lead to demands for self-managing. Women from all regions have relied on voluntary telemedicine services until recent policy changes, however, Northern Ireland was the only studied country where a fully remote medical abortion could not legally be carried out during the COVID-19 pandemic. The implementation of telemedicine services would, according to Broussard (2020), help meet the demand for truly patient-centred care.

4.1.7 Values

Table 11. Study findings, values.

England, Scotland, Wales	Aiken et al. (2018) described that 30% of women contacting the informal abortion provider Women on Web did so due to privacy and confidentiality concerns. Other factors were prior negative experiences of abortion services, feeling judged by caregivers and experiencing stigma. Women having repeated abortions described intensified stigma and guilt. The way that sub-sectional abortions were described in media and politics created further stigma, according to women interviewed by Hoggart et al. (2017). In another interview study by Whitehouse et al. (2021), women described protestors outside clinics having a negative impact on their abortion experience. As presented by Lee et al. (2018), medical practitioners spoke of abortions as an integral part of health. The practitioner's role is to relieve stress and abortion services should therefore be talked about as a normal part of healthcare. Working with abortion was presented as fulfilling and the fact that the abortion seeker should be able to freely decide was emphasized (Lee et al., 2018)
Ireland	The staff's lack of knowledge, as a direct cause of sudden policy changes, acted as a barrier to safe and supportive care, according to O'Shaughnessy et al. (2021). Reviews of Irelands abortion information service, MyOptions, showed that patients feel left alone, didn't feel trust towards the care sector, experienced unnecessary stress and that the services were not accessible for patients who were deaf or would rather keep the contact methods to texts or email (Grimes et al., 2022). The study by Stifani et al. (2022) indicated that more than 2/3 of included trainees were willing to provide abortion services in the future, however, they expressed the need for more training and exposure to enable professional support. Fears of legal prosecutions were reported from medical providers in all three regions, as well as the stigma around abortion seeking, according to Calkin and Berny (2021). They also stated that an uneven accessibility created an unequal distribution of services for people in remote areas or with a lower socio-economic status. Broussard (2020) meant that the ability to choose the abortion method was strongly associated with dignity and autonomy, and that structural stigma influenced the abortion experience. The English policy change of 2018, allowing women to take the second medication at home has been presented as a good example for future regulation changes.
Northern Ireland	Significant differences regarding beliefs of decriminalization and willingness to participate in medical or surgical abortions between studied medical profession groups were reported in the study by Bloomer et al. (2021). However, the overall results indicated favourable factors for the development of abortion services in the country. Kirk et al. (2021) stated that there was a significant absence of anti-choice protests during lockdowns in 2020. The study further indicated that safe local treatment was still inaccessible for many women. The ability for abortion seekers to freely choose the abortion method was strongly associated with dignity and autonomy, but structural stigma still influenced the abortion experience, according to Broussard (2020). The English policy change of 2018, allowing women to take the second medication at home was presented as a good example for future regulation changes (Broussard, 2020). Fears of legal prosecutions have been reported from medical providers in all three regions, as well as the stigma around abortion seeking, according to Calkin and Berny (2021).

Regarding the key components and values of the WHO's guidelines, a recurring theme in all regions was the abortion seekers' feelings of guilt and stigma from both medical providers, medial discourse and abortion protestors (see table 11). Dignity, autonomy, trust and supportive care have all been mentioned as important factors for abortion seekers, and despite this, these elements have been reported as lacking in all three regions. The English policy change of 2018 was presented as a good example for future policy changes in Ireland and Northern Ireland. Furthermore, the ability to freely choose the abortion procedure was associated with good abortion experiences in Northern Ireland (Broussard, 2020). Overall, studies from all regions presented similar results, mentioning stigma, unequal access to care and the importance of dignity and autonomy.

5 DISCUSSION

5.1 Discussion of results

There is an observed gap in the information covered by the national regulations and the WHO guidelines. As an example, there are no legal requirements regarding post abortion care in any of the studied regions. As a suggestion for the future, the framework could be used to guide what components of care regulations should cover. The articles reviewed here have, to some extent, filled this gap.

In Ireland, as presented in the Health (Regulation of Termination of Pregnancy) Act 2018, the Act was due to be reviewed after a maximum of three years after implementation. The review has not yet been published; however, the Department of Health has recently facilitated a public consultation to seek the views of the public regarding the operation of the Act. The review might lead to future policy changes which this text cannot take into consideration. Furthermore, there was only a limited number of published studies investigating the current abortion provision in the Irish regions, and as they often had different approaches and highlight findings that were not always easily comparable. It shall also be noted that the current legislation in Northern Ireland came into force the same month as COVID-19 reached Europe, and that the pandemic affected all parts of society – including the newly introduced abortion services. It will therefore take time until the regulations have been properly established and reviewed, post- pandemic.

Hereby follows further discussions based on the indicators used.

5.1.1 Abortion regulation

The guideline recommending against any gestational limits has not been met in any of the three regions, with varying policies depending on the gestational age, making it harder to access abortion services the further the pregnancy has elapsed. WHO's guidelines focus mainly on the health of the pregnant woman, unlike laws and regulations in all three studied regions. With Offences against the Person Act (1861) still being in place in the United Kingdom, the foetus' right to life is accordingly valued above the woman's right to freely decide on the number, spacing and timing of children, which, by WHO (2021), is stated as being part of the human rights spectra. It can therefore be discussed whether regulations limiting abortion services can be viewed as intrusive of the pregnant woman's human rights, whatever the reasoning behind set regulations. It appears that abortions in a later gestational age are considered morally wrong. WHO does not discuss this question in their publication, and the guidelines advocate for no gestational age limits as there is proof of the availability of safe abortion methods in all stages of pregnancies. Results from this study further indicate that many women still rely on abortion travels even in cases where the recent decriminalization of abortions in the Irish regions would be legally justified, which indicates a failure of providing the needed services within their country of residence. Furthermore, these findings argue that the potential legal repercussions reported in all three regions acts as a potential barrier to safe abortion services.

5.1.2 Services across the continuum of care

The guidelines recommend provision of information and counselling by an array of professions (WHO, 2022). Information regarding counselling was not easily accessed through recent research, and neither was it mentioned in any of the national policies included in this text. However, the termination itself must in the UK, including Northern Ireland, be carried out by a registered medical practitioner, and in Ireland by an obstetrician. Findings from the literature review indicate a lack of quality in available internet-based information in all three regions, however, information received by abortion providers in England, Scotland and Wales has been reported as very good (Cameron et al., 2016; Purcell et al., 2017). In the Irish regions, the lack of abortion related information has been described as a barrier to accessible services, which is arguable to correlate with insufficient knowledge and experience among medical staff in Ireland. O'Shaughnessy et al. (2021) state that sudden policy changes increase the risk of difficulties with lack of knowledge within the healthcare system, which might be the case in both Ireland and Northern Ireland.

5.1.3 Pre abortion care

The best practice pre abortion care recommended by WHO aim to not hinder accessibility of abortion services. Ireland is the only country where waiting time is mandatory and the consultation and termination could not, by law, be carried out on the same day. This goes against the recommendations of WHO and especially limits accessibility for women living in remote areas according to studies by e.g., Caird et al. (2015). However, long waiting times occur to be an issue in all regions, majorly impacting women's experience of care (e.g., Aiken et al., 2018; Broussard, 2020; Horgan et al., 2021) and findings from England, Scotland and Wales imply that the requirement of two medical practitioners approval before termination extends waiting times (Lee et al., 2018). This requirement is valid in all three regions. Regarding conscious objection, the laws in all regions align with the recommendations of WHO stating that these objections should be regulated to not adventure the accessibility and/or quality of abortion services. Despite this, findings from Ireland argue that the conscious objection does affect the national provision of abortion services (Calkin & Berny, 2021; Grimes et al, 2022). In general, the regions of England, Scotland and Wales as well as Northern Ireland seem to be more aligned with the WHO recommendations for pre abortion care, e.g., by not requiring ultrasound as a prerequisite for abortion while studies suggest that medical staff in Ireland are inadequately trained in pre abortion care (O'Shaughnessy et al., 2021).

5.1.4 Abortion care

The national Acts included in this text from Ireland and England, Scotland and Wales fail to mention regulations regarding abortion methods in the different stages of pregnancies. However, as presented by HSE (2018) and NHS (2020), used methods, more or less, correspond to recommendations presented by WHO. Surgical abortions are rarely offered in the Irish regions as national regulations do not allow abortions past the 12th week of gestation (unless certain criteria have been met). Findings from this text indicate the failure of providing women with their preferred abortion method in all studied regions. Despite this, findings argue that abortion services provided follow national policies. The guidelines state that

medical abortions may be carried out by an array of medical professionals, which is not the case in any of the regions, where only a very limited selection of professions are allowed to perform the terminations. Discussions about this limitation can therefore be made regarding conscientious objection and difficulties in finding willing doctors, as this problem could partly be solved if a greater number of practitioners had the ability to provide care.

5.1.5 Post abortion care

Post abortion care is not covered by any of the legislations, but findings from all regions suggest that complications are rare and well handled. This indicates that women are adequately informed about the signs of complications and/or an uncompleted abortion. However, studies conducted in the Irish regions reveal that the fear of complications was an important factor for women to opt for in-person care. Such findings have not been reported from England, Scotland and Wales, possibly due to the countries' longer history of providing partially self-managed abortions. In line with WHO recommendations, contraception consultation is an integrated part of abortion services in all studied regions (Bloomer et al., 2021; Horgan et al., 2021; Kumar et al., 2019). However, post abortion usage of the most effective methods (Baron et al., 2018), LARC, has decreased significantly during the pandemic. Reynold-Wright et al. (2021) discuss that this could either be due to patients' willingness to avoid hospitals during the pandemic or failure in providing proper contraception counselling in the telemedical model, further research is required to understand this rationale. Although it should be noted that WHO does not recommend any specific contraception methods.

5.1.6 Service-delivery and self-management approaches

WHO states that all sequences of a medical abortion could be carried out by the pregnant person herself and recommends giving the option of telemedicine to abortion seekers. The same statement has been made by Donovan (2019) for Guttmacher Institute. During the COVID-19 pandemic, all three regions made temporary regulations that legalized the option of telemedical abortions. However, in Northern Ireland the exemption did not cover the whole procedure but only the administration of the second abortifacient agent, Mifepristone. In all three regions, the implementation has been successful in regard to safety, effectiveness, patient satisfaction and ability to cut waiting times. However, none of the regions have yet made these temporary acts permanent.

5.1.7 Values

Dignity, autonomy, equality, confidentiality, communication, social support, supportive care and trust are all components that have been described by WHO (2022) as key indicators of qualitative and safe abortion services. Despite this, neither of the reviewed national policies mention any of these values. On the contrary, with Offences against the Person Act (1861) still being in place in the United Kingdom, it can be further discussed whether national regulations oppose said guidelines, enabling dis-humane and non-patient centred services, valuing the foetus' right to life above the woman's. This argument is backed by findings from this review, as the patient's feelings of guilt and stigma is presented as a recurring theme. Similar results from an array of cultural contexts have been summarized in a review by Hanschmidt et al. (2016). It shall be noted that it is difficult to statute against values. However, conscious

objection was reported to have a more significant impact on the care in the Irish regions, and it is possible to argue that legalising abortion normalizes the procedure that in extension influences social values regarding them. Regulation of personal values, expressed as conscientious objection, cannot affect the service provision for the care recipient. However, sudden policy changes will not drastically change social norms, nor the needed knowledge among medical practitioners, and this is important to consider while changing abortion laws (Berer, 2017). A strategy to change social norms that several studies have indicated to be successful is *organized diffusion*, which in short can be described as a process to motivate members of society to talk about, and share new ideas with their social network rather than changes through a top-down implementation (e.g., Cislaghi et al., 2019; Francis et al., 2021).

Further important discussions regarding the inequality of care were presented by Caird et al., (2015), as home-abortions in Scotland were only permitted in cases where the woman lived within 30 minutes from a clinic. As previously stated (see 4.1.4 Abortion care), before policy changes regarding telemedicine, women in Scotland had to go to a clinic to be administered medications, but they were thereafter allowed to leave. Purcell et al. (2017) describe that many women felt forced to pass their abortion at home and therefore experienced the travelling as challenging after leaving the clinic, especially in cases where public transport had to be used. These findings indicate the importance of economic and social factors of abortion care and that the services provided expose limitations of equal distributions and similar results have been presented in a different context by de Moel and Shelley (2017).

5.2 Discussion of method

To fulfil the study aim a literature review was conducted. The selection of a literature review to compare abortion services in three regions against a framework provided by WHO was considered appropriate, given the limited time frame and sensitivity of the subject.

The review included both quantitative and qualitative research as both kinds of data were considered advantageous to understand the subject studied. Initially, the objective was to include 30 articles, however only 20 relevant ones were found during the set search period. The aim was to use several databases for the article search as this supports the credibility of the study (Henricsson, 2017). Both CINAHL and PubMed were used as these are recommended by e.g., Karolinska Institute (2022). However, most of the studies included were derived from the initially searched PubMed as most articles appeared in both databases. There is also a current discussion in the scientific field whether one or more search strings should be utilized while conducting literature reviews, and some might argue that this study should have been made on one search string, rather than 15.

Furthermore, it was agreed to only include articles published after the most recent policy changes in each of the regions. This was done successfully but some of the articles were based on data collected whilst previous regulations were in place. This acts as an unavoidable limitation given the tight time frame between policy changes and data collection, and future studies might have broader and more nuanced evidence to base reflections on. Overall, studies from the Irish regions were noticed to more often be based on the perspective of healthcare providers, while all the studies from England, Scotland and Wales were patient-centred. This is potentially a consequence of the lower absolute number of abortion service recipients in

Northern Ireland and Ireland, or that abortion continues to be more stigmatized in these regions. Further research is needed to understand this.

The articles were read individually but the interpretation of the results and application of the framework was continuously discussed by the two researchers, as well as with a supervisor. According to Henricsson (2017), the credibility of reviews improves by using this approach. Being two different authors also provides a possibility to more easily identify individual prejudices. All literature and policies reviewed were read in their original language. Accordingly, translation bias was avoided which improves the trustworthiness of the review. This is further discussed by e.g., Squires (2009).

The choice to use a deductive approach might have contributed to the loss of interesting findings, solely because these did not fit under the study's framework. For example, a recurring theme that was not included in this analysis discussed the lack of funding for abortion care in the Irish regions and the potential dangers this might cause for future services (Kirk et al., 2020). An alternative approach would have been to use an inductive design and develop themes based on the findings from the articles (as described by e.g., Bryman, 2001). However, the chosen method created structure, and the usage of WHO's guidelines clarified the public health relevance of the review. The number of relevant articles available was limited and did not provide information on all subjects discussed in the WHO guidelines. Hence, there are indicators presented in the guidelines that this review could not provide information regarding the regions' delivery on. Moreover, the articles from the different regions covered different topics and perspectives. Thus, comparisons were not always easily made.

This literature review was guided by a framework consisting of WHO recommendations, to ensure access to safe abortion services at the national level. The study reviewed regional capacities to meet these recommendations and the framework was detailed and specific as to standards of care, and help to identify where gaps in national policies and provisions of services exist. Basing the evaluation on a global and objective framework on safe abortion services has been assessed to improve the theoretical transferability of this study's method and the objectivity of the chosen framework implies that the utilization of this study's method can be applicable to an array of cultural and geographical contexts. The thematic analysis was simplified in that the framework made clear what the study aimed to assess, but also required additional scrutiny of the selected studies, as additional steps were needed to compare and contrast the regions included in this study.

The arguable high transferability of this study's results is grounded on the potential interest found by governments in understanding how set abortion regulations, and non-legal factors, influence the actual abortion provision within the jurisdiction. However, Graneheim and Lundman (2004) states that the transferability can only be decided by the reader, but that it can be increased by thorough descriptions of how, and in which contexts, results were obtained.

Inclusion criteria such as peer revision improve the quality of the review (Östlundh, 2017) but might hinder inclusion of valuable grey literature, especially in such cases where the publication limit is arguably narrow (Paez, 2017). While conducting a literature review, ethical considerations must be made regarding representation of the included study researchers.

Moreover, implicit bias is a psychological phenomenon based on an individual's background and experience unconsciously influencing decision making. The peer review process tends to benefit more privileged groups and scientific journals are not immune to gender and racial discrimination. Hence, people of colour, women and younger scientists might systematically find it more difficult to pass a peer review process (IOPScience, n.d.). Accordingly, important perspectives might not have been included in this review. Failure to include relevant literature could impact the internal validity of this study. However, the selected studies benefited from peer-reviews in that such reviews imply that researchers underwent ethical oversight processes, which benefits this review.

5.3 Conclusion

The findings of this study indicate that the abortion laws in the countries of the United Kingdom and Ireland are relatively aligned with the recommendations provided in the recently published WHO framework. However, reviewed literature shows that non-legal barriers impact the actual provision of abortion services. While the abortion services carried out in the regions are safe and complication rates are low, many women, especially in Ireland and Northern Ireland, report that the lack of clinics and trained medical providers reduce the accessibility of care. These findings indicate that non legal barriers need to be managed in order for policies to be operative. Furthermore, the review revealed inequalities related to service provision in all of the three regions, based on residential area and/or economic assets, which is something that should be considered when developing healthcare functions. Finally, telemedicine services implemented during the pandemic have been assessed as effective, safe and accepted among care recipients and have also been included in recommendations by WHO. The findings of this study further motivate the permanent legalization of these models.

This study has contributed with information on how different regions of the United Kingdom and Ireland deliver abortion services. Moreover, the review has demonstrated how the new WHO guidelines could be used as a framework to evaluate national abortion service provision, and to our knowledge, this is the first study demonstrating this approach. As abortion regulations are currently being discussed worldwide and women's abortion rights are threatened in several parts of the world, research highlighting the topic of abortion care continues to be of highest relevancy. However, as the laws of two of the regions are recently implemented, and the COVID-19 pandemic created quite exceptional care conditions and limitations, it would be valuable to conduct a similar review in a few years when the abortion service provision in these regions have been properly established. Results from a review of research into abortion services related to WHO framework can say something about the type of abortion services provided, and not provided, to inform policy governors regarding the relation between legislation and service provision. By extension, this knowledge could possibly improve the abortion situation for the 40 % of women without access to safe abortion services worldwide.

6 REFERENCES

Abortion Act 1967, UK Public General Acts (1967). https://www.legislation.gov.uk/ukpga/1967/87

Abortion (Northern Ireland) Regulations (2020), S.I. 2020/345. https://www.legislation.gov.uk/uksi/2020/345/regulation/1/made

* Aiken, A., Guthrie, K. A., Schellekens, M., Trussell, J., & Gomperts, R. (2018). Barriers to Accessing Abortion Services and Perspectives on using Mifepristone and Misoprostol at Home in Great Britain. *Contraception, 97(2),* 177–183. https://doi.org/10.1016/j.contraception.2017.09.003

* Aiken, A., Lohr, P. A., Lord, J., Ghosh, N., & Starling, J. (2021a). Effectiveness, Safety and Acceptability of No-test Medical Abortion (Termination of Pregnancy) provided via Telemedicine: A National Cohort Study. *BJOG : An International Journal of Obstetrics and Gynaecology, 128(9),* 1464–1474. https://doi.org/10.1111/1471-0528.16668

* Aiken, A., Starling, J. E., Gomperts, R., Scott, J. G., & Aiken, C. E. (2021b). Demand for Self-managed Online Telemedicine Abortion in eight European Countries during the COVID-19 Pandemic: A Regression Discontinuity Analysis. *BMJ Sexual & Reproductive Health, 47(4),* 238–245. https://doi.org/10.1136/bmjsrh-2020-200880

An Roinn Sláinte Department of Health. 2021. Notifications in Accordance with Cection 20 of the Health (Regulation of Termination of Pregnancy) Act 2018. Annual report 2020. Retrieved April 27, 2022, from https://www.gov.ie/en/publication/ef674-health-regulation-of-termination-of-pregnancy-act-2018-annual-report-on-notifications-2020/

Baron, M. M., Potter, B., & Schrager, S. (2018). A Review of Long-Acting Reversible Contraception Methods and Barriers to Their Use. *WMJ : Official Publication of the State Medical Society of Wisconsin, 117(4)*, 156–159.

Bearak, J., Popinchalk, A., Ganatra, B., Moller, A., Tunçalp, Ö., Beavin, C., Kwok, L. & Leontine, A. (2020). Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion: Estimates from a Comprehensive model for 1990–2019. *Lancet Glob Health, 2020(8),* 1152-1161. https://doi.org/10.1016/S2214-109X(20)30315-6

Berer M. (2017). Abortion Law and Policy Around the World: In Search of Decriminalization. *Health and Human Rights, 19(1),* 13–27.

* Bloomer, F., Kavanagh, J., Morgan, L., McLaughlin, L., Roberts, R., Savage, W., & Francome, C. (2022). Abortion Provision in Northern Ireland: The Views of Health Professionals Working in Obstetrics and Gynaecology units. *BMJ Sexual & Reproductive Health, 48(1),* 35–40. https://doi.org/10.1136/bmjsrh-2020-200959

Bowling, A. (2014). *Research methods in health: investigating health and health services*. (4th ed.). Open University Press

Braun, V. & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3(2),* 77-101. https://doi.org/10.1191/1478088706qp063oa

* Broussard K. (2020). The Changing Landscape of Abortion care: Embodied Experiences of Structural Stigma in the Republic of Ireland and Northern Ireland. *Soc Sci Med, 245*. https://doi.org/10.1016/j.socscimed.2019.112686

Bryman, A. (2001). *Social Research Methods*. (1st ed.). Oxford University Press

* Caird, L., Cameron, S. T., Hough, T., Mackay, L., & Glasier, A. (2016). Initiatives to Close the Gap in Inequalities in Abortion Provision in a Remote and Rural UK setting. *The Journal of Family Planning and Reproductive Health Care, 42(1),* 68–70. https://doi.org/10.1136/jfprhc-2015-101196

* Calkin, S. & Berny, E. (2021). Legal and Non-legal Barriers to Abortion in Ireland and the United Kingdom. *Medicine access @ Point of Care, 5,* 1-10. https://journals-sagepub-com.libraryproxy.his.se/doi/pdf/10.1177/23992026211040023

* Cameron, S. T., Glasier, A., & Johnstone, A. (2016). Shifting Abortion Care from a Hospital to a Community Sexual and Reproductive Health care Setting. *The Journal of Family Planning and Reproductive Health Care, 42(2),* 127–132. https://doi.org/10.1136/jfprhc-2015-101177

Cislaghi, B., Denny, E. K., Cissé, M., Gueye, P., Shrestha, B., Shrestha, P. N., Ferguson, G., Hughes, C., & Clark, C. J. (2019). Changing Social Norms: The Importance of "Organized Diffusion" for Scaling Up Community Health Promotion and Women Empowerment Interventions. *Prevention science : the official journal of the Society for Prevention Research*, *20*(6), 936–946. https://doi.org/10.1007/s11121-019-00998-3

de Moel, C., & Shelley, J. (2017). The Legal and Non-legal Barriers to Abortion Access in Australia: A Review of the Evidence. *The European Journal of Contraception & Reproductive Health Care. 22*. 1-9. https://10.1080/13625187.2016.1276162

Department of Health and Social Care [DHSC] (2022, 4 January). Abortion Statistics, England and Wales: 2020. Retrieved 12 April, 2022, from https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2020/abortion-statistics-england-and-wales-2020

Department of Health and Social Care [DHSC] (2020, 30 March). Temporary Approval of Home use for Both Stages of Early Medical Abortion. Retrieved 10 May, 2020, from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf

Donovan, M. (2019). Improving Access to Abortion via Telehealth. *Guttmacher Policy Review, 22,* 23-28. Retrieved 26 May, 2022, from https://www.guttmacher.org/sites/default/files/article_files/gpr2202319.pdf

* Duffy, D. N., Pierson, C., & Best, P. (2018). A Formative Evaluation of Online Information to Support Abortion Access in England, Northern Ireland and the Republic of Ireland. *BMJ Sexual & Reproductive Health, 45(1), 32–37.* https://doi.org/10.1136/bmjsrh-2018-200086

Eighth Amendment of the Constitution Act (1983), Houses of the Oireachtas (1983). https://www.irishstatutebook.ie/eli/1983/ca/8/enacted/en/print.html

Erdman, J. N. & Cook, R. J. (2020). Decriminalization of Abortion - A Human Rights Imperative. *Best Practice & Research Clinical Obstetrics & Gynaecology, 2020(62).* 11-24. https://doi.org/10.1016/j.bpobgyn.2019.05.004

Framework. (n.d.). Merriam-Webster.com Dictionary, Merriam-Webster, Retrieved 13 May, 2022, from https://www.merriam-webster.com/dictionary/framework

Francis, S., Shrestha, P, N., Shrestha, B., Ferguson, G., Batayeh, B., Hennink, M. &Clark, C, J. (2021). The Influence of Organised Diffusion on Social Norms Change: Addressing Intimate Partner Violence in Nepal. *Global Public Health, 16(4),* 610-622. https://10.1080/17441692.2020.1845767

Graneheim, U. H., & Lundman, B. (2004). Qualitative Content Analysis in Nursing Research: Concepts, Procedures and Measures to achieve Trustworthiness. *Nurse education today, 24(2),* 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

* Grimes, L., O'Shaughnessy, A., Roth, R., Carnegie, A. & Duffy, D. N. (2022). Analysing MyOptions: Experiences of Ireland's Abortion Information and Support Service. *BMJ Sexual & Reproductive Health, bmjsrh-2021-201424.* https://doi.org/10.1136/bmjsrh-2021-201424

Hanschmidt, F., Linde, K., Hilbert, A., Riedel-Heller, S, G. & Kersting, A. (2016). Abortion Stigma: A Systematic Review. *Perspective on Sexual and Reproductive Health, 48(4),* 169-177. https://10.1363/48e8516

Health (Regulation of Termination of Pregnancy) Act (2018), Houses of the Oireachtas (2018). https://www.irishstatutebook.ie/eli/2018/act/31/enacted/en/pdf

Health Service Executive [HSE]. (2018). Surgical Abortion. Retrieved 6 May, 2022, from https://www2.hse.ie/conditions/abortion/methods/surgical/

Henricson, M. (2017). Diskussion [discussion]. In M. Henricson (ed.), *Vetenskaplig teori och metod: från idé till examination inom omvårdnad* [Scientific theory and method: From idea to examination in nursing]. (2nd ed.). Studentlitteratur AB

Hillen, J., Mallon, S. & Morgan, S. (2022). Northern Ireland Hospital Based Termination of Pregnancy Statistics 2020/2021. Hospital Information Branch Information & Analysis Directorate. https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-termination-of-pregnancy-stats-20-21.pdf

* Hoggart, L., Newton, V. L., & Bury, L. (2017). 'Repeat Abortion', a phrase to be avoided? Qualitative Insights into Labelling and Stigma. *The Journal of Family Planning and Reproductive Health Care, 43(1),* 26–30. https://doi.org/10.1136/jfprhc-2016-101487

* Horgan, P., Thompson, M., Harte, K., & Gee, R. (2021). Termination of Pregnancy Services in Irish General Practice from January 2019 to June 2019. *Contraception, 104(5),* 502–505. https://doi.org/10.1016/j.contraception.2021.05.021

Human Fertilisation and Embryology Act 1990, UK Public General Acts (1990). https://www.legislation.gov.uk/ukpga/1990/37

International Planned Parenthood Federation [IPPF]. (2014). Youth and Abortion: Key Strategies and Promising Practices for Increasing Young Women's Access to Abortion Services. https://www.ippf.org/resource/youth-and-abortion-guidelines

IOPScience. (n.d.). Implicit Bias in Peer Review. Retrieved 9 May, 2022, from https://publishingsupport.iopscience.iop.org/questions/implicit-bias/

Karolinska Institute. (2022, 6 April). Structured Literature Review - A Guide for Students. Retrieved 9 May, 2022, from https://kib.ki.se/en/search-evaluate/systematic-reviews/structured-literature-reviews-guide-students

* Kirk, S., Morgan, L., McDermott, S., McLaughlin, L., Hunter, C., & Farrington, T. (2021). Introduction of the National Health Service Early Medical Abortion Service in Northern Ireland - An Emergency Response to the COVID-19 Pandemic. *BMJ Sexual & Reproductive Health, 47(4),* 293–295. https://doi.org/10.1136/bmjsrh-2020-200920

* Kumar, U., Pollard, L., Campbell, L., Yurdakul, S., Calvete, C. C., Coker, B., Chen, T., & Douiri, A. (2019). Specialist Follow-up Contraceptive Support after Abortion- Impact on Effective Contraceptive use at Six Months and Subsequent Abortions: A Randomised Controlled Trial. *PloS one, 14(6),* e0217902. https://doi.org/10.1371/journal.pone.0217902

* Lee, E., Sheldon, S. & Macvarish, J. (2018). The 1967 Abortion Act fifty years on: Abortion, Medical authority and the Law Revisited. *Social Science & Medicine, 212,* 26-32. https://doi.org/10.1016/j.socscimed.2018.07.010.

Moreau, C., Shankar, M., Glasier, A., Cameron, S., & Gemzell-Danielsson, K. (2021). Abortion Regulation in Europe in the era of COVID-19: A Spectrum of Policy Responses. *BMJ Sexual & Reproductive Health, 47(4),* e14. https://doi.org/10.1136/bmjsrh-2020-200724

National Abortion Federation [NAF] (2020). 2020 Clinical Policy Guidelines for Abortion Care. https://prochoice.org/wp-content/uploads/2020_cpgs_final.pdf

National Health Service [NHS]. (2020). What happens - Abortion. Retrieved 6 May, 2022, from https://www.nhs.uk/conditions/abortion/what-happens/

Northern Ireland (Executive Formation etc) Act (2019), UK Public General Acts (2019). https://www.legislation.gov.uk/ukpga/2019/22/section/9

Offences against the Person Act 1861, UK Public General Acts (1861). https://www.legislation.gov.uk/ukpga/Vict/24-25/100

* O'Shaughnessy, E., O'Donoghue, K. & Leitao, S. (2021). Termination of Pregnancy: Staff Knowledge and Training. *Sexual & Reproductive Healthcare, 28,* 100613. https://doi.org/10.1016/j.srhc.2021.100613

Paez, A. (2017). Gray Literature: An Important Resource in Systematic Reviews. *J Evid Based Med, 10*, 233– 240. https://doi.orr/10.1111/jebm.12266

Public Health Scotland. (2021). Termination of Pregnancy: Year ending December 2020. https://publichealthscotland.scot/media/7976/2021-05-25-terminations-2020-report.pdf

* Purcell, C., Cameron, S., Lawton, J., Glasier, A. & Harden, J. (2017). Self-management of First Trimester Medical Termination of Pregnancy: A Qualitative Study of Women's Experiences. *BJOG an international Journal of Obstetrics and Gynecology, 124(13),* 2001-2008. https://doi.org/10.1111/1471-0528.14690

* Reynolds-Wright, J.J., Johnstone, A., McCabe, K., et al. (2021). Telemedicine Medical Abortion at Home under 12 weeks' Gestation: A Prospective Observational Cohort Study during the COVID-19 Pandemic. *BMJ Sexual & Reproductive Health*, *47*, 246-251. https://srh.bmj.com/content/47/4/246

Shanawani H. (2016). The Challenges of Conscientious Objection in Health care. *Journal of Religion and Health*, *55(2),* 384–393. https://doi.org/10.1007/s10943-016-0200-4

Singh, S., Wulf, D., Hussain, R., Bankole, A. & Sedgh, G. (2009). Abortion Worldwide: A Decade of Uneven Progress. Guttmacher Institute.

* Stifani, B. M., McDonnell, B. P., Corbett, G., Avila, K., Chavkin, W., Russell, N., & Benfield, N. C. (2021). Attitudes and Experiences with Termination of Pregnancy among Irish Obstetrics & Gynaecology Trainees in the context of Recent Legal Change: A Survey Study. *European Journal of Obstetrics & Gynecology and Reproductive Biology: X*, *13,* 100137. https://doi.org/10.1016/j.eurox.2021.100137

Suri, H. 2020. Ethical Considerations of Conducting Systematic Reviews in Educational Research. In O. Zawacki-Richter, M. Kerres, S. Bedenlier, M. Bond, and K. Buntins (ed.). *Systematic Reviews in Educational Research*. (p. 41-54). Springer VS. https://doi.org/10.1007/978-3-658-27602-7_3.f

Squires A. (2009). Methodological Challenges in Cross-language Qualitative Research: A Research Review. *International Journal of Nursing Studies*, *46(2),* 277–287. https://doi.org/10.1016/j.ijnurstu.2008.08.006

United Nations [UN]. (n.d.). The 17 goals. Retrieved April 11, 2022, from https://sdgs.un.org/goals

* Whitehouse, K. C., Blaylock, R., Makleff, S., & Lohr, P. A. (2021). It's a small bit of advice, but actually on the day, made such a difference…: Perceptions of Quality in Abortion Care in England and Wales. *Reproductive Health, 18(1*), 221. https://doi.org/10.1186/s12978-021-01270-0

World Health Organization [WHO]. (n.d.). Abortion, Barriers to Safe Abortions. Retrieved November 18, 2021, from https://www.who.int/health-topics/abortion#tab=tab_3

World Health Organization [WHO]. (2022). Abortion care guideline. ISBN 978-92-4-003948-3

World Health Organization [WHO]. (2021, 25 November). Abortion. Retrieved April 11, 2022, from https://www.who.int/news-room/fact-sheets/detail/abortion

World Health Organization [WHO]. (2020). Basic Documents: Forty-ninth edition. ISBN 978-92-4-000051-3

World Health Organization [WHO]. (2012). Safe Abortion: Technical and Policy Guidance for Health Systems (2:nd ed.). ISBN 978 92 4 154843 4

Östlundh, L. (2017). Informationssökning [Information Retrieval] . In F, Friberg (Ed.), Dags för uppsats – Vägledning för litteraturbaserade examensarbeten [Time for Essay - Guidance for Literature Based Degree Theses]. (3d ed.). (p. 172). Studentlitteratur AB.

7 APPENDICE

7.1 Appendix A

Article	Country	Abortion regulation	Services across the continuum of care	Pre abortion care	Abortion care	Post-abortion care	Service-delivery options and self-management approaches	Values
Aiken et al. (2018) Examine British women's reasons to contact informal abortion care provider Women on Web Mixed method study (content analysis + demographic analysis)	England, Scotland and Wales	There are women experiencing barriers to access legally available abortion services. Some immigrants and visa holders cannot access legal abortion.		30% that contacted the informal provider did it due to privacy and confidentiality concerns. Also, prior negative experience of abortion care, stigma and family/partner disapproval.			Some women rather seeked informal care to be able to have an at-home abortion, due to logistic reasons (distance/children/work), preferences, mental health problems.	30% that contacted the informal provider did it due to privacy and confidentiality concerns. Also, prior negative experience of abortion care, privacy concerns, stigma, living in small communities.
Aiken et al. (2021a) Compare the outcome of in-clinic and telemedical abortions Cohort study	England and Wales	from 30/3-2020 no-test medical abortion allowed at home up to 10 weeks of pregnancy	Consultation over video/telephone, information regarding post-abortion care provided verbally, in writing and through online resources	Mean waiting time from referral to treatment was 4.2 days shorter after telemedicine-model was introduced, ultrasound was only required if necessary, after ultra sound patients could take medicines at home.	No-test medical abortion is only permitted before 10 weeks gestation, WHO recommendation says 12 weeks. Telemedicine model compared to traditional in-person care showed better effectiveness, treatment success and serious adverse events did not differ between methods. 96% acceptability of telemedicine and 80% reported it as a preference for the future.	24/7 telephone service, each patient is informed about signs of failed abortion/complications and handed a pregnancy test.	Telemedicine model compared to traditional in-person care showed better effectiveness, treatment success and serious adverse events did not differ between methods. 96% acceptability of telemedicine and 80% reported it as a preference for the future. Medicines delivered to home or to collect at clos clinic. Further evidence that the new telemedicine model improved abortion access is that the rate of women seeking abortion outside the formal healthcare sector was significantly reduced.	
Aiken et al. (2021b) Investigate whether demand for self-managed abortion provided by online telemedicine increased during the beginning of the Covid-19 pandemic Retrospective cohort	Northern Ireland, Great Britain	Few European countries made major changes regarding abortion accessibility except for Great Britain, legal risks associated with telemedicine.	Northern Ireland recorded a significant increase in telemedicine requests from private telemedicine services (Women on Web) since in-clinic appointments were only available by traveling abroad which during the pandemic was not possible.	Great Britain authorized abortions without the need for in-person tests or ultrasounds.		Follow up care is recommended to be provided in person.	When Great Britain implemented a fully remote no-test telemedicine service in 2020 an 88% decrease in requests from private telemedicine services (women on Web) was recorded, this decrease points to the need for removal of barriers in abortion care. Northern Ireland showed a 28% increase in requests, observed increases in telemedicine requests may represent a shift in demands from in-clinic to self-managed abortions, a "pills by post" service was introduced in Northern Ireland by BPAS, the implementation of telemedicine in line with WHO recommendations would help to meet the demand for truly patient-centred care.	

Article	Country	Abortion regulation	Services across the continuum of care	Pre abortion care	Abortion care	Post-abortion care	Service-delivery options and self-management approaches	Values
Bloomer et al. (2021) Investigate the views of health professionals on decriminalization and their willingness to participate in abortion care Cross-sectional descriptive study	Northern Ireland	A majority of clinical staff support decriminalization of abortion up to 24 weeks gestation.	Results indicate a lower support of decriminalization and willingness to participate in both medical and surgical abortions amongst sexual and reproductive health (SRH) clinicians, who are currently the providers of early medical abortion services in NI.	The rapidly set up sexual and reproductive health clinics (following the Covid-19 pandemic) met a substantial proportion of abortion needs, providing short waiting times.		The rapidly set up SHR clinics (following the Covid-19 pandemic) met a substantial proportion of abortion needs, providing post-abortion contraception.		Significant differences regarding beliefs of decriminalization and willingness to participate in medical or surgical abortions between study groups were reported. However, the overall results indicate favourable factors for the development of abortion services.
Broussard, K. (2020) Investigate experiences of structural stigma regarding abortions in Ireland and Northern Ireland Semi-structured, in-depth interviews	Northern Ireland, Ireland	Fear of legal repercussions, greater access allows women to terminate their pregnancies at earlier gestations, decriminalization of self-managed abortion would lead to a reduced stigma.	Greater need for further information regarding the process and what to expect, misinformation regarding safety of self-managed abortion methods.	Patient experiences would improve by reducing waiting periods.		Respondents that preferred the clinic stated the thought of self-managing as associated with fears of complications.	Self-managing allows the patient to feel more empowered regarding how they want the procedure to be carried out, many respondents requested telemedicine as their geographical position didn't allow for in- clinic abortions, popular discourse portrays telemedicine as dangerous.	The ability to choose the abortion method is strongly associated with dignity and autonomy, structural stigma influences the abortion experience. The English policy change of 2018, allowing women to take the second medication at home is presented as a good example for future regulation changes.
Caird et al. (2015) Piloting four different initiatives that could poentially improve abortion services for women living inremote Scottish area Evaluation	Scotland			Abortion clinic in remote area is only open once a week, women have to wait for assessment and abortion. Piloting delivering abortion from local clinics did not show any success as it happened to rarely for the staff to train routines and procedures and medicines expired.	Only using local anaesthesia instead of general for early abortions (<9 weeks) made it possible for women to have assessment, abortion and discharge at the same day. Availability of doctors was a problem but 83% of women stated they would recommend this type of abortion. Outpatient medical abortion was only allowed if the woman lived 30 minutes from the hospital where she took the first medication, studies from Norway have shown that an hour is a better limit. The women who had an outpatient medical abortion reported it as a positive experience.		Some women in these areas had to travel over 100miles for assessment. Telephone assessment and consultation was a successful approach.	

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Calkin and Berny (2021) Comparing legal and non-legal barriers to abortion care in three regions. Policy review	UK and Ireland	In Ireland, women >12 weeks gestation are denied care and forced to travel abroad, doctors find the law too restrictive. In NI, most of the Trusts only provide care <10 weeks gestation, despite the legal 12-week limit. Scottish abortion settings are difficult to access >18 weeks, despite the 24-week limit in the UK. In Wales as of 2019, there were no surgical options provided beyond 16 weeks and in many cases beyond 12 weeks. The English abortion providers interpreter the regulations in the least restrictive way, and 98% of performed abortions were granted due to the risk of the person's mental health. Many women still rely on England's clinics to access abortion care.	The Northern Ireland Health Minister is yet to commission abortion care, and the services are not easily available to abortion seekers. In England, there are limited services for women with medical complexities, which in 2019 resulted in 46 cases where BPAS was unable to secure hospital treatment leading to the women having no option but to continue with their pregnancies.	The mandatory waiting period in Ireland leads to the denial of care for some abortion seekers. A geographical unevenness has been recorded due to obstructive doctors. In England, two doctors need to approve abortions which might cause delayed care. The criminal law framework might also incite fear in some practitioners. The limited accessibility of abortion care for later pregnancies might be because of the lack of support from medical providers "distaste" for later abortions. Abortion access in Scotland and Wales differs in different regions depending on the services authorized at a local level.	Ireland - 98% of abortions took place before 12 weeks gestation (2019). England - 85 % of abortions were induced with medication rather than vacuum aspiration (2020). Scotland - in 2020, 81% of abortions took place <9 weeks and 97% were carried out medically.		The geographical unevenness in the Irish abortion services were temporarily ameliorated by telemedicine services introduced during the Covid-19 pandemic. This temporary provision has, in the UK, lead to waiting times falling by more than a week. It also led to abortions taking place at earlier gestations which demonstrates that the previous legal requirement of taking the first pill in a clinic acts as a barrier to abortion care. The temporary change also resulted in the largest percentage of abortions carried out under 9 weeks since reporting in Scotland began as well as lifting the barriers to abortion care for certain populations in the country. Inadequate services will continuously lead to a higher demand for self- managed abortions.	Fear of legal prosecutions have been reported in all regions, as well as the stigma around abortion seeking. Uneven accessibility creates an unequal distribution of services for people in remote areas or with a lower socio-economic status.
Cameron et al. (2016) Compare abortion delivery between hospital and SRH clinic setting in terms of effectiveness, safety and patient satisfaction Medical journal review + surveys	Scotland		Women rate both hospitals and SRH clinics very good at delivering information (93% and 100%, respectively). Surveys with UK SRH clinicians show enthusiasm about delivering more abortion care.	All women at both settings had their gestational age assessed by ultrasound. Waiting time decreased from 7 to 5.9 days when care was delivered from SRH.	Outpatient early medical abortion in community sexual and reproductive health services (SRH) is as safe as when delivered from hospital setting.	No difference between setting in terms of reattendance for complications, higher success rate for abortions at SRH (women did pregnancy test after 2 weeks), more telephone contact after from women having abortion at SRH (false worries about failed abortion).		
Duffy et al. (2018) Assessing available abortion information online Formative evaluation	England, Northern Ireland, the Republic of Ireland		Web based searches were made to evaluate the quality of the results. Less than 1/3 of sources were judged as good/excellent, almost 1/2 of all articles, regardless of regions, was inaccurate with the countries' current legislative. Northern Ireland showed most inaccurate information (48.4%) and Republic of Ireland the least (45.5%).				Telemedicine services were only available in Northern Ireland and the republic of Ireland (at the time of the research) provided by voluntary organizations in the Netherlands.	

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Grimes et al. (2022) Research Irish residents' experience of the service of MyOptions Cross sectional, mixed methods survey	Ireland	Need for added service regarding appointment bookings, need for more information for patients >12 weeks gestation.	More training is needed, MyOptions does not arrange appointments, article argues for serious limitations with the service.	Takes time to make an appointment, 19% stated doctors were unwilling to provide care or help, problem with conscientious objection.	Surgical abortions are rarely offered.			Lack of trust, patients are left for themselves, unnecessary stress, not accessible for patients who are deaf or would rather keep the contact methods to texts or email.
Hoggart et al. (2017) Evaluate the demographics of women having more than one abortion and examine the study population's own experience of having more than one abortion Mixed method study (demographic analysis + qualitative interview study)	England and Wales	Policy concern around 'repeat abortion' was included in British governments' 2013 framework for Sexual Health Improvements without accompanying rationale.			It's not uncommon to have several abortions during the reproductive lifespan.	In 2014, 37% of all abortions in England and Wales were subsequent. There was not an evident pattern for post abortion behaviour for women who in a later phase of life have subsequent abortions. However, many women wish not to get pregnant again and therefore try to change contraception method. However, women having another unintended/unwanted pregnancy report getting pregnant even while using contraception (emergency contraception methods included) or difficulties continuing contraception due to side effects. There was a dissatisfaction with available contraception methods, and these cannot be argued as a tool to reduce abortions if they are not acceptable to its users.		Women having more than one abortion experience intensified stigmatisation, shame and self-blame even in cases where contraception methods were used. Also, the language used in media highlights repeated abortion as something shameful and problematic.
Horgan et al. (2021) Describe how a GP-delivered community medical abortion service is provided in Ireland Retrospective chart review	Ireland	Five cases (out of 420) during a 6-month period had a gestational age exceeding legal limit, need for pathway for these cases.		Need for research regarding whether the three-day mandatory waiting time enhances safety or acts as a barrier to care.	Abortion care follows national guidelines.	6 cases (out of 420) had a mild infection, 33 were referred to hospital, contraception use in the post- abortion group went from 34% to 69%. The article refers to WHO's guidelines regarding abortion services.		
Kirk et al. (2021) Investigate the experience of the implemented abortion care during the pandemic in Northern Ireland Retrospective cohort	Northern Ireland		Without (geographical) access to clinics, many women went without local care. A partnership with the charity Informing Choices NI was established to facilitate self-referral, initial assessments and safeguarding.	Out of 572 initial clients during the first three months after the decriminalization, 1/3 were treated as very early medical abortions, which allows treatment without ultrasound. This was made possible due to quick referrals and short waiting times.	There is no surgical option and no service for women at 10 weeks gestation or more, which means Northern Irish women still need to travel abroad to access abortion services.	No reported serious complications and contraception is offered at all clinics.	The second medication (Mifepristone) could during the pandemic be taken at home, however the home use of Misoprotol was not authorized as it was in the rest of the UK.	During lockdowns, there was a significant absence of anti-choice protests. Safe local treatment is still inaccessible for many women.

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Kumar et al. (2019) Exmine if the post-abortion use of contraception methods increase for women receiving specialist counceling RCT	England					Women in England are obliged to free contraceptive methods. A group of women who had had an abortion and then received specialist contraceptive support 2-4 weeks and 3 months post-abortion neither reported greater contraception use after 6 months or fewer subsequent abortions after 2 years than the control group of women only receiving standard care (information on how to consult SRH or GP). However, the per protocol group did show better results for abort outcomes.		
Lee et al. (2018) Revisit the "remarkable authority" that the Abortion Act (1967) ascribed to doctors. Semi-structured interview schedule	England and Wales	Medical professionals stated the law as a hampering force to the exercise of clinical judgment. The 1967 Act decriminalized abortions in cases where certain conditions were met.	Medical professionals found that an array of medical practitioners should be allowed to work with abortion cases, as long as they have the right attitude and experience.	The "two doctors' signature" is, by medical practitioners, strongly resented and presented as a barrier to care. An overall support of allowing nurses to prescribe and perform abortions.			The 50-year-old Act is interpreted to mean that both abortifacient agents must be taken on licensed premises. Overall support from medical providers of self-managing abortions and they referred to the proven safety and effectiveness seen in other countries.	Abortions services were, by health practitioners, spoken of as an integral part of health. The practitioner's role is to relieve stress and abortion services should therefore be talked about as a normal part of healthcare. Working with abortion was presented as fulfilling. The fact that the abortion seeker should be able to freely decide is emphasized. Autonomy and dignity were discussed in every theme in the article, but also equality and stigma.
O'Shaughnessy et al. (2021) Investigate staff knowledge on abortion services Cross sectional study	Ireland	Staff presented lack of knowledge (except regarding gestation for early pregnancies)	Lack of knowledge is stated as barrier to care, information and qualitative counselling.	Staff presented a lack of knowledge regarding pre abortion care.	A majority of staff members knew about the main abortion methods.	Staff wanted more training.		The lack of knowledge that comes from sudden policy changes acts as a barrier to safe care.

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Purcell et al. (2017) Exploring Scottish women's experience of passing an abortion at home after having administrated abortifacient agents in-clinic Qualitative interview study	Scotland		The women felt well informed regarding the process of the passing and said this was an important factor to feel comfortable passing at home.		Participants primarily found passing a medical abortion at home to be acceptable and/or preferable, particularly where this was experienced as a decision made jointly with health professionals. However, the experience of this differed, some women appreciated the privacy and wished the medicine could have been administrated at home as well, others felt forced to pass at home. The transport from the hospital to home was challenging for many women experiencing bleedings and pain. Especially for women who did not have anyone who could drive them or afford a taxi felt very exposed in public transport.	Women found it reassuring that they could make telephone contact with the clinic in case of concerns. They were also provided with a pregnancy test to take after two weeks to confirm the success of the abortion.		
Reynold-Wright et al. (2021) Assess the effectiveness, safety and acceptability of telemedical abortion Cohort study (questionnaires + medical journals)	Scotland	The abortion law in Scotland was changed to permit telemedical abortion service from the first of April 2020.	Information regarding the telemedical approach was available via NHS online.	Women older than 16 could have telephone consultation. During consultation the need of ultrasound was analysed based on gestational age/pregnancy symptoms/last period. 21.3% of women needed pre-ultrasound.	Women administrated both medications at home. 98% of abortions were successful.	Women were provided with low sensitivity pregnancy tests to determine success of abortion. Contraception consultation was provided during the pre-abortion consultation and women who wished were sent pills and/or condoms. However, the rate of women having chosen a LARC method was very low (< 1/10) compared to previous studies (1/3). It's not possible to say if this was due to the pandemic or the telemedical approach. Also 18,5% of women made telephone contact due to concerns for complications and/or ongoing pregnancy, and 8,4% attended a clinic for check-up. This is higher than expected but could be due to the questionnaire on day four actively forcing women to reflect upon potential complications etc.	Telemedical abortion with consultation over telephone, gestational age determined based on the date of last menstrual period and delivery of drugs for administration at home was permitted for medical abortion < 12 weeks during the pandemic. 95% of women were very or somewhat satisfied with the telemedical approach and 89% would opt for a telemedical abortion again if they had to.	

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Stifani et al. (2022) Examine Irish obstetrics and gynaecology trainees' experiences with abortion services Cross sectional web-based survey	Ireland	58.8% of respondents (obstetrics and gynaecology trainees) reported being in favour of the current Irish law. 20% believed abortion services should be available upon request even after 12 weeks gestation. 20% were in favour of a more restrictive law.	70.6% of respondents had a "perfect knowledge score" regarding abortions.		23.5% reported previous involvement in abortion care outside of Ireland. 76.5% currently worked in units providing abortion services. >60% had participated in abortion care since the service was introduced but only 25.5% had provided surgical abortions. Results also indicate that 30% of respondents would be more willing to provide medical abortions rather that surgical.	Results indicate concerns about complications following surgical procedures.		More than 2/3 were willing to provide abortion care in the future (supportive care), however, more training and exposure is needed to enable professional support.
Whitehouse et al. (2021) Examine women's perception of qualitative abortion care Qualitative interview studies	England and Wales	Independent abortion providers can only provide abortion care up to 23 weeks and 6 days of gestation.	Being well informed with correct information important factor of QOC. Being informed through several sources improved QOC. Wanted information to cover post-abortion support, complication signs, time expectations.	Short waiting time had a large impact on the experience of care.	BPAS provide 43% OF abortions in England and Wales (50 clinics, 5 telemedicine hubs, only one clinic can provide medical abortion after 10 week), some participants reported feeling rushed when having an abortion, some participants said they didn't get prepared about the pain, some participants reported not getting to pick abortion method due to gestational age (negative experience).	Identification of excess bleeding and access to postabortion counselling is information that women experience would increase the QOC, positive experience not feeling pressured to use certain contraception methods.	Positive experience being able to choose abortion environment, long travel distance negative experience of abortion, difficulties with childcare and travel expenses. Participants who'd had telephone consultation said this was a good experience.	Some waiting rooms lacked privacy, concerns to be recognized, protesters outside of clinics.

7.2 Appendix B

Article	Checklist	Article strengths	Article limitations
Aiken et al. (2018)	GRAMMS - mixed method studies	Motivated use of both methods, no sample - all inquiries to organization was analyzed, emails were anonymized before analysis, clear suggestions on how abortion availability could improve in UK	Only covered one specific organization
Aiken et al. (2021a)	CASP - cohort studies	Covered three main abortion providers, large sample (n=52 142), adjusted for baseline differences between groups, several outcome measurements, proper discussion of limitations.	Could not capture minor complications, patient behavior could have changed due to the pandemic
Aiken et al. (2021b)	STROBE - observational studies	Clear exclusion criteria, relevant methods and results for future shifts in demands and pre-existing barriers to safe abortion care	Only covered three Covid-affected months (limited time frame)
Bloomer et al. (2022)	STROBE - cross sectional study	Clear study aim, p-values were presented, valuable results	Missing data was excluded from the study, external validity was not discussed
Broussard, K. (2020)	CASP - qualitative studies	Relevant methods and choice of respondents, a pilot test was conducted, gives examples of possible future interventions, the researchers possible effect on respondents was discussed	The results have lost some relevance since national policies have changed, does not present study limitations
Caird et al. (2015)	SQUIRE 2.0	Equity focus, piloted four different interventions	Old, only piloting, brief descriptions
Calkin and Berny (2021)	CASP - systematic review (policy)	Results can be applied to the local population, the review address a clearly focused question	An explanation on how data was collected is missing, limited time frame between policy changes and data collection
Cameron et al. (2016)	STROBE - observational studies	the only comparative study of outpatient EMA delivered from a community and hospital setting in the same city, in the same population, using the same clinical protocols, and compared over the same time frame.	The gestational mean age was different at the two settings, thus influencing risks for complications, waiting times etc. Could only access local hospitals computer systems, complications that were taken care of elsewhere were not tracked.
Duffy et al. (2018)	STROBE - observational studies	Study conducted from a care seeker's perspective rather than per protocol. Covers all the three regions included in review.	Tool used was not peer reviewed
Grimes et al. (2022)	GRAMMS - mixed methods	Valid results that can be used in evaluating the abortion service, good choice of methods	A limited representativeness as an online survey often results in missing data due to respondents choosing to skip questions
Hoggart et al. (2017)	GRAMMS - mixed method studies	Topic not covered by any of the other articles, good mixed method approach, recruitment process planned to avoid stigmatization	Weak findings (women having repeat abortions are a diverse group), does not discuss limitations, the age limit for study population (16-24 years) was not motivated

Article	Checklist	Article strengths	Article limitations
Horgan et al. (2021)	CASP - retrospective cohort studies	Clearly focused issue, similar results have been reported in previous studies	Only a small number of participants despite the larger number of people contacted, biases or confounders were not mentioned
Kirk et al. (2021)	CASP - retrospective cohort studies	Meets study aim with clear results, gives examples for future studies and policy changes	Biases or confounders were not mentioned, only presents official data from national sources
Kumar et al. (2019)	CASP - RCT	RCT design provide the most reliable evidence, analyzed missing data (no significant differences in terms of demographics and between groups), standardized questionnaires used to minimize bias, proper discussion of potential limitations	Low follow up rates (although comparable to similar studies), risk of self-selection bias, interviewer was unblinded
Lee et al. (2018)	CASP - qualitative research	Clear with the lack of generalizability of findings, however, they investigate opinions of an important group	Lack of generalizability, small sample, does not mention what role the researchers might have played
O'Shaugnessy et al. (2021)	STROBE - cross sectional study	Presents limitations and their possible effect on results, usage of relevant methods for data collection and analysis, thorough presentation of results	Small number of participants, recruitment bias, hard to present accurate response rate
Purcell et al. (2017)	CASP - qualitative research	Relevancy could be questioned as women could now administer the medications at home, rich data that gave new insights in women's experiences, recruitment covered both SRH and hospital settings, interview scheme was developed from available literature and with input from study advisory group, member checking for analysis and coding	Small sample that did not allow comparisons with other clinical settings
Reynold-Wright et al. (2021)	STROBE - observational studies	Recent study, combining objective and subjective measurements, high respondent rate (98% and 91%)	The study was conducted during the Covid-19 pandemic, thus the care seeking behavior of women might differ under other circumstances. Ecological validity could be questioned as women were asked to assess signs of complications which might make them experience more symptoms. Missing data has not been analyzed.
Stifani et al. (2021)	STROBE - cross sectional study	Limitations were discussed, every possible participant was contacted, outcomes are presented and explained in a meaningful fashion, . Previously used study questions were included in the study	Respondents who were more interested in the topic might have been more prone to participating, no confounders mentioned, not generalizable for the larger population, no validated tools were used
Whitehouse et al. (2021)	CASP - qualitative research	Not limited to a certain abortion method, themes exemplified with quotations, let participants define QOC themselves, member checked coding and analysis	Lack of ethnical diversity (86% white, all English speaking), participants recruited from independent caregiver - possible to question generalizability to other settings,